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TECHNICAL PROPOSAL | PUBLIC VERSION

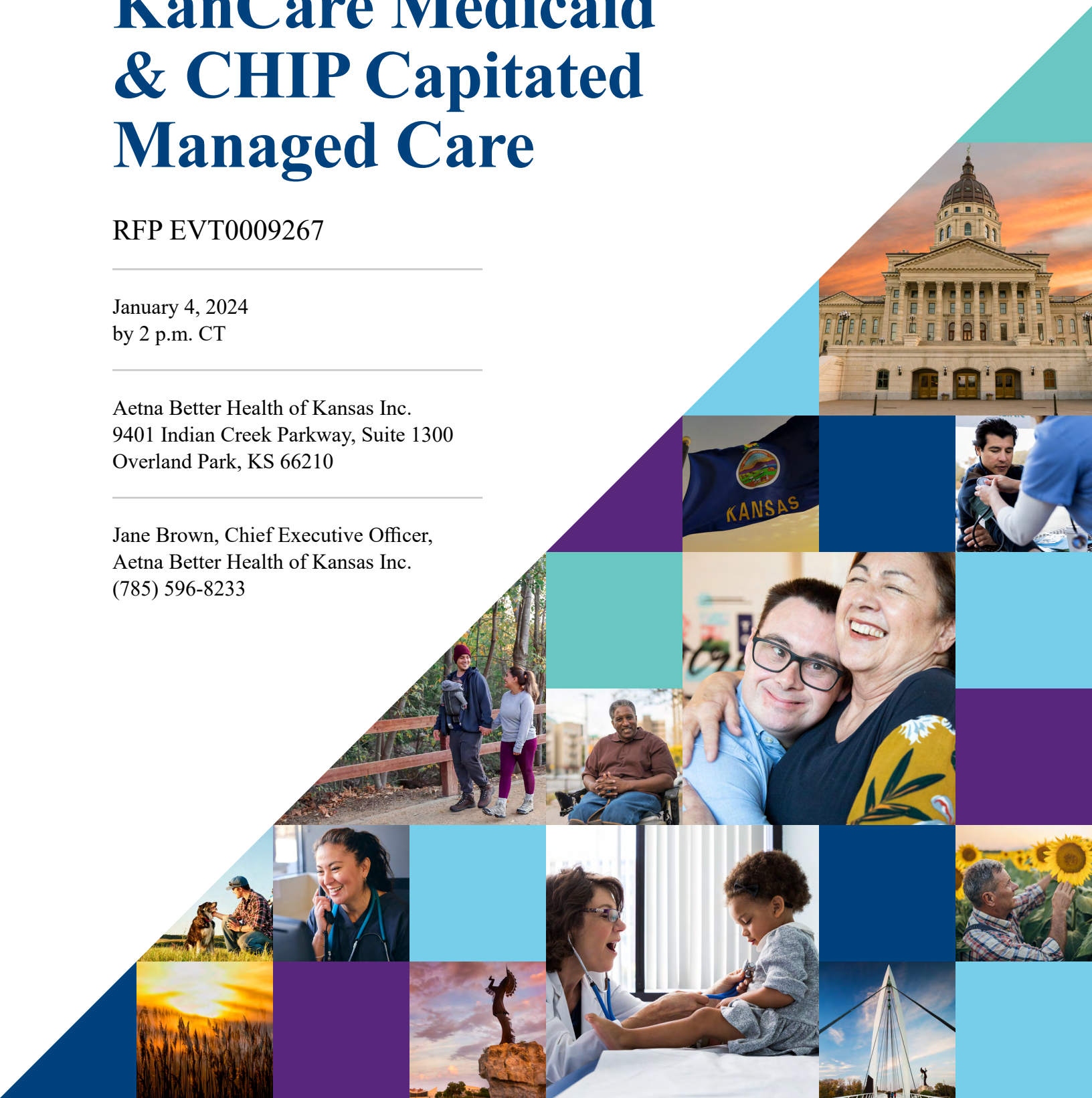
KanCare Medicaid & CHIP Capitated Managed Care

RFP EVT0009267

January 4, 2024
by 2 p.m. CT

Aetna Better Health of Kansas Inc.
9401 Indian Creek Parkway, Suite 1300
Overland Park, KS 66210

Jane Brown, Chief Executive Officer,
Aetna Better Health of Kansas Inc.
(785) 596-8233



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Tab 1

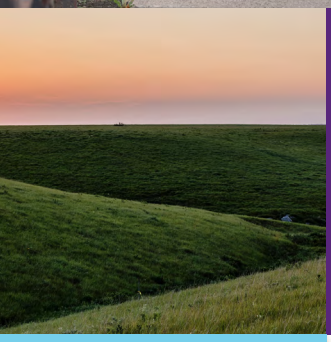

Table of Contents – Technical Proposal

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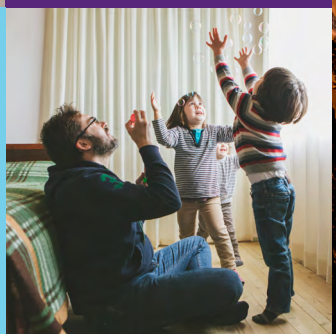
Transmittal Letter

Tab 2



Aetna Better Health® of Kansas
9401 Indian Creek Parkway, Suite
1300 Overland Park, KS 66210

January 3, 2024

Amanda Acuna
Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka, Kansas 66612-1286

RE: Bid Event Number EVT0009267

Dear Ms. Acuna:

Aetna Better Health® of Kansas Inc. is pleased to present its response to the State of Kansas, Kansas Department of Health and Environment, and Kansas Department for Aging and Disability Services for Bid Event Number EVT0009267 for KanCare Medicaid & CHIP Capitated Managed Care.

Aetna attests to the following:

(a) the bidder is the prime CONTRACTOR and identifying all Subcontractors;

Aetna is the prime contractor and has identified all subcontractors in Attachment 4.3a included after this letter.

(b) the bidder is a corporation or other legal entity;

Aetna Better Health of Kansas Inc. is a registered corporation in the State of Kansas.

(c) no attempt has been made or will be made to induce any other person or firm to submit or not to submit a proposal;

Aetna neither has made any attempts nor will it in the future make any inducements to any other person or firm to submit or not submit a proposal.

(d) the bidder does not discriminate in employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin or disability;

Aetna does not discriminate in employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or disability.

(e) no cost or pricing information has been included in the transmittal letter or the technical proposal;

Aetna has not included in the transmittal letter or the technical proposal any cost or pricing information.

(f) The bidder accepts all provisions found in Contractual Provisions Attachment DA-146a (see Attachment 7, Contractual Provisions Attachment DA-146a), which are incorporated by reference and made a part of this CONTRACT;

Aetna accepts all provisions found in Contractual Provisions Attachment DA-146a (see Attachment 7, Contractual Provisions Attachment DA-146a).

(g) The bidder accepts all requirements, terms, and conditions of the RFP. If the bidder has an objection to, or is unwilling to comply with, any of the requirements, terms, or conditions of the RFP, the bidder must identify the exceptions in writing, include the exceptions document in a separate tab labeled "Tab 2a", and include Tab 2a in the Table of Contents;

Aetna accepts all requirements, terms, and conditions of the RFP.

(h) The bidder has no actual, apparent, or potential conflict of interest, direct or indirect, that would conflict with the performance of services under this contract. If the bidder has an actual, apparent, or potential conflict of interest, the bidder must disclose the conflict of interest, include a proposed conflict of interest mitigation plan document in a separate tab labeled "Tab 2b", and include Tab 2b in the Table of Contents;

Aetna presently has no interest, direct or indirect, which would conflict with the performance of services under this contract and shall not employ, in the performance of this contract, any person having a conflict. Notwithstanding the foregoing, we note that Aetna Better Health of Kansas is an affiliate of CaremarkPCS Health L.L.C. (CaremarkPCS), which may provide pharmacy benefit management services in Kansas for Aetna Better Health of Kansas and its competitors. This relationship does not pose an actual or potential conflict of interest given that the business relationship between CaremarkPCS and Aetna Better Health of Kansas will be conducted at arm's length and given the safeguards the combined Aetna and CVS organizations have implemented to ensure appropriate separation of the two organizations.

Integrity is a core value of CVS Health. Where an Aetna Medicaid organization health plan engages affiliates to perform services in support of its operations, it does so pursuant to one or more formal, arm's-length intercompany agreements either directly with the health plan or downstream with an affiliate of the health plan. All such contracts are submitted to appropriate regulators for review and approval, as applicable. We also separate and restrict communication and information exchange across our many business units and affiliates by implementing firewalls to prevent the sharing of member data and competitive information. CVS personnel are required to complete mandatory corporate integrity training that contains a specific module on the identification of potential conflicts of interest and actions employees are required to take if faced with a potential conflict situation, including reporting potential conflicts to the Compliance department. These policies will prevent any actual conflict of interest and maintain fairness, independence, and objectivity.

(i) the person signing the proposal is authorized to make decisions as to pricing quoted and has not participated, and will not participate, in any action contrary to the above statements;

Jane Brown, the person signing the proposal, is authorized to make decisions as to pricing quoted and has not participated, and will not participate, in any action contrary to the above statements.

(j) whether there is a reasonable probability that the bidder is or will be associated with any parent, affiliate, or subsidiary organization, either formally or informally, in supplying any service or furnishing any supplies or equipment to the bidder, which would relate to the performance of this contract. If the statement is in the affirmative, the bidder is required to submit with the proposal, written certification and authorization from the parent, affiliate, or subsidiary organization granting the State and/or the federal government the right to examine any directly pertinent books, documents, papers, and records involving such transactions related to the contract. Further, if at any time after a proposal is submitted, such an association arises, the bidder will obtain a similar certification and authorization and failure to do so will constitute grounds for termination for cause of the contract at the option of the State;

There is a reasonable probability that the bidder, Aetna Better Health of Kansas Inc., will be assisted by the following affiliates, who will provide some of the services related to the performance of this contract: Aetna Medicaid Administrators LLC and CaremarkPCS Health L.L.C. A written certification and authorization from these affiliates granting the State and/or the federal government the right to examine any directly pertinent books, documents, papers, and records involving such transactions related to the contract is included as Attachment 4.3j to our response.

(k) the bidder agrees that any lost or reduced federal matching money resulting from unacceptable performance in a CONTRACTOR task or responsibility defined in the RFP, CONTRACT or modification shall be accompanied by reductions in state payments to CONTRACTOR; and

Aetna agrees that any lost or reduced federal matching money resulting from unacceptable performance in a contractor task or responsibility defined in the RFP, contract, or modification shall be accompanied by reductions in state payments to Contractor.

(l) the bidder has not been retained, nor has it retained a person to solicit or secure a state contract on an agreement or understanding for a commission, percentage, brokerage, or contingent fee, except for retention of bona fide employees or bona fide established commercial selling agencies maintained by the bidder for the purpose of securing business. For breach of this provision, the State shall have the right to reject the bidder's proposal, terminate the CONTRACT for cause and/or deduct from the CONTRACT price or otherwise recover the full amount of such commission, percentage, brokerage, or contingent fee or other benefit.

Aetna has not been retained, nor has it retained a person to solicit or secure a state contract on an agreement or understanding for a commission, percentage, brokerage, or contingent fee, except for retention of bona fide employees or bona fide established commercial selling agencies maintained by the bidder for the purpose of securing business.

Aetna Better Health of Kansas Inc. has proudly served Kansans since 2019 with our entry to the KanCare 2.0 Program. Today, we serve nearly 140,000 Kansans. It would be our sincere privilege to continue to serve and support the State's most vulnerable citizens through the evolution of the KanCare program. We are well-positioned to continue our collaborative partnership to improve coordination and integration of physical health, behavioral health, and long-term services and supports; support members successfully in their communities; promote wellness and healthy lifestyles; identify gaps related to Social Determinants of Health disparities; champion health equity; focus on workforce expansion needs and lower the overall cost of health care. We are passionate in our commitment to the goal of helping Kansans achieve healthier, more fulfilling, and independent lives.

Sincerely,

Jane Brown
Chief Executive Officer
Aetna Better Health of Kansas Inc.

Attachment 4.3(a) Subcontractors

Subcontractor	Services Provided
Access2Care	Provides non-emergency medical transportation (NEMT).
Aetna Medicaid Administrators (AMA)	Provides, among other things, personnel, administrative services, medical management, operations management, financial books, and records management to the Aetna Medicaid organization.
Availity	Provides an online, multi-payer portal for providers, providing access to multiple self-service tools and provider-initiated transactions. Compliant with all HIPAA regulations and no cost for providers to register to use online tools.
Center for the Study of Services	Conducts surveys for Aetna: • Medicaid CAHPS Surveys – Adult and Child • HCBS or other LTSS Member Surveys • Provider Satisfaction Surveys
Cotiviti Services LLC	Provides prospective and retrospective solutions for claims processing including performing checks for billing accuracy, clinical appropriateness, contract compliance, network value, and payment responsibility. Also provides provider overpayment recovery, data mining and Diagnosis-related group ("DRG") services for Aetna Medicaid.
CQ Fluency	Provides language services that require either a written translation or verbal interpretation of a foreign language into English, or vice versa.
mPulse Mobile, Inc.	Provides a multimodal outreach solution that allow health plans to impact members' health and wellbeing as will be measured by Health Plan HEDIS, quality, process, other jointly defined success criteria.
CVS Caremark	Provides pharmacy benefits management services.
eviCore healthcare	Provides utilization management services related to radiology.
Cloud Technology Innovations LLC dba Healthcare Fraud Shield	Provides the Kansas Special Investigations (SIU) functions including identifying fraud, waste, abuse and conducting investigations.
Healthy Profits, LLC d.b.a. HealPros, LLC	Provides services for in-home preventative screenings for Diabetes Retinal Eye (DRE) Exam Screenings and Hemoglobin A1c Testing; RCA is attached to the master as an exhibit, and State notification complete.
Language Line	Providers over the phone interpretation services.
Office Ally	Provides claims clearinghouse. Provides online website and forms for Providers to be able to submit claims electronically. This service is free to Providers.
OptumInsight	Provides services that include contract compliance, duplicate payment, coordination of benefits, data mining, retroactive termination and credit balance services.
ProgenyHealth	Provides NICU care management services.

Subcontractor	Services Provided
Public Partnerships LLC (PPL)	Provides electronic visit verification (EVV) services. Provides services for Supports and Training for Employing People Successfully (STEPS) program.
PYX Health	Provides a platform that combines compassionate humans and an interactive mobile app to help with loneliness/social isolation and its negative health impacts.
Red Card Systems, LLC (aka Zelis)	Performs services relating to the production and delivery of Medicaid identification cards and other enrollment-related print communications to Aetna plan members.
SkyGen	Provides dental and vision services.

Certification

Re: Aetna Better Health of Kansas Inc.'s Response to the KanCare Medicaid & CHIP Capitated Managed Care RFP; Transmittal Letter Section 4.3(j): Certification of Aetna Medicaid Administrators LLC

Aetna Medicaid Administrators LLC certifies as follows:

Aetna Medicaid Administrators LLC, an affiliate of Aetna Better Health of Kansas Inc. (Aetna), will provide certain subcontracted services to Aetna, which will relate to Aetna's performance of any contract awarded as a result of the KanCare Medicaid & CHIP Capitated Managed Care RFP (Contract).

Aetna Medicaid Administrators LLC authorizes the State of Kansas and/or the federal government the right to examine any directly pertinent books, documents, papers and records involving transactions related to the Contract.

Aetna Medicaid Administrators LLC

Bryan Nazworth
Signature

Bryan Nazworth
Name

VP, CFO Medicaid
Title

11/7/2023
Date

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Certification

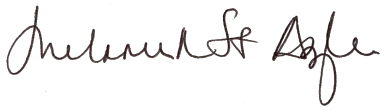
Re: Aetna Better Health of Kansas Inc.'s Response to the KanCare Medicaid & CHIP Capitated Managed Care RFP; Transmittal Letter Section 4.3(j): Certification of CaremarkPCS Health L.L.C.

CaremarkPCS Health L.L.C. certifies as follows:

CaremarkPCS Health L.L.C., an affiliate of Aetna Better Health of Kansas Inc. (Aetna), will provide certain subcontracted services to Aetna, which will relate to Aetna's performance of any contract awarded as a result of the KanCare Medicaid & CHIP Capitated Managed Care RFP (Contract).

CaremarkPCS Health L.L.C. authorizes the State of Kansas and/or the federal government the right to examine any directly pertinent books, documents, papers and records involving transactions related to the Contract.

CaremarkPCS Health L.L.C.



Signature

Melanie K. St Angelo
Name

Assistant Secretary
Title

10/30/2023
Date

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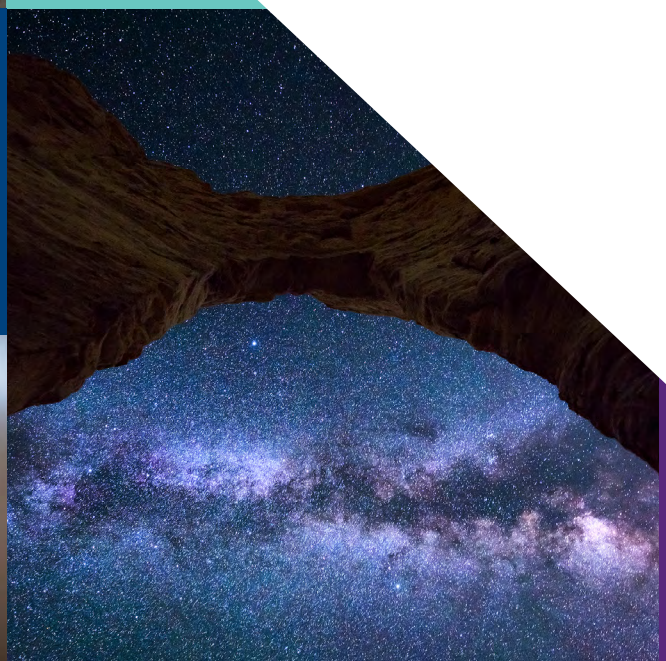
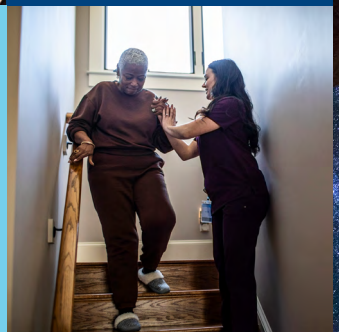
Executive Summary

Tab 3





Executive Summary

2030 Healthy Kansans

> **All people in Kansas reach their full health potential through sustainable, equitable, and empowered communities.**
>
> 138.KS23

As an incumbent MCO in Kansas, Aetna Better Health of Kansas Inc. (Aetna), a division of Aetna Inc., one of the nation's leading diversified health care benefits companies, and part of the CVS Health family, is pleased to submit our proposal to continue to help the State of Kansas, by and through the Kansas Department of Health and Environment (KDHE) and the Kansas Department for Aging and Disability Services (KDADS), advance the vision and goals identified in the Healthy Kansans 2030 State Assessment Report. Our shared vision is to help Members achieve health, wellness, and independence through innovative and collaborative strategies, such as:

- Improve Member experience and satisfaction.
- Improve health outcomes by providing holistic care to Members that is integrated, evidence-based, well-coordinated, and that recognizes the impact of social determinants of health (SDOH).
- Reduce health care disparities.
- Expand our Provider network and direct care workforce capacity and skill sets.
- Improve Provider experience and encourage Provider participation in Medicaid.
- Increase the use of cost-effective strategies to improve health outcomes and the service delivery system.
- Leverage data to promote continuous quality improvement to achieve the goals of the KanCare program.

In compliance with contract requirements and the seven 1915(c) waivers for HCBS, we are passionately dedicated to delivering innovative health care solutions to Kansas' most vulnerable people. Leveraging our Kansas experience and proven approach (described below and throughout our response), we will partner with the State to prioritize the health of Kansans because we know Healthier Happens Together™.

Our Experience—Why Aetna?

We know Kansas and we know Kansans. Since 2019, we have served KanCare Members, supported KanCare Providers, and collaborated with community organizations across Kansas. Today we provide high-quality care and services to nearly 140,000 Kansans, which includes D-SNP, Foster Care, and LTSS Members. During our time in Kansas, we have received:

- NCQA Health Accreditation along with NCQA LTSS Distinction as of 2022
- NCQA Health Equity Distinction with 100% score in September 2022
- STEVIE Award for our Food Insecurity Performance Improvement Project June 2023

In addition to our Kansas experience, we bring Aetna Medicaid's 37 years of experience to Kansas. Today Aetna Medicaid serves 2.6 million Members across 15 health plans and 6.9 million dual-eligible Members across the country. In 2024, our D-SNP plan achieved a 4-Star overall rating along with the superior CAHPs results described in the following table.

CAHPS Measure Category	Star Rating for Kansas D-SNP
Care coordination	5 (out of 5)
Getting needed care	4
Getting needed prescription drugs	5
Overall rating of health plan	5

Additionally, in 2024, 87% of Aetna's Medicare plans across all contracts achieved a 4-Star rating or higher. Our affiliated health plans have pursued and earned NCQA Health Plan Accreditation in 100% of our eligible markets with an average score of 94%, and LTSS and Multicultural Distinction in all eligible Medicaid markets as of 2022. We will leverage Aetna Medicaid's and CVS Health's experience to invest in innovative capabilities in Kansas to set a new standard for health care by creating a more connected and seamless health journey.

Our Approach

Our approach to meeting all RFP requirements includes operational, technical, clinical, and administrative capabilities that reflect our shared values, emphasizing person-centered, local coordination that enables timely whole-person care and addresses fundamental health disparity gaps and Member social needs. Local presence, focusing on holistic well-being, simplicity, leading and implementing change, and attracting and inspiring are the five guiding principles we used to develop our KanCare approach. We will continue to use these same guiding principles as we implement new strategies to meet the changing health care needs of KanCare Members.

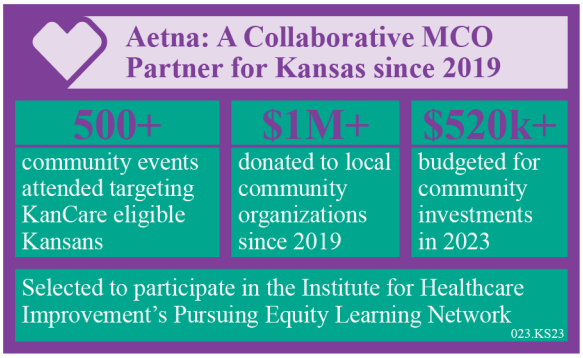
Local Presence

We engage Members with the care they need where, when, and how they need it through our integrated One Team, One Member care coordination model and targeted population health initiatives. Our dedicated staff of over 350 Kansans live and work in the same neighborhoods as those we serve. We have over 200 licensed care coordinators in Kansas, supporting LTSS and non-LTSS Members. Our team is familiar with local issues, health care needs, and cultural considerations. As our team grows, we commit to hiring more Kansans and making significant investments to build a workforce pipeline and address health care shortages through Kansas.

In collaboration with CVS Health, we bring a Medicaid at the Corner Store philosophy to Kansas. This philosophy makes health care services and social supports more convenient and accessible. Members can receive health services at local CVS Health retail locations and at our Community Resource Centers (CRCs) in rural and urban communities. Between Jan. 1 and Aug. 31, 2023, 769 of our KanCare Members visited a MinuteClinic.

Community Investment and Local Partnerships

Healthier Members start with healthier communities. Through local investments and partnerships, we are strengthening Member support networks. Drawing on a legacy of community investment and local support, we work to build healthier communities and care for the most vulnerable populations. Through our parent company, CVS Health, we've invested



nearly $600,000 in Kansas with an additional $320,000 planned in 2024. Additionally, since 2019 Aetna has donated over $1 million to support organizations addressing access to care in rural areas, workforce development in mental health and disability services, child care, food insecurity, and education, including:

- $150,000 to the Kansas University Endowment Association for their Baby Talk program, a pregnancy and newborn education program.
- $70,000 to the Ronald McDonald House Charities of Kansas City.
- $15.7 million for 997 affordable housing units in Kansas for families and older adults.

Focusing on Holistic Well-Being

We help Members achieve better health at a lower cost using data driven analytics with a focus on promoting health equity while addressing SDOH needs and health disparities. Our goal is to improve the collective Member health status by driving improved clinical outcomes that benefit both individuals and communities.

Our population health programs are developed using health equity principles and strategies to increase preventive services, assure appropriate treatment protocols, and increase quality outcomes. This occurs together with value-based purchasing, customized data sharing, a Quality team that works daily with Providers, our Member and Provider Advisory Councils, our national and local Quality and Health Equity teams, and our Better Together: Social Impact Solutions program. We address all factors that influence population health and meet the physical, emotional, and social needs of Members through a fully integrated service model.

Better Together: Social Impact Solutions Programming Curtails Barriers to Care

Our proprietary Better Together: Social Impact Solutions program reduces barriers to care by integrating Members, Providers, and local community-based organizations to meet SDOH needs. We integrate SDOH and health data to provide a nuanced understanding of Members, their communities, and risks to achieving our health equity goal. In November 2023, we launched our Member Real Engagement and Community Help (REACH) Team, a proactive SDOH call center that joins our Social Impact team along with the Community Collaboration and Real Engagement Solutions (CARES) team. CARES focuses on closing service gaps in Kansas communities and attended over 500 events and meetings in 2023 to engage local organizations with measurable impact.

Addressing Health Equity

We are focused on identifying health disparities, addressing social risk factors, and working toward dismantling the systemic and structural barriers that generate bias or discrimination in health care. As a result, we developed a Health Equity HEDIS dashboard to identify and measure Member health disparities by stratifying HEDIS measure rates by race, ethnicity, gender, and age. The dashboard provides intuitive data visualization, reports, predictive analytics, and time series forecasting that allow us to identify populations with disparities and provide actionable insights, track and monitor effectiveness of programs and interventions, implement clinical interventions, conduct Member outreach, and inform value-based contracting.

Simplicity through Clear Member and Provider Engagement Strategies

Making it Easier for Members

We are accustomed to breaking down silos and creating new collaborations to better serve Members. Early and frequent Member engagement leads to higher quality outcomes and lower overall costs. Our focused approach achieved a 32% improvement in our Health Screening Tool (HST) completion rate from January 2020 to November 2023. In 2024, we will implement our After-Hours Care Coordination Outreach support. We also plan to continue using mPulse campaigns to deliver tailored conversations and leverage phone, face-to-face, secure opt-in text, and email outreach. **Our recent 24-month analysis showed the cumulative effect on Members resulted in 20% more obtaining services when they received four modes of outreach instead of only two.** Additionally, our feedback structure includes a Member Advisory Council and a Provider Advisory Council to solicit feedback regarding access to services, service delivery, gaps in support systems, engagement with system staff, cultural competency, and member and family knowledge of services and supports.

Making it Easier for Providers

Since 2019, we have achieved a 36% Provider network growth rate (**Figure ES-1**) with all Providers participating in a value-based program.

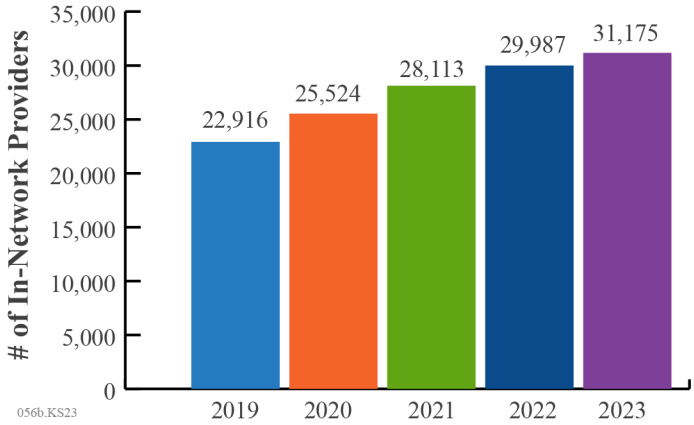


Figure ES-1: Provider Network Growth. *36% growth since 2019*

From Jan. 1, 2023–Nov. 30, 2023, we conducted more than 25 in-person and virtual listening sessions and meetings across Kansas, speaking to Providers of all types and in all areas of the State, including community-based organizations, associations, and stakeholders. Our conversations have inspired empathy and creativity to join in finding ways to simplify our processes and reduce provider administrative burden. Providers are asking for timely payment of claims, simple and streamlined authorization processes, prompt and personalized support to address issues, and on-the-ground resources that aid in improving quality and maximizing their participation. We are fully prepared to do just that, by simplifying the prior authorization process and easing administrative burden with i2i and Availity™ provider Portal.

Leading and Implementing Change

We challenge the status quo with investments in new technologies, business models, and partnerships. At the heart of what we do are the relationships we cherish. Building and fostering these relationships—the kind necessary to make a lasting difference—takes time and investment. To make certain that we continue provide leadership in the Medicaid markets we serve, Aetna has committed to the **$130M Roadmap for Medicaid Technology Innovation by 2025.** Our roadmap enhances Member and Provider digital capabilities, increases our care management capabilities, and supports more efficient issue-resolution processes. Most of these solutions are live, including FamilyCare Central, or will be ready to support the new KanCare Contract on or before Jan. 1, 2025, further enhancing our capabilities to better serve Members, Providers, and the larger community.

Expanding Data Interoperability

[redacted]

Attracting and Inspiring

As we continue our collaborative, adaptable, and local approach to managed care, we aim to build on our strong foundation of access, expertise you can trust, whole-person care, and community investment. **We strive to unlock the power of our people to transform health care by giving them the tools and training needed to develop innovative quality improvement strategies**. Aetna works diligently to inspire Members and their family and support persons to engage with us through a regular cadence of outreach and communication, including our member-facing tools and website, our community resources, and their care team.

In 2024, we will launch FamilyCare Central in Kansas for comprehensive care coordination that makes key information available to all authorized individuals in a Member's Care team. We also offer a host of value-added benefits ranging from incentive cards to housing supports to rewards for completing health screenings, prenatal visits, and immunizations. In 2022, we spent over $1.8 million on Member incentive programs. As a current MCO, we know Kansans. We know their challenges and their needs, which is why, as noted in the 2022 KanCare Annual Report, we have invested nearly $14 million in VABs since 2020 to help Members with SDOH needs.

Aetna Better Health of Kansas: The Best Choice for Healthy Kansans 2030

In developing this proposal, our team has carefully considered KanCare's goals and objectives to develop our unique approaches that connect Member's needs to effective care, allowing them to thrive. **We believe our partnership has brought significant value,** and we have demonstrated our commitment to the KanCare goals and priorities with innovative program improvements since 2019. This proposal details our approach to continuing that momentum forward and demonstrates our readiness for the future of KanCare and the communities served.

Thank you for your leadership, partnership, and serious consideration of our qualifications. We look forward to the opportunity to continue to build on all that we have accomplished.

That's how Healthier Happens in Kansas.

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Required Forms

Tab 4

Attachment 2
Signature Sheet

ATTACHMENT 2: SIGNATURE SHEET

Item: KanCare Medicaid & CHIP Capitated Managed Care
Agency: Kansas Department of Health and Environment (KDHE), Kansas Department for Aging and Disability Services (KDADS)
Closing Date: January 4, 2024, 2:00 PM CST

By submission of a bid and the signatures affixed thereto, the bidder certifies all products and services proposed in the bid meet or exceed all requirements of this specification as set forth in the request and that all exceptions are clearly identified.

Aetna Better Health of Kansas Inc.
Legal Name of Person, Firm or Corporation

9401 Indian Creek Parkway, Suite 1300
Mailing Address

Overland Park, Kansas
City & State

66210
Zip

855-221-5656 (TTY: 711)
Toll Free Telephone

855-221-5656 (TTY: 711)
Local Telephone

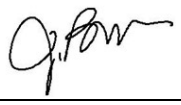
Not applicable
Cell Phone

833-857-7050
Fax Number

81-3370401
Tax Number

CAUTION: If your tax number is the same as your Social Security Number (SSN), you must leave this line blank. DO NOT enter your SSN on this signature sheet. If your SSN is required to process a Contract award, including any tax clearance requirements, you will be contacted by an authorized representative of the Office of Procurement and Contracts at a later date.

Brownj15@aetna.com
E-Mail


Signature

01/03/2024
Date

Jane Brown
Typed Name

Chief Executive Officer
Aetna Better Health of Kansas Inc.
Title

In the event the **contact for the bidding process** is different from above, indicate contact information below.

Not applicable.
Bidding Process Contact Name

Mailing Address | City & State

Zip Code

Toll Free Telephone | Local Telephone

Cell Phone | Fax Number

E-Mail

If **awarded a CONTRACT and purchase orders** are to be directed to an address other than above, indicate mailing address and telephone number below.

Not applicable.
Award Contact Name

Mailing Address | City & State

Zip Code

Toll Free Telephone | Local Telephone

Cell Phone | Fax Number

E-Mail

Attachment 3
Tax Clearance Certificates

Kansas
Department of Revenue

Laura Kelly, Governor
Mark A. Burghart, Secretary

www.ksrevenue.gov

CERTIFICATE OF TAX CLEARANCE

Aetna Better Health of Kansas

ISSUE DATE
12/06/2023

TRANSACTION ID
TYCF-JPHS-JHMR

CONFIRMATION NUMBER
CRT6-KTK8-CB63

TAX CLEARANCE VALID THROUGH 03/05/2024

Verification of this certificate can be obtained on our website, www.ksrevenue.org, or by calling the Kansas Department of Revenue at 785-296-3199

Kansas
Department of Revenue

Laura Kelly, Governor
Mark A. Burghart, Secretary

www.ksrevenue.gov

CERTIFICATE OF TAX CLEARANCE

Access2Care, LLC

ISSUE DATE
11/03/2023

TRANSACTION ID
TFXJ-277E-RB4G

CONFIRMATION NUMBER
CA22-GAJD-HA6J

TAX CLEARANCE VALID THROUGH 02/01/2024

Verification of this certificate can be obtained on our website, www.ksrevenue.org, or by calling the Kansas Department of Revenue at 785-296-3199

Kansas
Department of Revenue

Laura Kelly, Governor
Mark A. Burghart, Secretary

www.ksrevenue.gov

CERTIFICATE OF TAX CLEARANCE

Aetna Medicaid Administrators LLC

DBA as Aetna

ISSUE DATE
12/05/2023

TRANSACTION ID
TC8K-263E-YX7R

CONFIRMATION NUMBER
C42X-DX46-58YR

TAX CLEARANCE VALID THROUGH 03/04/2024

Verification of this certificate can be obtained on our website, www.ksrevenue.org, or by calling the Kansas Department of Revenue at 785-296-3199

Kansas
Department of Revenue

Laura Kelly, Governor
Mark A. Burghart, Secretary

www.ksrevenue.gov

CERTIFICATE OF TAX CLEARANCE

Availity LLC

ISSUE DATE
12/07/2023

TRANSACTION ID
T8DS-K3MG-MBCD

CONFIRMATION NUMBER
CX2K-CK64-4XK8

TAX CLEARANCE VALID THROUGH 03/06/2024

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Kansas
Department of Revenue

Laura Kelly, Governor
Mark A. Burghart, Secretary

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CERTIFICATE OF TAX CLEARANCE

Center for the Study of Services

DBA as Center for the Study of Services

ISSUE DATE
12/07/2023

TRANSACTION ID
TFR7-SK5P-7RNN

CONFIRMATION NUMBER
CDR2-AB47-8JGR

TAX CLEARANCE VALID THROUGH 03/06/2024

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Kansas
Department of Revenue

Laura Kelly, Governor
Mark A. Burghart, Secretary

www.ksrevenue.gov

CERTIFICATE OF TAX CLEARANCE

Cloud Technology Innovations, LLC

DBA as Healthcare Fraud Shield

ISSUE DATE
12/04/2023

TRANSACTION ID
T3MX-RN6E-FJXF

CONFIRMATION NUMBER
CGBY-X78B-PTAT

TAX CLEARANCE VALID THROUGH 03/03/2024

Verification of this certificate can be obtained on our website, www.ksrevenue.org, or by calling the Kansas Department of Revenue at 785-296-3199

Kansas
Department of Revenue

Laura Kelly, Governor
Mark A. Burghart, Secretary

www.ksrevenue.gov

CERTIFICATE OF TAX CLEARANCE

Cotiviti, Inc.

ISSUE DATE
12/05/2023

TRANSACTION ID
TJHA-N47H-TTA7

CONFIRMATION NUMBER
CFHD-6BNA-5SRC

TAX CLEARANCE VALID THROUGH 03/04/2024

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Kansas
Department of Revenue

Laura Kelly, Governor
Mark A. Burghart, Secretary

www.ksrevenue.gov

CERTIFICATE OF TAX CLEARANCE

CQ Fluency, LLC

ISSUE DATE
12/08/2023

TRANSACTION ID
TG85-326C-5YGD

CONFIRMATION NUMBER
C2N2-NS34-H4P3

TAX CLEARANCE VALID THROUGH 03/07/2024

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Kansas
Department of Revenue

Laura Kelly, Governor
Mark A. Burghart, Secretary

www.ksrevenue.gov

CERTIFICATE OF TAX CLEARANCE

mPulse Mobile

ISSUE DATE
12/05/2023

TRANSACTION ID
T3NK-RDCE-FYN3

CONFIRMATION NUMBER
CJS2-55FN-8SKB

TAX CLEARANCE VALID THROUGH 03/04/2024

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Kansas
Department of Revenue

Laura Kelly, Governor
Mark A. Burghart, Secretary

www.ksrevenue.gov

CERTIFICATE OF TAX CLEARANCE

CaremarkPCS Health, LLC

ISSUE DATE
11/30/2023

TRANSACTION ID
TF3S-XSKC-D84J

CONFIRMATION NUMBER
CPJ6-7DBA-H8FP

TAX CLEARANCE VALID THROUGH 02/28/2024

Verification of this certificate can be obtained on our website, www.ksrevenue.org, or by calling the Kansas Department of Revenue at 785-296-3199

Kansas
Department of Revenue

Laura Kelly, Governor
Mark A. Burghart, Secretary

www.ksrevenue.gov

CERTIFICATE OF TAX CLEARANCE

EviCore Healthcare MSI, LLC

ISSUE DATE
11/20/2023

TRANSACTION ID
T3G3-GYXH-4YTF

CONFIRMATION NUMBER
CKSD-P33S-CFJM

TAX CLEARANCE VALID THROUGH 02/18/2024

Verification of this certificate can be obtained on our website, www.ksrevenue.org, or by calling the Kansas Department of Revenue at 785-296-3199

Kansas
Department of Revenue

Laura Kelly, Governor
Mark A. Burghart, Secretary

www.ksrevenue.gov

CERTIFICATE OF TAX CLEARANCE

Healthy Profits LLC

DBA as HealPros LLC

ISSUE DATE
12/07/2023

TRANSACTION ID
TMSD-C5XE-X6GB

CONFIRMATION NUMBER
C4KA-NYHA-KBNT

TAX CLEARANCE VALID THROUGH 03/06/2024

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Kansas
Department of Revenue

Laura Kelly, Governor
Mark A. Burghart, Secretary

www.ksrevenue.gov

CERTIFICATE OF TAX CLEARANCE

Language Line, LLC

DBA as LanguageLine Solutions

ISSUE DATE
12/11/2023

TRANSACTION ID
TAPS-8SD3-N82P

CONFIRMATION NUMBER
CET4-SG6N-8TPG

TAX CLEARANCE VALID THROUGH 03/10/2024

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Kansas
Department of Revenue

Laura Kelly, Governor
Mark A. Burghart, Secretary

www.ksrevenue.gov

CERTIFICATE OF TAX CLEARANCE

Office Ally, Inc.

ISSUE DATE
12/04/2023

TRANSACTION ID
TMEH-3EMC-GFK2

CONFIRMATION NUMBER
CFYY-J7KF-KRD6

TAX CLEARANCE VALID THROUGH 03/03/2024

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Kansas
Department of Revenue

Laura Kelly, Governor
Mark A. Burghart, Secretary

www.ksrevenue.gov

CERTIFICATE OF TAX CLEARANCE

OptumInsight, Inc.

ISSUE DATE
12/05/2023

TRANSACTION ID
THN2-EBTH-TXEC

CONFIRMATION NUMBER
CET5-Y8PA-45MG

TAX CLEARANCE VALID THROUGH 03/04/2024

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Kansas
Department of Revenue

Laura Kelly, Governor
Mark A. Burghart, Secretary

www.ksrevenue.gov

CERTIFICATE OF TAX CLEARANCE

ProgenyHealth, LLC

ISSUE DATE
12/05/2023

TRANSACTION ID
T8YB-7BJR-6TRY

CONFIRMATION NUMBER
CHMF-EYS6-N4F4

TAX CLEARANCE VALID THROUGH 03/04/2024

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Kansas
Department of Revenue

Laura Kelly, Governor
Mark A. Burghart, Secretary

www.ksrevenue.org

CERTIFICATE OF TAX CLEARANCE

Public Partnerships LLC

ISSUE DATE
12/12/2023

TRANSACTION ID
TMAM-4G6B-45PP

CONFIRMATION NUMBER
CCMG-P3EA-X24K

TAX CLEARANCE VALID THROUGH 03/11/2024

Verification of this certificate can be obtained on our website, www.ksrevenue.org, or by calling the Kansas Department of Revenue at 785-296-3199

Kansas
Department of Revenue

Laura Kelly, Governor
Mark A. Burghart, Secretary

www.ksrevenue.gov

CERTIFICATE OF TAX CLEARANCE

Pyx Health, Inc.

ISSUE DATE
12/05/2023

TRANSACTION ID
T3CP-5HBJ-7M2R

CONFIRMATION NUMBER
CK22-KE6H-N8BD

TAX CLEARANCE VALID THROUGH 03/04/2024

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Kansas
Department of Revenue

Laura Kelly, Governor
Mark A. Burghart, Secretary

www.ksrevenue.gov

CERTIFICATE OF TAX CLEARANCE

Zelis Payments Holdings, LLC

ISSUE DATE
12/04/2023

TRANSACTION ID
TTRG-JHGN-C3XP

CONFIRMATION NUMBER
C3KT-4324-25XG

TAX CLEARANCE VALID THROUGH 03/03/2024

Verification of this certificate can be obtained on our website, www.ksrevenue.org, or by calling the Kansas Department of Revenue at 785-296-3199

Kansas
Department of Revenue

Laura Kelly, Governor
Mark A. Burghart, Secretary

www.ksrevenue.gov

CERTIFICATE OF TAX CLEARANCE

SKYGEN USA, LLC

ISSUE DATE
11/03/2023

TRANSACTION ID
T5MY-D88G-X85E

CONFIRMATION NUMBER
C5JA-GN45-DBGS

TAX CLEARANCE VALID THROUGH 02/01/2024

Verification of this certificate can be obtained on our website, www.ksrevenue.org, or by calling the Kansas Department of Revenue at 785-296-3199

Attachment 4

Immigration Reform and Control Certification

ATTACHMENT 4: IMMIGRATION REFORM & CONTROL CERTIFICATION

CERTIFICATION REGARDING IMMIGRATION REFORM & CONTROL

All Contractors are expected to comply with the Immigration and Reform Control Act of 1986 (IRCA), as may be amended from time to time. This Act, with certain limitations, requires the verification of the employment status of all individuals who were hired on or after November 6, 1986, by the Contractor as well as any subcontractor or sub-subcontractor. The usual method of verification is through the Employment Verification (I-9) Form. With the submission of this bid, the Contractor hereby certifies without exception that Contractor has complied with all federal and state laws relating to immigration and reform. Any misrepresentation in this regard or any employment of persons not authorized to work in the United States constitutes a material breach and, at the State's option, may subject the contract to termination and any applicable damages.

Contractor certifies that, should it be awarded a contract by the State, Contractor will comply with all applicable federal and state laws, standards, orders and regulations affecting a person's participation and eligibility in any program or activity undertaken by the Contractor pursuant to this contract. Contractor further certifies that it will remain in compliance throughout the term of the contract.

At the State's request, Contractor is expected to produce to the State any documentation or other such evidence to verify Contractor's compliance with any provision, duty, certification, or the like under the contract.

Contractor agrees to include this Certification in contracts between itself and any subcontractors in connection with the services performed under this contract.

Chief Executive Officer
Aetna Better Health of Kansas Inc. 01/03/2024

Signature, Title of Contractor **Date**

Attachment 5
Policy Regarding Sexual Harassment

ATTACHMENT 5: POLICY REGARDING SEXUAL HARASSMENT

POLICY REGARDING SEXUAL HARASSMENT

WHEREAS, sexual harassment and retaliation for sexual harassment claims are unacceptable forms of discrimination that must not be tolerated in the workplace; and

WHEREAS, state and federal employment discrimination laws prohibit sexual harassment and retaliation in the workplace; and

WHEREAS, officers and employees of the State of Kansas are entitled to working conditions that are free from sexual harassment, discrimination, and retaliation; and

WHEREAS, the Governor and all officers and employees of the State of Kansas should seek to foster a culture that does not tolerate sexual harassment, retaliation, and unlawful discrimination.

NOW THEREFORE, pursuant to the authority vested in me as Governor of the State of Kansas, I hereby order as follows:

1. All Executive Branch department and agency heads shall have available, and shall regularly review and update at least every three years or more frequently as necessary, their sexual harassment, discrimination, and retaliation policies. Such policies shall include components for confidentiality and anonymous reporting, applicability to intern positions, and training policies.

2. All Executive Branch department and agency heads shall ensure that their employees, interns, and contractors have been notified of the state's policy against sexual harassment, discrimination, or retaliation, and shall further ensure that such persons are aware of the procedures for submitting a complaint of sexual harassment, discrimination, or retaliation, including an anonymous complaint.

3. Executive Branch departments and agencies shall annually require training seminars regarding the policy against sexual harassment, discrimination, or retaliation. All employees shall complete their initial training session pursuant to this order by the end of the current fiscal year.

4. Within ninety (90) days of this order, all Executive Branch employees, interns, and contractors under the jurisdiction of the Office of the Governor shall be provided a written copy of the policy against sexual harassment, discrimination, and retaliation, and they shall execute a document agreeing and acknowledging that they are aware of and will comply with the policy against sexual harassment, discrimination, and retaliation.

5. Matters involving any elected official, department or agency head, or any appointee of the Governor may be investigated by independent legal counsel.

6. The Office of the Governor will require annual mandatory training seminars for all staff, employees, and interns in the office regarding the policy against sexual harassment, discrimination, and retaliation, and shall maintain a record of attendance.

7. Allegations of sexual harassment, discrimination, or retaliation within the Office of the Governor will be investigated promptly, and violations of law or policy shall constitute grounds for disciplinary action, including dismissal.
8. This Order is intended to supplement existing laws and regulations concerning sexual harassment and discrimination, and shall not be interpreted to in any way diminish such laws and regulations. The Order provides conduct requirements for covered persons, and is not intended to create any new right or benefit enforceable against the State of Kansas.
9. Persons seeking to report violations of this Order, or guidance regarding the application or interpretation of this Order, may contact the Office of the Governor regarding such matters.

Agreement to Comply with the Policy Against Sexual Harassment, Discrimination, and Retaliation.

I hereby acknowledge that I have received a copy of the State of Kansas Policy Against Sexual Harassment, Discrimination, and Retaliation established by Executive Order 18-04 and agree to comply with the provisions of this policy.

01/03/2024	Jane Brown Chief Executive Officer Aetna Better Health of Kansas Inc.
Signature and Date	**Printed Name**

Attachment 6
Boycott of Israel Form

ATTACHMENT 6: BOYCOTT OF ISRAEL FORM

CERTIFICATION OF COMPANY NOT CURRENTLY ENGAGED IN A BOYCOTT OF GOODS OR SERVICES FROM ISRAEL

In accordance with HB 2482, 2018 Legislative Session, the State of Kansas shall not enter into a contract with a Company to acquire or dispose of goods or services with an aggregate price of more than $100,000, unless such Company submits a written certification that such Company is not currently engaged in a boycott of goods or services from Israel that constitutes an integral part of business conducted or sought to be conducted with the State.

As a Contractor entering into a contract with the State of Kansas, it is hereby certified that the Company listed below is not currently engaged in a boycott of Israel as set forth in HB 2482, 2018 Legislature.

Chief Executive Officer
Aetna Better Health of Kansas Inc. 01/03/2024
Signature, Title of Contractor **Date**

Jane Brown
Printed Name

Aetna Better Health of Kansas Inc.
Name of Company

Event Details

STATE OF KANSAS
Event Details

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	1
Event Round	**Version**		
1	2		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time		**Finish Time**	
10/02/2023 09:00:00 CDT		01/04/2024 14:00:00 CST	

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: AETNA BETTER HEALTH OF KANSAS INC
4500 EAST COTTON CENTER BOULEVARD
PHOENIX AZ 85040-8840
United States

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States
Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

Event Description
State of Kansas

Kansas Department of Health and Environment
Kansas Department for Aging and Disability Services

General Comments

- **********
0005 - Request for Proposal pursuant to K.S.A. 75-37,102

- **********
Pre-proposal Conference - A mandatory pre-proposal conference will be held at 9:00 AM, on October 16, 2:00, via Zoom:

Please see section 3.2.2 of the Bid documents, for Prebid instructions on how to receive call in information.

Attendance is required for this pre-proposal conference. Failure to attend the pre-bid conference will result in rejection of your bid. Questions requesting clarification of the Bid Event must be submitted electronically (MS Word) to the Procurement Officer (Event Contact) indicated in the bidding instructions, prior to close of business on October 23, 2023. Impromptu questions may be permitted, and spontaneous unofficial answers provided, however bidders should understand that the only official answer or position of the State of Kansas will be presented in writing.

Failure to notify the Procurement Officer (Event Contact) of any conflicts or ambiguities in the Bid Event may result in items being resolved in the best interest of the State. Any modification to this Bid Event as a result of the pre-proposal conference, as well as written answers to written questions, shall be made in writing by addendum and dispatched to all bidders associated to this event. Only written communications are binding.

Answers to questions will be available in the form of an addendum on the Procurement and Contracts' website, http://admin.ks.gov/offices/procurement-contracts

It shall be the responsibility of all participating bidders to acquire any and all addenda and additional information as it is made available from the web site cited above. Vendors/Bidders not initially invited to participate in this Bid Event must notify the Procurement Officer (Event Contact) of their intent to bid at least 24 hours prior to the event's closing date/time. Bidders are required to check the website periodically for any additional information or instructions.

- **********
0008 - Invitation for Bid

- **********
BIDDER MUST OBTAIN A CURRENT TAX CLEARANCE CERTIFICATE
A “Tax Clearance” is a comprehensive tax account review to determine and ensure that the account is compliant with all primary Kansas Tax Laws administered by the Kansas Department of Revenue (KDOR) Director of Taxation. Information pertaining to a Tax Clearance is subject to change(s), which may arise as a result of a State Tax Audit, Federal Revenue Agent Report, or other lawful adjustment(s).

INSTRUCTIONS: To obtain a Current Tax Clearance Certificate, you must:
• Go to http://ksrevenue.org/taxclearance.html to request a Tax Clearance Certificate
• Return to the website the following working day to see if KDOR will issue the certificate
• If issued an official certificate, print it and attach it to your bid response
• If denied a certificate, engage KDOR in a discussion about why a certificate wasn’t issued

Bidders (and their subcontractors) are expected to submit a current Tax Clearance Certificate with every event response.

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	2
Event Round	**Version**		
1	2		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time	**Finish Time**		
10/02/2023 09:00:00 CDT	01/04/2024 14:00:00 CST		

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: AETNA BETTER HEALTH OF KANSAS INC
4500 EAST COTTON CENTER BOULEVARD
PHOENIX AZ 85040-8840
United States

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States
Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

REMINDER: You will need to sign back into the KDOR website to view and print the official tax clearance certificate.

Information about Tax Registration can be found at the following website:
http://www.ksrevenue.org/busregistration.html

Procurement and Contracts reserves the right to confirm tax status of all potential contractors and subcontractors prior to the release of a purchase order or contract award.

In the event that a current tax certificate is unavailable, Procurement and Contracts reserves the right to notify a bidder (one that has submitted a timely event response) that they have to provide a current Tax Clearance Certificate within ten (10) calendar days, or Procurement and Contracts may proceed with an award to the next lowest responsive bidder, whichever is determined by the Director of Purchases to be in the best interest of the State.

****
The State of Kansas, as a matter of public policy, encourages anyone doing business with the State of Kansas to take steps to discourage human trafficking. If prospective bidders/vendors/Contractors have any policies or participate in any initiatives that discourage human trafficking the prospective bidder/vendor/Contractor is encouraged to submit same as part of their bid response.

****
During the 2012 Session, the Kansas Legislature enacted a Bidder Preference Program which created three (3) bid preferences. To see if you qualify for any of the preferences, please go to the following website for more information:
https://admin.ks.gov/offices/procurement-contracts/bidding--contracts/bidder-programs/certified-business-and-disabled-veteran-owned-business.

To claim this preference, the bid response must include the Preference Request Form and you must respond to the applicable Bidder Preference category in the question under the General Questions section on the following page(s).

****
During the 2014 Session, the Kansas Legislature enacted the Disabled Veteran Owned Business bidder preference program. For more information or to see if you qualify, please go to the following website:
https://admin.ks.gov/offices/procurement-contracts/bidding--contracts/bidder-programs/bidder-preference-program

To claim this preference, the bid response must include a copy of the letter from Procurement and Contracts certifying your company as a Disabled Veteran Owned Business and you must respond to the applicable Disabled Veteran Owned Business category in the question under the General Questions section on the following page(s).

General Questions

Question	UOM	Best	Worst	Response
Please select ONE category from the following list with regard to a Bidder Preference. If selecting a Bidder Preference category, supporting documentation must accompany this bid response. (Note: #3 "State Use Purchases" category does not apply to Requests for Proposals)				

Options:		Select One
	Not claiming any Bidder Preference Category	X
	Claiming the Disabled Veteran Owned Business Category	
	Claiming the State Use Purchases Bidder Preference Category	
	Claiming the Certified Business Bidder Preference Category	

Required: Yes Mandatory Response: No

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	3
Event Round	**Version**		
1	2		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time		**Finish Time**	
10/02/2023 09:00:00 CDT		01/04/2024 14:00:00 CST	

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: AETNA BETTER HEALTH OF KANSAS INC
4500 EAST COTTON CENTER BOULEVARD
PHOENIX AZ 85040-8840
United States

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States
Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

Response Comments

Is a completed Boycott of Israel form included with your bid event submission?

Yes

Required: Yes Mandatory Response: No

Response Comments

Is a completed Sexual Harassment form included with your bid event submission?

Yes

Required: Yes Mandatory Response: No

Response Comments

Is a completed Immigration Reform and Control form included with this bid event submission (refer to Appendix B - Terms and Conditions, Event Details document)?

Yes

Required: Yes Mandatory Response: No

Response Comments

Does your organization accept the State of Kansas terms and conditions as stated?

Yes

Required: Yes Mandatory Response: No

Response Comments

Is a current Tax Clearance Certificate included with this bid event submission (refer to Appendix B - Terms and Conditions, Event Details document)?

Yes

Required: Yes Mandatory Response: No

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	4
Event Round	**Version**		
1	2		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time		**Finish Time**	
10/02/2023 09:00:00 CDT		01/04/2024 14:00:00 CST	

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: AETNA BETTER HEALTH OF KANSAS INC
4500 EAST COTTON CENTER BOULEVARD
PHOENIX AZ 85040-8840
United States

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States
Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

Response Comments

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	5
Event Round	**Version**		
1	2		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time	**Finish Time**		
10/02/2023 09:00:00 CDT	01/04/2024 14:00:00 CST		

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: AETNA BETTER HEALTH OF KANSAS INC
4500 EAST COTTON CENTER BOULEVARD
PHOENIX AZ 85040-8840
United States

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States
Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

Line Details

No Bid: ☐

Line: 1 **Item ID:** **Line Qty:** 1.00 **UOM:** Each **Bid Qty:** 1
Required: No **Reserve Price:** No
Min/Max Qty: No min / No max

Description: KanCare Medicaid and CHIP Capitated Managed Care Services

Question	UOM	Best	Worst	Response
What is your bid price?				See Cost Proposal for pricing.

Required: Yes Mandatory Response: No

Response Comments

See Cost Proposal for pricing.

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	6
Event Round	**Version**		
1	2		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time		**Finish Time**	
10/02/2023 09:00:00 CDT		01/04/2024 14:00:00 CST	

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: AETNA BETTER HEALTH OF KANSAS INC
4500 EAST COTTON CENTER BOULEVARD
PHOENIX AZ 85040-8840
United States

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States
Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

Bidder Information

Firm Name:	Aetna Better Health of Kansas Inc.				
Name:	Jane Brown	**Signature:**		**Date:**	01/03/2024
Phone #:	785-596-8233	**Fax #:**	833-857-7050		
Street Address:	9401 Indian Creek Parkway, Suite 1300				
City & State:	Overland Park, KS	**Zip Code:**	66210		
Email:	brownj15@aetna.com				

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	7
Event Round	**Version**		
1	2		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time		**Finish Time**	
10/02/2023 09:00:00 CDT		01/04/2024 14:00:00 CST	

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: AETNA BETTER HEALTH OF KANSAS INC
4500 EAST COTTON CENTER BOULEVARD
PHOENIX AZ 85040-8840
United States

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States
Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

Appendix A - Line Specifications

Line: 1 **Item ID:** **Line Qty:** 1 **UOM:** Each
Description: KanCare Medicaid and CHIP Capitated Managed Care Services

Item Specifications

Manufacturer:			
Mfg Item ID:			
Item Length:	0	**Item Height:**	0
Item Width:	0	**Dimension UOM:**	
Item Volume:	0	**Volume UOM:**	
Item Weight:	0	**Weight UOM:**	
Item Size:		**Item Color:**	

Shipping Information

Schedule:	1	**Ship To:**	Procurement and Contracts
Quantity:	1		Procurement and Contracts
Due Date:	01/09/2024		900 SW Jackson
Freight Terms:			Suite 451 South
Ship Via:			Topeka KS 66612
			United States

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	8
Event Round	**Version**		
1	2		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time		**Finish Time**	
10/02/2023 09:00:00 CDT		01/04/2024 14:00:00 CST	

Event Currency: US Dollar
Bids allowed in other currency: No

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Appendix B - Terms & Conditions

1. It is the bidder's responsibility to submit questions, acknowledge addenda and attend pre-bid conferences as indicated in this event or attachment(s). When communicating always refer to the Bid Event ID.

2. Conflict of Interest: With the submission of a response for this bidding event, you certify that you do not have any substantial conflict of interest sufficient to influence the bidding process of this event. A conflict of substantial interest is one which a reasonable person would think would compromise the opening bidding process.

3. BIDDER MUST OBTAIN A CURRENT TAX CLEARANCE CERTIFICATE A "Tax Clearance" is a comprehensive tax account review to determine and ensure that the account is compliant with all primary Kansas Tax Laws administered by the Kansas Department of Revenue (KDOR) Director of Taxation. Information pertaining to a Tax Clearance is subject to change(s), which may arise as a result of a State Tax Audit, Federal Revenue Agent Report, or other lawful adjustment(s). INSTRUCTIONS: To obtain a Current Tax Clearance Certificate, you must: 1) Go to: http://ksrevenue.org/taxclearance.html to request a Tax Clearance Certificate; 2) Return to the website the following working day to see if KDOR will issue the certificate; 3) If issued an official certificate, print it and attach it to your bid response; and 4) If denied a certificate, engage KDOR in a discussion about why a certificate wasn't issued. Bidders (and their subcontractors) are expected to submit a current Tax Clearance Certificate with every event response. REMINDER: You will need to sign back into the KDOR website to view and print the official tax clearance certificate. Information about Tax Registration can be found at the following website:
http://www.ksrevenue.org/busregistration.html. Procurement and Contracts reserves the right to confirm tax status of all potential contractors and subcontractors prior to the release of a purchase order or contract award. In the event that a current tax certificate is unavailable, Procurement and Contracts reserves the right to notify a bidder (one that has submitted a timely event response) that they have to provide a current Tax Clearance Certificate within ten (10) calendar days, or Procurement and Contracts may proceed with an award to the next lowest responsive bidder, whichever is determined by the Director of Purchases to be in the best interest of the State.

4. Immigration and Reform Control Act of 1986 (IRCA): All contractors are expected to comply with the Immigration and Reform Control Act of 1986 (IRCA), as may be amended from time to time. This Act, with certain limitations, requires the verification of the employment status of all individuals who were hired on or after November 6, 1986, by the contractor as well as any subcontractor or sub-contractors. The usual method of verification is through the Employment Verification (I-9) form. With the submission of this bid, the contractor hereby certifies without exception that such contractor has complied with all federal and state laws relating to immigration and reform. Any misrepresentation in this regard or any employment of persons not authorized to work in the United States constitutes a material breach and, at the State's option, may subject the contract to termination for cause and any applicable damages. Unless provided otherwise herein, all contractors are expected to be able to produce for the State any documentation or other such evidence to verify Contractor's IRCA compliance with any provision, duty, certification, or like item under the contract.
Bidders must submit a Certification Regarding Immigration Reform and Control form with every event response. The form can be found at the following website:
http://www.admin.ks.gov/docs/default-source/ofpm/procurement-contracts/irca.doc.

5. Competition: The purpose of this Request is to seek competition. The bidder shall advise Procurement and Contracts if any specification, language or other requirement inadvertently restricts or limits bidding to a single source. Notification shall be in writing and must be received by Procurement and Contracts no later than five (5) business days prior to the event closing date. The Director of Purchases reserves the right to waive minor deviations in the specifications which do not hinder the intent of this Request.

6. Acceptance or Rejection: The State reserves the right to accept or reject any or all bid responses or part of a response; to waive any informalities or technicalities; clarify any ambiguities in responses; modify any criteria in this Event; and unless otherwise specified, to accept any item in a response.

7. Disclosure of Bid Event Content and Proprietary Information: All bid responses become the property of the State of Kansas. The Kansas Open Records Act (K.S.A. 45-215 et seq) requires public information be placed in the public domain at the conclusion of the selection process, and be available for examination by all interested parties. More information on this subject can be found at the following website:
http://admin.ks.gov/offices/chief-counsel/kansas-open-records-act.

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	9
Event Round	**Version**		
1	2		
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United States
Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

8. Debarment of State Contractors. Any Contractor who defaults on delivery or does not perform in a satisfactory manner as defined in this Agreement may be barred for a period up to three (3) years, pursuant to K.S.A. 75-37,103, or have its work evaluated for pre-qualification purposes. Contractor shall disclose any conviction or judgment for a criminal or civil offense of any employee, individual or entity which controls a company or organization or will perform work under this Agreement that indicates a lack of business integrity or business honesty. This includes (1) conviction of a criminal offense as an incident to obtaining or attempting to obtain a public or private contract or subcontract or in the performance of such contract or subcontract; (2) conviction under state or federal statutes of embezzlement, theft, forgery, bribery, falsification or destruction of records, or receiving stolen property; (3) conviction under state or federal antitrust statutes; and (4) any other offense the State determines to be so serious and compelling as to affect responsibility as a state contractor. For the purpose of this section, an individual or entity shall be presumed to have control of a company or organization if the individual or entity directly or indirectly, or acting in concert with one or more individuals or entities, owns or controls twenty-five (25) percent or more of its equity, or otherwise controls its management or policies. Failure to disclose an offense may result in disqualification of the Proposal or termination of the Agreement, as determined by the State.

9. Accounts Receivable Set-Off Program: If during the course of this contract the Contractor is found to owe a debt to the State of Kansas, agency payments to the Contractor may be intercepted / setoff by the State of Kansas. Notice of the setoff action will be provided to the Contractor. Pursuant to K.S.A. 75-6201 et seq, Contractor shall have the opportunity to challenge the validity of the debt. If the debt is undisputed, the Contractor shall credit the account of the agency making the payment in an amount equal to the funds intercepted. K.S.A. 75-6201 et seq. allows the Director of Accounts and Reports to set off funds the State of Kansas owes Contractors against debts owed by the contractor to the State of Kansas. Payments set off in this manner constitute lawful payment for services or goods received. The Contractor benefits fully from the payment because its obligation to the State is reduced by the amount subject to setoff.

Last Updated: 01/24/2019

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Acknowledgement of Amendment(s)

Office of Procurement and Contracts
900 SW Jackson St., Room 451 South
Topeka, KS 66612

Kansas
Department of Administration

Phone: 785-296-2376
Fax: 785-296-7240
https://admin.ks.gov/offices/procurement-contracts

Adam Proffitt, Secretary
Todd Herman, Director

Laura Kelly, Governor

AMENDMENT

Date:	October 20, 2023
Amendment Number:	1
RFP Number:	EVT0009267
Closing Date:	January 4, 2024, 2:00 PM
Procurement Officer: **Telephone:** **E-Mail Address:** **Web Address:**	Amanda Acuna 785-296-5419 Amanda.Acuna@ks.gov http://admin.ks.gov/offices/procurement-and-contracts/
Agency:	Kansas Department of Health and Environment (KDHE), Kansas Department for Aging and Disability Services (KDADS)
Item:	KanCare Medicaid & CHIP Capitated Managed Care

Conditions:

1. The deadline for submitting written questions requesting clarifications has been extended to October 27, 2023, by 12 p.m. CT to allow adequate time for review and response.

2. Technical issues were experienced with the following two folders in the KanCare Bidder's Library and have since been resolved.
    a. De-Identified Claims Data
    b. EDI Companion Guides

A signed copy of this Addendum must be submitted with your bid. If your bid response has been returned, submit this Addendum by the closing date indicated above.

I (We) have read and understand this addendum and agree it is a part of my (our) bid response.

NAME OF COMPANY OR FIRM: Aetna Better Health of Kansas Inc.

SIGNED BY: _____

TITLE: Chief Executive Officer DATE: 01/03/2024

It shall be the vendor's responsibility to monitor this website on a regular basis for any changes/addenda.
http://admin.ks.gov/offices/procurement-and-contract

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Office of Procurement and Contracts
900 SW Jackson St., Room 451 South
Topeka, KS 66612

Phone: 785-296-2376
Fax: 785-296-7240
https://admin.ks.gov/offices/procurement-contracts

Adam Proffitt, Secretary
Todd Herman, Director

Laura Kelly, Governor

AMENDMENT

Date:	November 28, 2023
Amendment Number:	2
RFP Number:	EVT0009267
Closing Date:	January 4, 2024, 2:00 PM
Procurement Officer: **Telephone:** **E-Mail Address:** **Web Address:**	Amanda Acuna 785-296-5419 Amanda.Acuna@ks.gov http://admin.ks.gov/offices/procurement-and-contracts/
Agency:	Kansas Department of Health and Environment (KDHE), Kansas Department for Aging and Disability Services (KDADS)
Item:	KanCare Medicaid & CHIP Capitated Managed Care

Conditions: See response to questions and changes to RFP language below.

A signed copy of this Addendum must be submitted with your bid. If your bid response has been returned, submit this Addendum by the closing date indicated above.

I (We) have read and understand this addendum and agree it is a part of my (our) bid response.

NAME OF COMPANY OR FIRM: Aetna Better Health of Kansas Inc.

SIGNED BY: _____

TITLE: Chief Executive Officer DATE: 01/03/2024

It shall be the vendor's responsibility to monitor this website on a regular basis for any changes/addenda.
http://admin.ks.gov/offices/procurement-and-contract

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aetna®

Evidence of Certificate of Authority

Tab 5

STATE OF KANSAS

INSURANCE DEPARTMENT

CERTIFICATE OF AUTHORITY

AETNA BETTER HEALTH OF KANSAS INC.

a corporation organized under the laws of KANSAS

with statutory office at OVERLAND PARK, KANSAS

has complied with all the requirements of the insurance laws of this state applicable to said organization, and the said organization is hereby authorized and empowered to transact the following business, to wit:

HEALTH MAINTENANCE ORGANIZATION

within the State of Kansas from the 21st day of December, 2016, until such certificate is suspended or revoked by the Commissioner of Insurance.

In Witness Whereof, I, KEN SELZER, Commissioner of Insurance of Kansas, have hereunto affixed my signature and the seal of the Commissioner of Insurance, in the city of Topeka, Kansas, this 21st day of December, 2016.

Commissioner of Insurance

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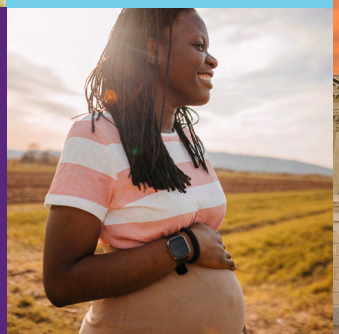
aetna®

Evidence of Financial Viability/Solvency

Tab 6







Bidder's Financial Statements

Financial Statements - Statutory Basis

Aetna Better Health of Kansas Inc.

Years Ended December 31, 2022 and 2021
with Report of Independent Auditors

Ernst & Young LLP
20 Church St, 19th Floor
Hartford, CT 06103

Tel: +1 860 247 3100
Fax: +1 860 727 9728
ey.com

Report of Independent Auditors

Board of Directors
Aetna Better Health of Kansas Inc.

Opinion

We have audited the statutory-basis financial statements of Aetna Better Health of Kansas Inc. (the "Company"), which comprise the balance sheets as of December 31, 2022 and 2021, and the related statements of operations, changes in capital and surplus and cash flow for the years then ended, and the related notes to the financial statements (collectively referred to as the "financial statements").

Unmodified Opinion on Statutory Basis of Accounting

In our opinion, the accompanying 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 the years then ended, on the basis of accounting described in Note 2.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the matter described in the Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles section of our report, the financial statements do not present fairly, in accordance with accounting principles generally accepted in the United States of America, the financial position of the Company at December 31, 2022 and 2021, or the results of its operations or its cash flows for the years then ended.

Basis for Opinion

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

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

As described in Note 2 to the financial statements, the Company prepared these financial statements using accounting practices prescribed or permitted by the Kansas Insurance Department, which is a basis of accounting other than accounting principles generally accepted in the United States of America. The effects on the financial statements of the variances between these statutory accounting practices described in Note 2 and accounting principles generally accepted in the United States of America, although not reasonably determinable, are presumed to be material and pervasive.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with the accounting practices prescribed or permitted by the Kansas Insurance Department.

Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for one year after the date that the financial statements are issued.

Auditor's Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with GAAS, we:

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

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

Ernst & Young LLP

April 27, 2023

Balance Sheets - Statutory Basis

(In Thousands)	December 31, 2022	2021
Admitted assets		
Cash and invested assets		
Bonds	$ 200,315	$ 179,979
Cash, cash equivalents and short-term investments	111,761	18,721
Other invested assets	3,435	3,079
Total cash and invested assets	315,511	201,779
Investment income due and accrued	1,963	1,682
Premiums and considerations receivable	109,212	71,516
Amounts receivable relating to uninsured plans	40	—
Current federal income tax recoverable	—	584
Net deferred tax asset	2,734	1,945
Health care and other amounts receivable	1,459	890
Total admitted assets	$ 430,919	$ 278,396

See accompanying Notes to the Statutory Financial Statements

Balance Sheets - Statutory Basis (continued)

(In Thousands)	December 31, 2022	2021
Liabilities and capital and surplus		
Liabilities:		
Claims unpaid	$ 171,801	$ 121,201
Accrued medical incentive pool and bonus amounts	7,333	1,000
Unpaid claims adjustment expenses	3,396	3,016
Aggregate health policy reserves	1,639	—
Premiums received in advance	7	11
General expenses due or accrued	10,190	4,083
Current federal income tax payable	958	—
Remittances and items not allocated	2,176	164
Amounts due to parent, subsidiaries and affiliates	59,991	6,696
Payable for securities	9,999	—
Funds held under reinsurance treaties	1,278	277
Liability for amounts held under uninsured plans	4,131	1,485
Other liabilities	673	448
Total liabilities	273,572	138,381
Capital and surplus:		
Gross paid in and contributed surplus	133,090	133,090
Unassigned surplus	24,257	6,925
Total capital and surplus	157,347	140,015
Total liabilities and capital and surplus	$ 430,919	$ 278,396

See accompanying Notes to the Statutory Financial Statements

Statements of Operations - Statutory Basis

(In Thousands)	Year ended December 31, 2022	2021
Revenues		
Premium income	$ 1,461,923	$ 1,133,122
Change in unearned premium reserves and reserve for rate credits	(1,272)	—
Total revenues	1,460,651	1,133,122
Benefits and expenses		
Claims	1,231,330	943,706
Net reinsurance recoveries	(3,385)	(2,567)
Claims adjustment expenses	47,922	46,795
General administrative expenses	133,255	105,308
Total benefits and expenses	1,409,122	1,093,242
Net underwriting gain	51,529	39,880
Investment gains		
Net investment income earned	8,116	6,353
Net realized capital losses less capital gains tax benefit	(1,060)	(464)
Total investment gains	7,056	5,889
Income before federal income taxes	58,585	45,769
Federal income tax expense	10,621	7,485
Net income	$ 47,964	$ 38,284

See accompanying Notes to the Statutory Financial Statements

Statements of Changes in Capital and Surplus - Statutory Basis

(In Thousands)	Year ended December 31, 2022	2021
Capital and surplus, beginning of year	$ 140,015	$ 126,413
Net income	47,964	38,284
Change in net unrealized capital losses less capital gains tax benefit	(4,219)	(70)
Change in net deferred income tax	(333)	833
Change in nonadmitted assets	(2,080)	(445)
Capital distribution to parent	—	(8,910)
Dividends to shareholder	(24,000)	(16,090)
Net change in capital and surplus	17,332	13,602
Capital and surplus, end of year	$ 157,347	$ 140,015

See accompanying Notes to the Statutory Financial Statements

Statements of Cash Flow - Statutory Basis

(In Thousands)	Year ended December 31, 2022	2021
Cash from operations		
Premiums collected	$ 1,424,537	$ 1,134,331
Investment income received	8,746	7,769
Claims paid	(1,173,609)	(935,704)
General administrative expenses and other benefits and expenses paid	(172,083)	(152,833)
Federal income taxes paid	(8,895)	(9,190)
Net cash provided by operating activities	78,696	44,373
Cash from investments		
Proceeds from investments sold, matured or repaid	48,501	56,848
Cost of investments acquired	(66,690)	(55,908)
Net cash (used in) provided by investment activities	(18,189)	940
Cash from financing and miscellaneous sources		
Capital returned to parent	—	(8,910)
Dividends to stockholder	(24,000)	(16,090)
Other cash provided by (used in) financing and miscellaneous activities	56,533	(37,825)
Net cash provided by (used in) financing and miscellaneous activities	32,533	(62,825)
Change in cash, cash equivalents and short-term investments	93,040	(17,512)
Cash, cash equivalents and short-term investments, beginning of year	18,721	36,233
Cash, cash equivalents and short-term investments, end of year	$ 111,761	$ 18,721
Supplemental disclosures of cash flow information from non-cash transactions		
Non-cash investment exchanges	$ 500	$ 4,575

See accompanying Notes to the Statutory Financial Statements

1. Organization and operation

Aetna Better Health of Kansas Inc. (the "Company") is a wholly-owned subsidiary of Aetna Health Holdings, LLC, whose ultimate parent is CVS Health Corporation ("CVS Health").

The Company was incorporated in the State of Kansas on July 25, 2016. Effective January 1, 2019, the Company contracts with the State of Kansas Department of Health and Human Services to provide health benefits to Medicaid, Home and Community Based waiver, and Children's Health Insurance Program ("CHIP") members. The Company's current contract with the State of Kansas runs through June 30, 2024. Effective January 1, 2021, the Company contracts Medicare Advantage policies administered by the Centers for Medicare & Medicaid Services ("CMS") within the State of Texas.

2. Summary of significant accounting policies

Accounting practices

The accompanying statutory financial statements of the Company have been prepared in conformity with accounting practices prescribed or permitted by the Kansas Insurance Department ("Kansas Department") ("Kansas Accounting Practices"). The Kansas Department recognizes statutory accounting practices prescribed or permitted by the State of Kansas for determining and reporting the financial condition and results of operations of an insurance company, which include accounting practices and procedures adopted by the National Association of Insurance Commissioners ("NAIC") and included in the Accounting Practices and Procedures Manual ("NAIC SAP").

Kansas Accounting Practices vary from U.S. generally accepted accounting principles ("GAAP"). The primary differences include the following:

- Certain assets, designated as nonadmitted assets (in part, uncollected premiums are nonadmitted in accordance with Statements of Statutory Accounting Principles ("SSAP") No. 6 - *Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers*) are not recorded as assets, but are charged to surplus. Thus, nonadmitting uncollected premiums eliminates the need for a separate allowance for doubtful accounts, which is utilized under GAAP;
- Certain assets, designated as nonadmitted assets (other receivables and prepaid capitation, which are nonadmitted in accordance with SSAP No. 4 - *Assets and Nonadmitted Assets)* are not recorded as assets, but are charged to surplus. Assets having economic value other than those which can be used to fulfill policyholder obligations, or those assets which are unavailable due to encumbrances or other third party interests are not recognized on the Balance Sheets, and are, therefore, considered nonadmitted;
- Bonds are recorded at amortized cost except for those with an NAIC designation of 3 through 6, which are reported at the lower of amortized cost or fair value. Therefore, changes in unrealized gains and losses for those securities held at amortized cost are not reflected in the financial statements. Under GAAP, bonds classified as available for sale are recorded at fair value, and related changes in unrealized gains and losses are recorded as a component of equity, net of deferred federal income taxes;
- In accordance with SSAP No. 26 - Revised - *Bonds*, an other-than-temporary impairment ("OTTI") loss is recorded as a realized loss equal to the entire difference between the bond's carrying value and its fair value at the Balance Sheet date of the reporting period at which the assessment is made and a new carrying value is established for prospective reporting periods. On a GAAP basis, when the Company does not intend to sell the security and it is more likely than not that the entity will not be required to sell such security before recovery of its amortized cost basis, the Company bifurcates an impairment into credit-related and non-credit related components. In evaluating whether a credit related loss exists, the Company considers a variety of factors including: the extent to which the fair value is less than the amortized cost basis; adverse conditions specifically related to the issuer of a security, an industry or geographic area; the payment structure of the security; the failure of the issuer of the security to make scheduled interest or principal payments; and any changes to the rating of the security by a rating agency. The amount of the credit-related component is recorded as an allowance for credit losses and recognized in net income, and the amount of the non-credit related component is included in other comprehensive income;
- In accordance with SSAP No. 43 - Revised - *Loan-Backed and Structured Securities* ("SSAP No. 43R"), OTTI on loan-backed or structured securities are recorded when fair value of the security is less than its

amortized cost basis at the Balance Sheet date and (1) the Company intends to sell the investment or (2) the Company does not have the intent and ability to retain the investment for the time sufficient to recover the amortized cost basis or (3) if the Company does not expect to recover the entire amortized cost basis of the security, even if it does not intend to sell the security and the Company has the intent and ability to hold. The condition in (2) above does not apply for GAAP. OTTI is recorded as the difference between the investment's amortized cost basis and the present value of cash flows expected to be collected;

- Deferred tax assets and liabilities are determined and admitted in accordance with SSAP No. 101 - *Income Taxes* ("SSAP No. 101"). Changes in net deferred tax assets and liabilities are reflected as changes in surplus, whereas under GAAP, changes in such assets and liabilities are reflected in net income. In addition, statutory accounting requires consideration of a statutory valuation allowance adjustment in the calculation of adjusted gross deferred tax assets and an admissibility test for adjusted gross deferred tax assets;
- In accordance with SSAP No. 2 - Revised - *Cash, Cash Equivalents, Drafts and Short-term Investments*, certain short-term borrowings are classified as a reduction of cash, cash equivalents, and short-term investments. Under GAAP, these amounts would have been classified as liabilities; and
- Cash, cash equivalents, and short-term investments in the Statements of Cash Flow represent cash balances and investments with remaining maturities of one year or less at the time of acquisition. Under GAAP, the corresponding caption of cash and cash equivalents includes cash balances and investments with initial maturities of three months or less. The statement does not classify cash flows consistent with GAAP and a reconciliation of net earnings to net cash provided by operations is not provided.

The effects of the foregoing variances from GAAP on the accompanying statutory financial statements have not been determined but are presumed to be material.

There were no prescribed or permitted practices by the State of Kansas that deviated from NAIC SAP for the years ended December 31, 2022 and 2021.

Use of estimates in the preparation of the financial statements

The preparation of these financial statements in conformity with Kansas Accounting Practices requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and revenue and expenses. Actual results could differ from those estimates.

Significant accounting policies

The Company applies the following significant accounting policies:

Cash, cash equivalents and short-term investments

Cash, cash equivalents and short-term investments, consisting primarily of money market instruments and other debt issues with an original maturity of up to one year, are carried at amortized cost. Short-term investments consist primarily of investments purchased with an original maturity date of greater than three months but less than one year. Cash equivalents consist of highly liquid instruments, which mature within three months from the date of purchase. The carrying amount of cash, cash equivalents and short-term investments approximates fair value. Cash accounts with positive balances shall not be reported separately from cash accounts with negative balances. If in the aggregate, the reporting entity has a net negative cash balance, it shall be reported as a negative asset and shall not be recorded as a liability.

Bonds

Bonds are carried at amortized cost except for those bonds with an NAIC designation of 3 through 6, which are carried at the lower of amortized cost or fair value. Bond premiums and discounts are amortized using the scientific interest method. When quoted prices in active markets for identical assets are available, the Company uses these quoted market prices to determine the fair value of bonds. This is used primarily for U.S. government securities. In other cases where a quoted market price for identical assets in an active market is either not available or not

observable, the Company estimates fair values using valuation methodologies based on available and observable market information or by using a matrix pricing model. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. The Company had no material investments where fair value was determined using broker quotes or an internal analysis of financial performance and cash flow projections at December 31, 2022 and 2021. Bonds include all investments whose maturity is greater than one year when purchased. Loan-backed and structured securities ("LB&SS") are carried at amortized cost adjusted for unamortized premiums and discounts and are accounted for using the retrospective adjustment method. Premiums and discounts on loan-backed and structured securities are amortized using the scientific interest method over the estimated remaining term of the securities, adjusted for anticipated prepayments. All adjustments between amortized cost and carrying value are reflected in unrealized capital gains and losses and are reported as direct adjustments to surplus.

Bonds are recorded as purchases or sales on the trade date.

The Company periodically reviews its bonds to determine whether a decline in fair value below the carrying value is other-than-temporary. For bonds, other than LB&SS, an OTTI shall be recorded if it is probable that the Company will be unable to collect all amounts due according to the contractual terms in effect at the date of acquisition. Declines deemed to be OTTI in the cost basis are recognized as realized capital losses. Yield-related impairments are deemed other-than-temporary when the Company intends to sell an investment at the reporting date before recovery of the cost of the investment.

For LB&SS, the Company records OTTI when the fair value of the loan-backed or structured security is less than the amortized cost basis at the balance sheet date and (1) the Company intends to sell the investment, (2) the Company does not have the intent and ability to retain the investment for the time sufficient to recover the amortized cost basis, or (3) the Company does not expect to recover the entire amortized cost basis of the security, even if it does not intend to sell the security and has the intent and ability to hold. If it is determined an OTTI has occurred because of (1) or (2), the amount of the OTTI is equal to the difference between the amortized cost and the fair value of the security at the balance sheet date and this difference is recorded as a realized capital loss. If it is determined an OTTI has occurred because of (3), the amount of the OTTI is equal to the difference between the amortized cost and the present value of cash flows expected to be collected, discounted at the loan-backed or structured security's effective interest rate and this difference is also accounted for as a realized capital loss.

The Company analyzes all relevant facts and circumstances for each investment when performing its analysis to determine whether an OTTI exists. Among the factors considered in evaluating whether a decline is other-than-temporary, management considers whether the decline in fair value results from a change in the quality of the investment security itself, whether the decline results from a downward movement in the market as a whole, the prospects for realizing the carrying value of the bond based on the investee's current and short-term prospects for recovery and other factors. The risks inherent in assessing the impairment of an investment include the risk that market factors may differ from the Company's expectations and the risk that facts and circumstances factored into its assessment may change with the passage of time. Unexpected changes to market factors and circumstances that were not present in past reporting periods may result in a current period decision to sell securities that were not other-than-temporarily impaired in prior reporting periods.

For the Company's bonds and LB&SS that provide for a prepayment penalty or acceleration fee in the event the bond or LB&SS is liquidated prior to its scheduled termination date, the Company reports such fees as investment income when earned.

Investment income due and accrued

Accrued investment income consists primarily of interest. Interest is recognized on an accrual basis and dividends are recorded as earned on the ex-dividend date. Due and accrued income is not recorded on: (a) bonds in default; and (b) bonds delinquent more than 90 days or where collection of interest is improbable. At December 31, 2022 and 2021, the Company did not have any nonadmitted investment income due and accrued.

Premiums and amounts due and unpaid

Premium revenue for health care products is recognized as income in the month in which enrollees are entitled to health care services. Premiums collected before the effective period are reported as premiums received in advance. Premiums related to unexpired contractual coverage periods are reported as unearned premiums and are included in aggregate health policy reserves in the Balance Sheets.

Nonadmitted amounts consist of all premiums due and unpaid greater than 90 days past due, with the exception of amounts due under government insured plans, which may be admitted assets under certain circumstances. In addition, for any customer for which the premiums due and unpaid greater than 90 days past due is more than a de minimus portion of the entire balance of premiums due and unpaid for that customer, the entire balance of premiums due and unpaid for that customer is nonadmitted. Management also performs a specific review of accounts and based on the results of the review, additional amounts may be nonadmitted. Uncollectible amounts are generally written-off and charged to revenue in the period in which the customer reconciliations are completed and agreed to by the customer (retroactivity) or when the account is determined to be uncollectible by the Company.

Medicare Advantage premiums and related subsidies

Through the Company's Medicare Advantage Part D annual contract with CMS, the Company receives monthly premium payments from CMS and members, as determined by the Company's annual bid process. The Company recognizes the revenue related to the CMS contract ratably over the term of its annual contract.

The CMS payment is subject to risk sharing provisions through the CMS risk corridor provision, which is accounted for as a retrospectively rated contract in accordance with SSAP No. 66 - *Retrospectively Rated Contracts*. Receivables related to the CMS risk corridor provision are included in accrued retrospective premiums and payables related to the CMS risk corridor provision are included in liability for amounts held under uninsured plans on the Balance Sheets.

Certain subsidies from CMS, including reinsurance payments, the coverage gap discount program and the cost-sharing portion of the low income subsidy, represent cost reimbursements under the Medicare Part D program for which the Company assumes no risk. Amounts received for these subsidies are not reflected as premium revenues, but rather are accounted for as deposits. Receivables for these subsidies are included in amounts receivable relating to uninsured plans and liabilities for these subsidies are included in liability for amounts held under uninsured plans on the Balance Sheets.

Claims and claims adjustment expenses and related reserves

Claims consist principally of fee-for-service medical claims and capitation costs. Claims unpaid and aggregate health policy reserves include the Company's estimate of payments to be made on claims reported but not yet paid and for health care services rendered to enrollees but not yet reported to the Company as of the Balance Sheet date. Such estimates are developed using actuarial principles and assumptions, which consider, among other things, historical and projected claim submission and processing payment patterns, medical cost trends, historical utilization of health care services, claim inventory levels, medical inflation, changes in membership and product mix, seasonality and other relevant factors. The Company reflects changes in estimates in claims costs in the Statements of Operations in the period they are determined. Capitation costs, which are recorded in claims in the Statements of Operations, represent contractual monthly fees paid to participating physicians and other medical providers for providing medical care, regardless of the medical services provided to the enrollee.

The Company generally compensates primary care physicians through prospective compensation arrangements, which incorporate quality assessment standards, comprehensiveness of care, utilization and office status components. These components are used to adjust the capitation payments to individual physician offices and to determine the amount of additional periodic payments. The Company has prospective compensation arrangements for mental health, substance abuse, diagnostic laboratory, radiology and diagnostic imaging services, podiatric

treatment, physical therapy and prescription drug dispensing. The Company has contracts that provide for all-inclusive per diem and per case hospitalization rates and fixed rates for ambulatory surgery, emergency room services and specialist services. The Company has also entered into quality based compensation arrangements with certain hospitals, as well as agreements with certain integrated health delivery systems under which the systems are compensated on a substantially fixed prospective basis for medical services, including primary, specialist and hospital care. The arrangements described above cover the majority of medical expenses, which are recorded in claims in the Statements of Operations.

The Company uses the triangulation method to estimate reserves for claims incurred but not reported. The method of triangulation makes estimates of completion factors that are then applied to the total paid claims (net of coordination of benefits) to date for each incurral month. This provides an estimate of the total projected incurred claims and total amount outstanding or claims incurred but not reported (claims unpaid). For the most current dates of service where there is insufficient paid claim data to rely solely on the triangulation method, the Company examines cost and utilization trends as well as environmental factors, plan changes, provider contracts, changes in membership and/or benefits, and historical seasonal patterns to estimate the reserve required for these months.

Claims adjustment expenses, which include cost containment expenses, represent the costs incurred related to the claim settlement process such as costs to record, process and adjust claims. These expenses are included in the Company's management agreement with an affiliate described in Note 5.

Aggregate health policy reserves and related expenses

Premium deficiency reserves (“PDR”) are recognized when it is probable that the expected future hospital and medical costs, including maintenance costs, will exceed anticipated future premiums and reinsurance recoveries on existing contracts. Anticipated investment income is not considered in the calculation of PDR. For purposes of calculating a PDR, contracts are grouped in a manner consistent with the method of acquiring, servicing and measuring the profitability of such contracts.

The Company had no PDR at December 31, 2022 or 2021.

Federal and state income taxes

The Company is included in the consolidated federal income tax return of its ultimate parent, CVS Health, pursuant to the terms of a tax sharing agreement. In accordance with the agreement, the Company’s current federal and state income tax provisions are generally computed as if the Company were filing a separate federal and state income tax return; current income tax benefits, including those resulting from net operating losses, are recognized to the extent expected to be realized in the consolidated return. Pursuant to the agreement, the Company has the enforceable right to recoup federal and state income taxes paid in prior years in the event of future net losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal and state income taxes.

Income taxes are accounted for under the asset and liability method. Deferred income tax assets (“DTAs”) and liabilities (“DTLs”) represent the expected future tax consequences of temporary differences generated by statutory accounting as defined in SSAP No. 101. DTAs and DTLs are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. DTAs and DTLs are computed by means of identifying temporary differences, which are measured using a balance sheet approach whereby statutory and tax basis balance sheets are compared. Current income tax recoverables include all current income taxes, including interest, reasonably expected to be recovered in a subsequent accounting period.

Pursuant to SSAP No. 101, gross DTAs are first reduced by a statutory valuation allowance adjustment to an amount that is more likely than not to be realized (“adjusted gross DTAs”). Adjusted gross DTAs are then admitted in an amount equal to the sum of paragraphs a., b. and c. below:

a. Federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse during a timeframe corresponding with Internal Revenue Code (“IRC”) tax loss carryback provisions.

b. The amount of adjusted gross DTAs, after the application of paragraph a. above, expected to be realized within the applicable period and that is no greater than the applicable percentage as determined using the applicable Realization Threshold Limitation Table. The applicable period refers to the number of years in which the DTA will reverse in the Company's tax return and the applicable percentage refers to the percentage of the Company's statutory capital and surplus as required to be shown on the statutory balance sheet adjusted to exclude any net DTAs, electronic data processing equipment and operating system software and any net positive goodwill ("Stat Cap ExDTA").

   The Realization Threshold Limitation Tables allow DTAs to be admitted based upon either realization within 3 years and 15% of Stat Cap ExDTA, 1 year and 10% of Stat Cap ExDTA, or no DTA admitted pursuant to this paragraph b. In general, the Realization Threshold Limitation Tables allow the Company to admit more DTAs if total DTAs as reported by the Company are a smaller percentage of statutory capital and surplus.

c. The amount of gross DTAs, after the application of paragraphs a. and b. above that can be offset against existing gross DTLs. In applying this offset, the Company considers the character (i.e. ordinary versus capital) of the DTAs and DTLs such that offsetting would be permitted in the tax return under existing enacted federal income tax laws and regulations and the reversal patterns of temporary differences.

Changes in DTAs and DTLs are recognized as a separate component of gains and losses in surplus ("Change in net deferred income tax") except to the extent allocated to changes in unrealized gains and losses. Changes in DTAs and DTLs allocated to unrealized gains and losses are netted against the related changes in unrealized gains and losses and are reported as "Change in net unrealized capital gains and (losses)", also a separate component of gains and losses in surplus.

The Company is subject to state income taxes in various states. State income tax expense is recorded in general administrative expenses in the Statements of Operations.

3. Bonds and other financial instruments

The following is a summary of bonds and other financial instruments receiving bond treatment, which includes cash equivalents, at December 31, 2022 and 2021:

December 31, 2022

(In Thousands)	Amortized cost	Statutory carrying value	Gross unrealized gains	Gross unrealized losses	Fair value
U.S. government	$ 16,655	$ 16,655	$ —	$ (1,605)	$ 15,050
All other governments	22,387	21,558	46	(971)	20,633
U.S. states, territories and possessions (direct and guaranteed)	4,701	4,701	29	(342)	4,388
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	1,115	1,115	—	(55)	1,060
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	40,372	40,372	—	(3,663)	36,709
Industrial and miscellaneous (unaffiliated)	220,828	216,098	146	(5,800)	210,444
Total	$ 306,058	$ 300,499	$ 221	$ (12,436)	$ 288,284

December 31, 2021

(In Thousands)	Amortized cost	Statutory carrying value	Gross unrealized gains	Gross unrealized losses	Fair value
U.S. government	$ 10,644	$ 10,644	$ 392	$ —	$ 11,036
All other governments	23,437	23,311	963	(106)	24,168
U.S. states, territories and possessions (direct and guaranteed)	13,046	13,046	530	(5)	13,571
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	29,874	29,874	1,322	(94)	31,102
Industrial and miscellaneous (unaffiliated)	115,198	115,106	3,589	(231)	118,464
Total	$ 192,199	$ 191,981	$ 6,796	$ (436)	$ 198,341

Summarized below are the Company's bonds and other financial instruments receiving bond treatment with unrealized losses at December 31, 2022 and 2021, along with the related fair values, aggregated by the length of time the investments have been in an unrealized loss position:

December 31, 2022

	Less than 12 months			12 months or greater		
(In Thousands, except number of securities)	Number of securities	Fair value	Unrealized losses	Number of securities	Fair value	Unrealized losses
U.S. government	5	$ 12,168	$ 1,033	2	$ 2,880	$ 572
All other governments	6	7,842	586	1	2,361	385
U.S. states, territories and possessions (direct and guaranteed)	3	2,157	161	1	1,118	181
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	1	1,060	55	—	—	—
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	15	$ 29,673	$ 2,805	6	$ 7,036	$ 858
Industrial and miscellaneous (unaffiliated)	42	43,921	2,503	28	26,172	3,297
Total	72	$ 96,821	$ 7,143	38	$ 39,567	$ 5,293

	Total		
(In Thousands, except number of securities)	Number of securities	Fair value	Unrealized losses
U.S. government	7	$ 15,048	$ 1,605
All other governments	7	10,203	971
U.S. states, territories and possessions (direct and guaranteed)	4	3,275	342
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	1	1,060	55
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	21	$ 36,709	$ 3,663
Industrial and miscellaneous (unaffiliated)	70	70,093	5,800
Total	110	$ 136,388	$ 12,436

December 31, 2021

(In Thousands, except number of securities)	Less than 12 months			12 months or greater		
	Number of securities	Fair value	Unrealized losses	Number of securities	Fair value	Unrealized losses
All other governments	1	1,029	13	1	2,700	93
U.S. states, territories and possessions (direct and guaranteed)	1	1,327	5	—	—	—
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political	5	$ 7,427	$ 94	—	$ —	$ —
Industrial and miscellaneous (unaffiliated)	17	18,833	178	1	1,945	53
Total	24	$ 28,616	$ 290	2	$ 4,645	$ 146

(In Thousands, except number of securities)	Total		
	Number of securities	Fair value	Unrealized losses
All other governments	2	3,729	106
U.S. states, territories and possessions (direct and guaranteed)	1	1,327	5
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	5	$ 7,427	$ 94
Industrial and miscellaneous (unaffiliated)	18	20,778	231
Total	26	$ 33,261	$ 436

The Company has reviewed the investments in the tables above and has concluded that these are performing assets generating investment income to support the needs of the business. In performing this review, the Company considered factors such as the quality of the investment security based on research performed by external rating agencies and internal credit analysts and the prospects of realizing the carrying value of the security based on the investment's current prospects for recovery. Furthermore, the Company has no intention to sell the investments in the tables above at December 31, 2022 and 2021 before their cost can be recovered . In determining if the Company needs to sell before full recovery of value, the Company considers the forecasted recovery period, expected investment returns relative to other funding sources, projected cash flow and capital requirements, regulatory obligations, and other factors. Unrealized losses at December 31, 2022 and 2021 were generally caused by the widening of market yields for these securities relative to the market yields when these securities were purchased.

The contractual or expected maturities of bonds and assets receiving bond treatment (e.g., cash equivalents and short-term investments) at December 31, 2022 were as follows:

(In Thousands)	Carrying value	Fair value
Due one year or less	$ 117,200	$ 116,836
Due after one year through five years	80,497	77,156
Due after five years through ten years	80,497	74,515
Due after ten years	22,305	19,777
Total	$ 300,499	$ 288,284

The maturity for mortgage pass-through securities, included in U.S. Government and U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions, is not based on stated maturity, but instead is based on prepayment assumptions. Prepayment assumptions are calculated utilizing published repayment factors that estimate the prepayment rates on the mortgages in the Federal National Mortgage Association and Government National Mortgage Association pools.

Proceeds from the maturities and sales of the Company's bonds and other financial instruments receiving bond treatment and the related gross realized capital gains and losses and the OTTI charges on bonds for the years ending December 31, 2022 and 2021 were as follows:

(In Thousands)	2022	2021
Proceeds from sales of bonds	$ 28,667	$ 31,546
Proceeds from maturities of bonds	9,834	25,302
Gross realized gains on sales of bonds	274	538
Gross realized losses on sales of bonds	663	112
OTTI charges on bonds that were in an unrealized loss position (included in net realized capital losses)	905	334

The Company conducts regular reviews of its bond investments to assess whether a decline in fair value below carrying value is an OTTI. The Company will also recognize an OTTI on bonds when the Company intends to sell a security that is in an unrealized loss position. Declines deemed to be OTTI are recognized as realized capital losses.

The Company's unrealized loss position on loan-backed and structured securities held by the Company at December 31, 2022 and 2021 is as follows:

(In Thousands)	2022	2021
Aggregate amount of unrealized losses		
Less than 12 months	$ 619	$ 83
12 months or greater	1,231	—
Aggregate related fair value of securities with unrealized losses		
Less than 12 months	$ 6,651	$ 10,114
12 months or greater	10,448	—

The Company has reviewed the loan-backed and structured securities in accordance with SSAP No. 43R in the tables above and have concluded that these are performing assets generating investment income to support the needs of the business. Furthermore, the Company has no intention to sell the securities at December 31, 2022 and 2021 before their cost can be recovered and does have the intent and ability to retain the securities for the time sufficient to recover the amortized cost basis; therefore, no OTTI was determined to have occurred on these securities.

4. Financial instruments

Financial instruments measured at fair value in the financial statements

The Company had no material assets and liabilities that are measured and reported at fair value as of December 31, 2022 and 2021.

The fair values of financial instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy. The following are the levels of the hierarchy and a brief description of the type of valuation information ("inputs") that qualifies a financial asset or liability for each level:

- **Level 1** – Unadjusted quoted prices for identical assets or liabilities in active markets.
- **Level 2** – Inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, inputs that are observable that are not prices (such as interest rates and credit risks) and inputs that are derived from or corroborated by observable markets.
- **Level 3** – Developed from unobservable data, reflecting the Company's own assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, the Company uses these quoted market prices to determine the fair value of financial assets and liabilities and classifies these assets and liabilities as Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, the Company estimates fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities would then be classified as Level 2. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

Transfers in and out of all levels are recognized at the end of the reporting period in which the transfer occurred.

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

December 31, 2022

(In Thousands)	Aggregate fair value	Admitted assets	(Level 1)	(Level 2)	(Level 3)
Assets					
Bonds, short term, and cash equivalents	$ 288,284	$ 300,499	$ 15,048	$ 273,236	$ —
Total	$ 288,284	$ 300,499	$ 15,048	$ 273,236	$ —

December 31, 2021

(In Thousands)	Aggregate fair value	Admitted assets	(Level 1)	(Level 2)	(Level 3)
Assets					
Bonds, short term, and cash equivalents	$ 198,341	$ 191,981	$ 11,033	$ 187,308	$ —
Total	$ 198,341	$ 191,981	$ 11,033	$ 187,308	$ —

In evaluating the Company's management of interest rate and liquidity risk and currency exposures, the fair values of all assets and liabilities should be taken into consideration, not only those presented above.

5. Information concerning parent, subsidiaries, and affiliates

As of and for the years ended December 31, 2022 and 2021, the Company had the following significant transactions with affiliates:

The Company and Aetna Medicaid Administrators LLC ("AMA") are parties to an administrative services agreement, under which AMA and certain of its affiliates provide certain administrative services, including cash management and accounting and processing of premiums and claims. Under this agreement, the Company will remit a percentage of its earned premium revenue, as applicable, to AMA as a fee. For these services, the Company was charged $108,749 thousand and $90,827 thousand in 2022 and 2021, respectively.

AMA and Aetna Health Management, LLC ("AHM"), indirectly wholly-owned subsidiaries of CVS Health, entered into a plan joinder agreement. Under this agreement, AHM has contracted with Caremark-PCS Health, LLC ("Caremark"), an affiliate, to deliver pharmacy benefit management services to the Company through the Company's administrative services agreement with AMA. The Company will make payments to AMA in accordance with the administrative services agreement.

As explained in Note 2, Aetna and its wholly-owned subsidiaries, including the Company, participate in a tax sharing agreement with CVS Health. All federal income tax receivables/payables are due from/due to CVS Health.

The Company invests in Aetna Partners Diversified Fund, LLC ("APDF"), an affiliated entity, that is a fund of hedge funds. The Company records this investment as an other invested asset. The value of the Company's investment in APDF was $3,435 thousand and $3,079 thousand at December 31, 2022 and 2021 respectively.

The amounts due to affiliates relates primarily to cash management activities that provide cash required for the Company to support operations as specified in the AMA agreement, noted above. The increases in current year balances are primarily due to pass through amounts and liquidity transfers.

At December 31, 2022 and 2021, the Company had the following amounts due to affiliates:

	December 31,	
(In Thousands)	**2022**	**2021**
Amounts due to affiliates		
Aetna Medicaid Administrators LLC	$ 59,991	$ 6,696
Total due to affiliates	$ 59,991	$ 6,696

At December 31, 2022 and 2021, the Company had no amounts due from affiliates.

The terms of settlement require that these amounts be settled within 45 days after the end of the calendar quarter.

6. Income taxes

The components of the net DTAs recognized in the Company's Balance Sheets are as follows:

	December 31, 2022		
(In Thousands)	**Ordinary**	**Capital**	**Total**
Gross DTAs	$ 2,718	$ 1,510	$ 4,228
Statutory valuation allowance adjustment	—	(1,182)	(1,182)
Adjusted gross DTAs	2,718	328	3,046
DTAs nonadmitted	—	—	—
Subtotal net admitted DTAs	2,718	328	3,046
DTLs	(18)	(294)	(312)
Net admitted DTAs/(DTLs)	$ 2,700	$ 34	$ 2,734

	December 31, 2021		
(In Thousands)	**Ordinary**	**Capital**	**Total**
Gross DTAs	$ 1,925	$ 307	$ 2,232
Statutory valuation allowance adjustment	—	(48)	(48)
Adjusted gross DTAs	1,925	259	2,184
DTAs nonadmitted	—	—	—
Subtotal net admitted DTAs	1,925	259	2,184
DTLs	(15)	(224)	(239)
Net admitted DTAs/(DTLs)	$ 1,910	$ 35	$ 1,945

	Change		
(In Thousands)	**Ordinary**	**Capital**	**Total**
Gross DTAs	$ 793	$ 1,203	$ 1,996
Statutory valuation allowance adjustment	—	(1,134)	(1,134)
Adjusted gross DTAs	793	69	862
DTAs nonadmitted	—	—	—
Subtotal net admitted DTAs	793	69	862
DTLs	(3)	(70)	(73)
Net admitted DTAs/(DTLs)	$ 790	$ (1)	$ 789

The amount of gross DTAs admitted under each component of SSAP No. 101 is as follows:

	December 31, 2022		
(In Thousands)	**Ordinary**	**Capital**	**Total**
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$ 2,699	$ 34	$ 2,733
(b) Adjusted gross DTAs expected to be realized (excluding the amount of DTAs after application of the threshold limitations (the lesser of (b)1 and (b)2 below))	19	—	19
1. Adjusted gross DTAs expected to be realized following the balance sheet date	19	—	19
2. Adjusted gross DTAs allowed per limitation threshold	XX	XX	23,192
(c) Adjusted gross DTAs (excluding the amount of DTAs from (a) and (b) above) offset by gross DTLs	—	294	294
(d) DTAs admitted as the result of application of SSAP No. 101	$ 2,718	$ 328	$ 3,046

	December 31, 2021		
(In Thousands)	**Ordinary**	**Capital**	**Total**
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$ 1,909	$ 35	$ 1,944
(b) Adjusted gross DTAs expected to be realized (excluding the amount of DTAs after application of the threshold limitations (the lesser of (b)1 and (b)2 below))	16	—	16
1. Adjusted gross DTAs expected to be realized following the balance sheet date	16	—	16
2. Adjusted gross DTAs allowed per limitation threshold	XX	XX	20,711
(c) Adjusted gross DTAs (excluding the amount of DTAs from (a) and (b) above) offset by gross DTLs	0	224	224
(d) DTAs admitted as the result of application of SSAP No. 101	$ 1,925	$ 259	$ 2,184

	Change		
(In Thousands)	**Ordinary**	**Capital**	**Total**
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$ 790	$ (1)	$ 789
(b) Adjusted gross DTAs expected to be realized (excluding the amount of DTAs after application of the threshold limitations (the lesser of (b)1 and (b)2 below))	3	—	3
1. Adjusted gross DTAs expected to be realized following the balance sheet date	3	—	3
2. Adjusted gross DTAs allowed per limitation threshold	XX	XX	2,481
(c) Adjusted gross DTAs (excluding the amount of DTAs from (a) and (b) above) offset by gross DTLs	—	70	70
(d) DTAs admitted as the result of application of SSAP No. 101	$ 793	$ 69	$ 862

($ in Thousands)	**2022**	**2021**
(a) Ratio percentage used to determine recovery period and threshold limitation amount	353 %	393 %
(b) Amount of adjusted capital and surplus used to determine recovery period threshold limitation in (b)2 above	$ 154,613	$ 138,070

There were no tax planning strategies impacting the Company's ordinary or capital DTAs.

The provision (benefit) for income taxes for the years ended December 31, 2022 and 2021 were as follows:

	December 31,		
(In Thousands)	**2022**	**2021**	**Change**
Federal income tax expense on operations	$ 10,621	$ 7,485	$ 3,136
Federal income tax (benefit) provision on net capital (losses) gains	(184)	114	(298)
Federal income tax incurred	$ 10,437	$ 7,599	$ 2,838

The tax effects of temporary differences that gave rise to deferred tax assets and liabilities at December 31, 2022 and 2021 were as follows:

	December 31,		
(In Thousands)	**2022**	**2021**	**Change**
DTAs:			
Ordinary			
Discounting of unpaid losses	$ 1,917	$ 1,560	$ 357
Nonadmitted assets	801	364	437
Other	—	1	(1)
Total ordinary DTAs	2,718	1,925	793
Statutory valuation allowance adjustment	—	—	—
Nonadmitted ordinary DTAs	—	—	—
Admitted ordinary DTAs	2,718	1,925	793
Capital			
Investments	342	307	35
Unrealized capital losses	1,168	—	1,168
Total capital DTAs	1,510	307	1,203
Statutory valuation allowance adjustment	(1,182)	(48)	(1,134)
Nonadmitted capital DTAs	—	—	—
Admitted capital DTAs	328	259	69
Admitted DTAs	3,046	2,184	862
DTLs:			
Ordinary			
Investments	18	15	3
Ordinary DTLs	18	15	3
Capital			
Investments	294	224	70
Capital DTLs	294	224	70
Total DTLs	312	239	73
Net admitted DTAs/(DTLs)	$ 2,734	$ 1,945	$ 789

The change in net deferred income taxes is comprised of the following:

	December 31,		
(In Thousands)	**2022**	**2021**	Change
Total DTAs	$ 3,046	$ 2,184	$ 862
Total DTLs	(312)	(239)	(73)
Net DTAs/(DTLs)	2,734	1,945	789
Tax effect of unrealized gains (losses)			(1,122)
Change in net deferred income tax			$ (333)

The valuation allowance adjustment to gross DTAs was $1,182 thousand as of December 31, 2022. The valuation allowance adjustment to gross DTAs was $48 thousand as of December 31, 2021.

The provision (benefit) for federal income taxes is different from that which would be obtained by applying the statutory federal income tax rate to income before income taxes. The items causing this difference are as follows:

($ in Thousands)	December 31, 2022	Effective tax rate	December 31, 2021	Effective tax rate
Provision computed at statutory rate	$ 12,264	21.0 %	$ 9,635	21.0 %
Health insurer fee	—	— %	—	— %
Transfer pricing adjustment	(2,059)	(3.5)%	(1,740)	(3.8)%
Tax-exempt interest	(121)	(0.3)%	(122)	(0.3)%
Change in nonadmitted assets	(437)	(0.7)%	(92)	(0.2)%
Prior year true-up	(11)	— %	9	— %
Change in valuation allowance adjustment	1,134	1.9 %	(924)	(2.0)%
Total	$ 10,770	18.4 %	$ 6,766	14.7 %
Federal and foreign income tax expense incurred	$ 10,437	17.9 %	$ 7,599	16.6 %
Change in net deferred income taxes	333	0.5 %	(833)	(1.9)%
Total statutory income taxes	$ 10,770	18.4 %	$ 6,766	14.7 %

The transfer pricing adjustment allows taxpayers to apply different methods to price current period intercompany services at arm's length prices (i.e., prices at which unrelated entities would be willing to transact), which results in a permanent deduction for tax reporting purposes.

At December 31, 2022 and 2021, the Company had no net capital loss or net operating loss carryforwards for tax purposes.

The amount of federal income taxes incurred that is available for recoupment in the event of future net losses are:

(In Thousands)

Year	Ordinary	Capital	Total
2022	$ 9,993	$ —	$ 9,993
2021	8,333	142	8,475
2020	N/A	—	—
Total	$ 18,326	$ 142	$ 18,468

The Company did not report any deposits as admitted assets under Internal Revenue Code Section 6603 at December 31, 2022 and 2021.

As discussed in Note 2, the Company is included in the consolidated federal income tax return of its parent, CVS Health, along with other affiliates, as of December 31, 2022 and 2021.

The Company does not have any tax loss contingencies for which it is reasonably possible that the total liability will significantly increase within twelve months of the reporting date.

The Company is subject to premium taxes in various states. These tax expenses are recorded in general administrative expenses in the Statements of Operations. The expenses for these taxes were $69,763 thousand and $59,902 thousand for the years ended December 31, 2022 and 2021, respectively. The Company's premium taxes payable of $9,689 thousand and $3,860 thousand at December 31, 2022 and 2021, respectively, are included in general expenses due or accrued in the Balance Sheets.

On August 16, 2022, President Biden signed into law the Inflation Reduction Act (the "Act"). Effective for tax years beginning after December 31, 2022, the Act includes a new corporate alternative minimum tax ("CAMT") on certain corporations. The Company is an applicable corporation as it is a member of an aggregate group with three-year average financial statement income of over $1 billion. The aggregate group of which the Company is a member has not determined as of the reporting date if it will be liable for CAMT in 2023. The financial statements as of December 31, 2022 do not include an estimated impact of the CAMT because a reasonable estimate cannot be made.

7. Claims liabilities

The following table shows the components of the change in claims unpaid, accrued medical incentive pool and bonus amounts, and unpaid claims adjustment expenses for the years ended December 31, 2022 and 2021:

(In Thousands)	2022	2021
Balance, January 1	$ 125,217	$ 119,470
Health care receivable	(2,600)	(1,364)
Balance, January 1, net of health care receivable	122,617	118,106
Incurred related to:		
Current year	1,291,510	1,016,143
Prior years	(15,643)	(28,209)
Total incurred	1,275,867	987,934
Paid related to:		
Current year	1,114,043	893,181
Prior years	107,108	90,242
Total paid	1,221,151	983,423
Balance, December 31, net of health care receivable	177,333	122,617
Health care receivable	5,197	2,600
Balance, December 31	$ 182,530	$ 125,217

Reserves for incurred claims and claims adjustment expenses attributable to insured events of prior years decreased by $15,643 thousand in 2022 and $28,209 thousand in 2021. Changes in prior periods' estimates represent the effect of favorable development of prior period health care cost estimates on current year net income, at each financial statement date. The favorable development of these reserves is primarily a result of the actual claim submission times for health care claims being shorter than the Company had anticipated, as well as lower than expected health care cost trends in determining claims unpaid at the prior financial statement date. Original estimates are increased or decreased as additional information becomes known regarding individual claims.

8. Capital and surplus and shareholder's dividend restrictions

The Company had 10,000 shares of common stock authorized with no par value, with 1,000 shares issued and outstanding at December 31, 2022 and 2021.

Dividend restrictions

Dividends on the Company's common capital stock are paid as declared by its Board of Directors, from earned surplus of the Company, not including surplus arising from the sale of stock. Generally, dividends may be paid on the Company's common capital stock without obtaining regulatory approval at an amount up to the greater of: a) the prior year net gain from operations, or b) ten percent of the prior year ending capital and surplus. In addition, the minimum Risk Based Capital requirements of the NAIC and, if applicable, the Kansas Insurance Department must

be maintained. Per instruction from the Kansas Insurance Department, an ordinary dividend up to ten percent of the prior year capital and surplus may be declared and paid without obtaining regulatory approval. Dividends, when paid, are not cumulative.

At December 31, 2022 and 2021, there was no portion of the Company's surplus that may be paid as ordinary dividends to its shareholder without prior approval from the Kansas Department.

The Company paid dividends in 2022 to its parent as follows:

- $10,000 thousand on September 1, 2022 – Ordinary
- $14,000 thousand on November 15, 2022 – Ordinary

The Company paid $16,090 thousand as an extraordinary dividend to its parent on August 31, 2021. The Kansas Department approved this dividend on August 30, 2021.

The Company paid $8,910 thousand as a return of capital to its parent on August 31, 2021. The Kansas Department approved this dividend on August 30, 2021.

There were no restrictions placed on the Company's surplus, including for whom the surplus was being held at December 31, 2022 and 2021, except as noted in Note 11.

9. Contingencies

Guaranty fund assessments

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers and life insurers as well as health insurers. The Company's assessments generally are based on a formula relating to the Company's health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively, the "ACA").

Litigation and regulatory proceedings

The following description of litigation and regulatory proceedings covers CVS Health and certain of its subsidiaries, including the Company. Certain of the proceedings described below may not impact the Company directly but may have an indirect impact on the Company as the Company is a member of the CVS Health holding company group (the "CVS Health Group").

The CVS Health Group has been involved or is currently involved in numerous legal proceedings, including litigation, arbitration, government investigations, audits, reviews and claims. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, the U.S. Department of Justice (the "DOJ"), state attorneys general, the U.S. Drug Enforcement Administration (the "DEA") and other governmental authorities.

Legal proceedings, in general, and securities, class action and multi-district litigation, in particular, and governmental special investigations, audits and reviews can be expensive and disruptive. Some of the litigation matters may purport or be determined to be class actions and/or involve parties seeking large and/or indeterminate amounts, including punitive or exemplary damages, and may remain unresolved for several years. The CVS Health Group also may be named from time to time in *qui tam* actions initiated by private third parties that could also be separately pursued by a governmental body. The results of legal proceedings, including government investigations, are often uncertain and difficult to predict, and the costs incurred in these matters can be substantial, regardless of the outcome.

The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and reasonably estimable, the Company does not establish an accrued liability.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and the Company is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters. The outcome of such governmental investigations or proceedings could be material to the Company.

Provider Proceedings

The CVS Health Group is named as a defendant in purported class actions and individual lawsuits arising out of its practices related to the payment of claims for services rendered to its members by providers with whom the CVS Health Group has a contract and with whom the CVS Health Group does not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that the CVS Health Group paid too little to its health plan members and/or providers for out-of-network services and/or otherwise allege that the CVS Health Group failed to timely or appropriately pay or administer out-of-network claims and benefits (including the CVS Health Group's post payment audit and collection practices and reductions in payments to providers due to sequestration). Other major health insurers are the subject of similar litigation or have settled similar litigation.

The CVS Health Group also has received subpoenas and/or requests for documents and other information from, and been investigated by, state Attorneys General and other state and/or federal regulators, legislators and agencies relating to, and the CVS Health Group is involved in other litigation regarding, its out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against one or more members of the CVS Health Group, including the Company, with respect to their respective out-of-network benefit payment and/or administration practices.

CMS Actions

CMS regularly audits the CVS Health Group's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to the Company's and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by providers. The CVS Health Group collects claim and encounter data from providers and generally relies on providers to appropriately code their submissions to the CVS Health Group and document their medical records, including the diagnosis data submitted to the CVS Health Group with claims. CMS pays increased premiums to Medicare Advantage plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to the CVS Health Group. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the CVS Health Group's plans, to validate coding practices and supporting medical record documentation maintained by providers and the resulting risk adjusted premium payments to the plans. CMS may require the CVS Health Group, including the Company, to refund premium payments if the CVS Health Group's, including the Company's, risk adjusted premiums are not properly supported by medical record data. The Office of the Inspector General of the U.S. Department of Health and Human Services ("OIG") also is auditing the CVS Health Group's risk adjustment-related data and that of other companies. The CVS Health Group expects CMS and the OIG to continue these types of audits.

In 2012, CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will extrapolate the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments

made under the contract being audited. For contract years prior to 2011, CMS did not extrapolate sample error rates to the entire contract. As a result, the revised methodology may increase the CVS Health Group's, including the Company's, exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of the CVS Health Group's Medicare Advantage contracts for various contract years for RADV audit, and the number of RADV audits continues to increase. The CVS Health Group is currently unable to predict which of its Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to the CVS Health Group, or the Company, the effect of any such refunds or adjustments on the actuarial soundness of the CVS Health Group's, including the Company's, Medicare Advantage bids, or whether any RADV audit findings would require the CVS Health Group, including the Company, to change its method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in the CVS Health Group's, including the Company's, bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG or otherwise, including audits of the CVS Health Group's medical loss ratio rebates, methodology and/or reports, could be material and could adversely affect the CVS Health Group's, including the Company's, results of operations, financial condition and/or cash flows.

On January 30, 2023, CMS released the final rule ("RADV Audit Rule"), announcing it may use extrapolation for payment years 2018 forward, for both RADV audits and OIG audits and eliminated the application of a FFS Adjuster in Part C contract-level RADV audits of Medicare Advantage organizations. In the RADV Audit Rule, CMS indicated that it will use more than one audit methodology going forward and indicated CMS will audit contracts it believes are at the highest risk for overpayments based on its statistical modeling, citing a 2016 Governmental Accountability Office report that recommended selection of contract-level RADV audits with a focus on contracts likely to have high rates of improper payment, the highest coding intensity scores, and contracts with high levels of unsupported diagnoses from prior RADV audits. The CVS Health Group is currently unable to predict which of its Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds for years prior to 2018 or prospective adjustments to Medicare Advantage premium payments made to the CVS Health Group, the effect of any such refunds or adjustments on the actuarial soundness of the CVS Health Group's Medicare Advantage bids, or whether any RADV audit findings would require the CVS Health Group to change its method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in the CVS Health Group's bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG or otherwise, including audits of the CVS Health Group's MLR rebates, methodology and/or reports, could be material and could adversely affect the CVS Health Group's operating results, cash flows and/or financial condition. The RADV Audit Rule does not apply to the CMS Part C Improper Payment Measures audits nor the HHS-RADV programs.

Medicaid

The Company's Medicaid products also are heavily regulated by CMS and state Medicaid agencies, which have the right to audit the Company's performance to determine compliance with CMS contracts and regulations. The Company's Medicaid products also are subject to complex federal and state regulations and oversight by state Medicaid agencies regarding the services the Company provides to Medicaid enrollees, payment for those services, network requirements (including mandatory inclusion of specified high-cost providers), and other aspects of these programs, and by external review organizations that audit Medicaid plans on behalf of the state Medicaid agencies. The laws, regulations and contractual requirements applicable to the Company and other participants in Medicaid programs, including requirements that the Company submit encounter data to the applicable state agency, are extensive, complex and subject to change. The Company has invested significant resources to comply with these standards, and its Medicaid program compliance efforts will continue to require significant resources. CMS and/or state Medicaid agencies may fine the Company, withhold payments to the Company, seek premium and other refunds, terminate the Company's existing contracts, elect not to award the Company new contracts or not to renew the Company's existing contracts, prohibit the Company from continuing to market and/or enroll members in or refuse to automatically assign members to one or more of the Company's Medicaid products, exclude the Company from participating in one or more Medicaid programs and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with CMS or state regulations or the Company's contractual requirements.

The Company cannot predict whether pending or future federal or state legislation or court proceedings will change various aspects of the Medicaid program, nor can it predict the impact those changes will have on its business operations or financial results, but the effects could be materially adverse.

Other Legal and Regulatory Proceedings

The CVS Health Group is also a party to other legal proceedings and is subject to government investigations, inquiries and audits and has received and is cooperating with the government in response to Civil Investigative Demands ("CIDs"), subpoenas or similar process from various governmental agencies requesting information. These other legal proceedings and government actions include claims of or relating to bad faith, medical or professional malpractice, breach of fiduciary duty, claims processing, dispensing of medications, non-compliance with state and federal regulatory regimes, marketing misconduct, denial of or failure to timely or appropriately pay or administer claims and benefits, provider network structure (including the use of performance-based networks and termination of provider contracts), rescission of insurance coverage, improper disclosure or use of personal information, anticompetitive practices, general contractual matters, product liability, intellectual property litigation and employment litigation. Some of these other legal proceedings are or are purported to be class actions or derivative claims. The CVS Health Group is defending itself against the claims brought in these matters.

Awards to the Company and others of certain government contracts, particularly Medicaid contracts and other contracts with government customers in the Company's health care and related benefits businesses, frequently are subject to protests by unsuccessful bidders. These protests may result in awards to the Company being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect the Company's results of operations. The Company will continue to defend contract awards it receives.

There also continues to be a heightened level of review and/or audit by regulatory authorities and legislators of, and increased litigation regarding, the Company's and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including manufacturers' rebates, pricing, the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers).

As a leading national health solutions company, the CVS Health Group regularly is the subject of government actions of the types described above. These government actions may prevent or delay the Company from implementing planned premium rate increases and may result, and have resulted, in restrictions on the Company's businesses, changes to or clarifications of the Company's business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to the Company by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

The Company can give no assurance that its businesses, financial condition, results of operations and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iii) pending or future federal or state government investigations of one or more of the CVS Health Group's and/or the Company's businesses, one or more of the industries in which the CVS Health Group and/or the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the CVS Health Group and/or the Company; (v) adverse developments in any pending *qui tam* lawsuit against the CVS Health Group and/or the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the CVS Health Group and/or the Company; or (vi) adverse developments in pending or future

legal proceedings against the CVS Health Group and/or the Company or affecting one or more of the industries in which the CVS Health Group and/or the Company competes and/or the health care industry generally.

Litigation Insurance Coverage

The Company maintains insurance coverage for certain litigation exposures in an amount it believes is reasonable.

Health Care Reform

The ACA made broad-based changes to the United States health care system. In June 2021, the United States Supreme Court dismissed a challenge on procedural grounds that argued the ACA is unconstitutional in its entirety and issued an opinion preserving the ACA and its consumer protections in its current form. Even though the ACA was deemed constitutional, there may nevertheless be continued efforts to invalidate, modify, repeal or replace portions of it. In addition to litigation, parts of the ACA continue to evolve through the promulgation of executive orders, legislation, regulations and guidance at the federal or state level. The Company expects the ACA, including potential changes thereto, to continue to significantly impact its business operations and operating results, including pricing, medical benefit ratios ("MBRs") and the geographies in which the Company's products are available.

10. Business concentrations

For the years ended December 31, 2022 and 2021, the Company recorded premiums under the Medicaid program of $1,261,643 thousand and $1,019,558 thousand, respectively, representing 86% for 2022 and 90% for 2021 of total premium revenue.

11. Minimum capital and surplus

Pursuant to the laws of the states in which the Company is licensed to do business, the Company is required to maintain a minimum surplus and capital stock as defined by the statutes and regulations of those states. At December 31, 2022 and 2021, the Company was in compliance with the minimum surplus and capital stock requirements of the states in which it is licensed to do business.

The NAIC utilizes risk-based capital (“RBC”) standards for health organizations, including HMOs, that are designed to identify weakly capitalized companies by comparing each company’s adjusted capital and surplus to its required capital and surplus (the “RBC Ratio”). The RBC Ratio is designed to reflect the risk profile of a company. Within certain ratio ranges, regulators have increasing authority to take action as the RBC Ratio decreases. There are four levels of regulatory action, ranging from requiring insurers to submit a comprehensive plan to the state insurance commissioner to requiring the state insurance commissioner to place the insurer under regulatory control. At December 31, 2022 and 2021, the Company had capital and surplus that exceeded the level that would require regulatory action.

12. Retrospectively rated contracts and contracts subject to redetermination

Retrospectively rated contracts

Through annual contracts with CMS, the Company offers insurance plans for Medicare-eligible individuals through the Medicare Advantage program. Members typically receive enhanced benefits over standard Medicare fee-for-service coverage, including reduced cost-sharing for preventative care, vision and other non-Medicare services. Members also typically receive coverage for certain prescription drugs, usually subject to a deductible, co-insurance and/or co-payment. The revenues ultimately received by the Company for each member are based on that member’s health status and demographic characteristics, as determined via the CMS risk adjustment process, under which the Company regularly submits risk adjustment data to CMS. As such, at December 31, 2022 the Company records a receivable for future revenues that it expects to receive from CMS in the third quarter of 2023, after the final reconciliation of risk adjustment data for contract year 2022 is complete. The Company estimates this receivable by taking into account risk adjustment data for contract year 2022 submitted to CMS prior to December 31, 2022, as well as its estimate of the impact of risk adjustment data for contract year 2022 that will be submitted prior to the

appropriate regulatory deadline in early 2023. These amounts are recognized in 2022 as premium income. In addition, the Company's Medicare Advantage contracts are subject to retrospective rating provisions under which the Company and CMS share in amounts above and below agreed-upon target medical benefit ratios. These accrued retrospective premiums, if any, are recorded through premiums and are estimated based on calculations that compare the Company's expected financial results for the contract against the appropriate medical benefit ratio target.

The Company had reinsurance and low-income subsidy (cost sharing portion) and CMS coverage gap discount payables of $4,131 thousand and $1,485 thousand at December 31, 2022 and 2021, respectively. These amounts are recorded in the liability for amounts held under uninsured plans on the Balance Sheets as per SSAP No. 47 - *Uninsured Plans.* These items relate to the Company's Medicare product offerings.

Accrued retrospective premiums are recorded as an adjustment to earned premiums and are estimated based on calculations that compare the Company's expected financial results for the contract against the appropriate medical benefit ratio target.

The total net premiums written by the Company during the years ended 2022 and 2021 that were subject to retrospective rating features were $1,461,923 thousand and $1,133,122 thousand, respectively, representing 100% in 2022 and 100% in 2021 of the total net premiums written.

13. Unusual or infrequent items

The Coronavirus Disease 2019 ("COVID-19") pandemic continues to evolve, and the Biden administration has indicated that they intend for the COVID-19 public health emergency to expire on May 11, 2023. The Company believes COVID-19's impact on the Company's businesses, operating results, cash flows and/or financial condition primarily will be driven by the geographies impacted and the severity and duration of the pandemic; the pandemic's impact on the U.S. and global economies and consumer behavior and health care utilization patterns; and the timing, scope and impact of stimulus legislation as well as other federal, state and local governmental responses to the pandemic. Those primary drivers are beyond the Company's knowledge and control. As a result, the impact COVID-19 will have on the Company's businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be adverse and material. COVID-19 also may result in legal and regulatory proceedings, investigations and claims against the Company.

14. Subsequent events

Type I - Recognized subsequent events

Subsequent events have been considered through April 27, 2023, the date on which the financial statements were available to be issued. The Company had no known reportable recognized subsequent events.

Type II - Nonrecognized subsequent events

Subsequent events have been considered through April 27, 2023, the date on which the financial statements were available to be issued. The Company had no known reportable nonrecognized subsequent events.

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Report of Independent Auditors on Supplementary Information

Board of Directors
Aetna Better Health of Kansas Inc.

We have audited the statutory-basis financial statements of Aetna Better Health of Kansas Inc. (the "Company") as of and for the years ended December 31, 2022 and 2021, and have issued our report thereon dated April 27, 2023, which contained an adverse opinion with respect to conformity with U.S. generally accepted accounting principles and an unmodified opinion with respect to conformity with accounting practices prescribed or permitted by the Kansas Insurance Department on those financial statements. Our audit was performed for the purpose of forming an opinion on the financial statements as a whole. The accompanying supplemental investment disclosures and supplemental schedule of life and health reinsurance disclosures are presented to comply with the National Association of Insurance Commissioners' Annual Statement Instructions and the National Association of Insurance Commissioners' Accounting Practices and Procedures Manual and for purposes of additional analysis and are not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the statutory-basis financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated, in all material respects, in relation to the financial statements as a whole.

Restriction on Use

This report is intended solely for the information and use of the Company and state insurance departments to whose jurisdiction the Company is subject and is not intended to be and should not be used by anyone other than these specified parties.

Ernst & Young LLP

April 27, 2023

Aetna Better Health of Kansas Inc.

Summary Investment Schedule

December 31, 2022

	($ in Thousands)	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement			
		1	2	3	4	5	6
	Investment Categories	Amount	Percentage of Column 1 Line 13	Amount	Securities Lending Reinvested Collateral Amount	Total (Col. 3 + 4) Amount	Percentage of Column 5 Line 13
1.	Long-Term Bonds (Schedule D, Part 1):						
	1.01 U.S. governments	16,653	5.278	16,653	0	16,653	5.278
	1.02 All other governments	21,558	6.833	21,558	0	21,558	6.833
	1.03 U.S. states, territories and possessions, etc. guaranteed	4,701	1.490	4,701	0	4,701	1.490
	1.04 U.S. political subdivisions of states, territories, and possessions, guaranteed	1,115	0.353	1,115	0	1,115	0.353
	1.05 U.S. special revenue and special assessment obligations, etc. non-guaranteed	40,372	12.796	40,372	0	40,372	12.796
	1.06 Industrial and miscellaneous	115,916	36.739	115,916	0	115,916	36.739
	1.07 Hybrid securities	0	0.000	0	0	0	0.000
	1.08 Parent, subsidiaries and affiliates	0	0.000	0	0	0	0.000
	1.09 SVO identified funds	0	0.000	0	0	0	0.000
	1.10 Unaffiliated bank loans	0	0.000	0	0	0	0.000
	1.11 Unaffiliated certificates of deposit	0	0.000	0	0	0	0.000
	1.12 Total long-term bonds	200,315	63.489	200,315	0	200,315	63.489
2.	Preferred stocks (Schedule D, Part 2, Section 1):						
	2.01 Industrial and miscellaneous (Unaffiliated)	0	0.000	0	0	0	0.000
	2.02 Parent, subsidiaries and affiliates	0	0.000	0	0	0	0.000
	2.03 Total preferred stocks	0	0.000	0	0	0	0.000
3.	Common stocks (Schedule D, Part 2, Section 2):						
	3.01 Industrial and miscellaneous Publicly traded (Unaffiliated)	0	0.000	0	0	0	0.000
	3.02 Industrial and miscellaneous Other (Unaffiliated)	0	0.000	0	0	0	0.000
	3.03 Parent, subsidiaries and affiliates Publicly traded	0	0.000	0	0	0	0.000
	3.04 Parent, subsidiaries and affiliates Other	0	0.000	0	0	0	0.000
	3.05 Mutual funds	0	0.000	0	0	0	0.000
	3.06 Unit investment funds	0	0.000	0	0	0	0.000
	3.07 Closed-end funds	0	0.000	0	0	0	0.000
	3.08 Exchange traded funds	0	0.000	0	0	0	0.000
	3.09 Total common stocks	0	0.000	0	0	0	0.000
4.	Mortgage loans (Schedule B)						
	4.01 Farm mortgages	0	0.000	0	0	0	0.000
	4.02 Residential mortgages	0	0.000	0	0	0	0.000
	4.03 Commercial mortgages	0	0.000	0	0	0	0.000
	4.04 Mezzanine real estate loans	0	0.000	0	0	0	0.000
	4.05 Total valuation allowance	0	0.000	0	0	0	0.000
	4.06 Total mortgage loans	0	0.000	0	0	0	0.000
5.	Real estate (Schedule A)						
	5.01 Properties occupied by company	0	0.000	0	0	0	0.000
	5.02 Properties held for production of income	0	0.000	0	0	0	0.000
	5.03 Properties held for sale	0	0.000	0	0	0	0.000
	5.04 Total real estate	0	0.000	0	0	0	0.000
6.	Cash, cash equivalents and short-term investments						
	6.01 Cash (Schedule E, Part 1)	11,577	3.669	11,577	0	11,577	3.669
	6.02 Cash equivalents (Schedule E, Part 2)	100,184	31.753	100,184	0	100,184	31.753
	6.03 Short-term investments (Schedule DA)	0	0.000	0	0	0	0.000
	6.04 Total cash, cash equivalents and short-term investments	111,761	35.422	111,761	0	111,761	35.422
7.	Contract loans	0	0.000	0	0	0	0.000
8.	Derivatives (Schedule DB)	0	0.000	0	0	0	0.000
9.	Other invested assets (Schedule BA)	3,435	1.089	3,435	0	3,435	1.089
10.	Receivable for securities	0	0.000	0	0	0	0.000
11.	Securities Lending (Schedule DL, Part 1)	0	0.000	0	0	0	0.000
12.	Other invested assets (Page 2, Line 11)	0	0.000	0	0	0	0.000
13.	Total invested assets	315,511	100.000	315,511	0	315,511	100.000

Aetna Better Health of Kansas Inc.
Supplemental Investment Risks Interrogatories
December 31, 2022

Of The	Aetna Better Health of Kansas Inc.				
ADDRESS (City, State and Zip Code)	Overland Park, KS 66210				
NAIC Group Code	0001	NAIC Company Code	16072	Federal Employer's Identification Number (FEIN)	81-3370401

The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by reporting the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 2 of this annual statement. ($ in Thousands) $ 430,919

2. Ten largest exposures to a single issuer/borrower/investment. ($ in Thousands)

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	DOVER CORP	Cash Equivalent	$ 10,237	2.4 %
2.02	DELMARVA POWER & LIGHT	Cash Equivalent	$ 9,999	2.3 %
2.03	CONSTELLATION EN GEN LLC	Cash Equivalent	$ 9,358	2.2 %
2.04	CARGILL INC	Cash Equivalent	$ 7,998	1.9 %
2.05	EASTMAN CHEMICAL CORP.	Cash Equivalent	$ 7,991	1.9 %
2.06	SEMPRA ENERGY	Cash Equivalent	$ 7,989	1.9 %
2.07	CONSOLIDATED EDISON	Cash Equivalent	$ 6,976	1.6 %
2.08	AMCOR FLEXIBLES NA	Cash Equivalent	$ 5,769	1.3 %
2.09	LOS ANGELES CALIF DEPT WTR & P REF-SER B	Bond	$ 5,719	1.3 %
2.10	MOHAWK INDUSTRIES INC	Cash Equivalent	$ 4,993	1.2 %

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC designation. ($ in Thousands)

	Bonds	1	2		Preferred Stocks	3	4
3.01	NAIC-1	$ 207,839	48.2 %	3.07	P/RP-1	$ 0	0.0 %
3.02	NAIC-2	$ 44,438	10.3 %	3.08	P/RP-2	$ 0	0.0 %
3.03	NAIC-3	$ 43,033	10.0 %	3.09	P/RP-3	$ 0	0.0 %
3.04	NAIC-4	$ 5,188	1.2 %	3.10	P/RP-4	$ 0	0.0 %
3.05	NAIC-5	$ 0	0.0 %	3.11	P/RP-5	$ 0	0.0 %
3.06	NAIC-6	$ 0	0.0 %	3.12	P/RP-6	$ 0	0.0 %

4. Assets held in foreign investments. ($ in Thousands)

4.01 Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets? Yes [ ] No [X]

If response to 4.01 above is yes, responses are not required for interrogatories 5 - 10.

4.02	Total admitted assets held in foreign investments	$ 26,973	6.3 %
4.03	Foreign-currency-denominated investments	$ 0	0.0 %
4.04	Insurance liabilities denominated in that same foreign currency	$ 0	0.0 %

Aetna Better Health of Kansas Inc.
Supplemental Investment Risks Interrogatories
December 31, 2022

5. Aggregate foreign investment exposure categorized by NAIC sovereign designation. ($ in Thousands)

		1	2
5.01	Countries designated NAIC-1	$ 6,910	1.6 %
5.02	Countries designated NAIC-2	$ 9,690	2.2 %
5.03	Countries designated NAIC-3 or below	$ 10,373	2.4 %

6. Largest foreign investment exposures by country, categorized by the country's NAIC sovereign designation. ($ in Thousands)

			1	2
	Countries designated NAIC - 1:			
6.01	Country 1:	Japan	$ 2,000	0.5 %
6.02	Country 2:	Saudi Arabia	$ 1,475	0.3 %
	Countries designated NAIC - 2:			
6.03	Country 1:	Mexico	$ 4,031	0.9 %
6.04	Country 2:	Panama	$ 2,746	0.6 %
	Countries designated NAIC - 3 or below:			
6.05	Country 1:	South Africa	$ 1,737	0.4 %
6.06	Country 2:	Vietnam	$ 1,460	0.3 %

		1	2
7.	Aggregate unhedged foreign currency exposure. ($ in Thousands)	$ 0	0.0 %

8. Aggregate unhedged foreign currency exposure categorized by NAIC Sovereign designation. ($ in Thousands)

		1	2
8.01	Countries designated NAIC-1	$ 0	0.0 %
8.02	Countries designated NAIC-2	$ 0	0.0 %
8.03	Countries designated NAIC-3 or below	$ 0	0.0 %

9. Largest unhedged foreign currency exposures by country, categorized by the country's NAIC sovereign designation. ($ in Thousands)

			1	2
	Countries designated NAIC - 1:			
9.01	Country 1:		$ 0	0.0 %
9.02	Country 2:		$ 0	0.0 %
	Countries designated NAIC - 2:			
9.03	Country 1:		$ 0	0.0 %
9.04	Country 2:		$ 0	0.0 %
	Countries designated NAIC - 3 or below:			
9.05	Country 1:		$ 0	0.0 %
9.06	Country 2:		$ 0	0.0 %

10. Ten largest non-sovereign (i.e. non-governmental) foreign issues. ($ in Thousands)

	1 Issuer	2 NAIC Designation	3	4
10.01	MITSUBISHI UFJ FIN GRP SR UNSECURED	1	$ 1,000	0.2 %
10.02	HSBC HOLDINGS PLC SR UNSECURED	1	$ 1,000	0.2 %
10.03	HONDA MOTOR CO LTD SR UNSECURED	1	$ 1,000	0.2 %
10.04	CREDIT SUISSE GROUP AG SR UNSECURED	2	$ 1,000	0.2 %
10.05	BANCOLOMBIA SA SR UNSECURED	3	$ 948	0.2 %
10.06	SEAGATE HDD CAYMAN SR UNSECURED	3	$ 468	0.1 %
10.07			$ 0	0.0 %
10.08			$ 0	0.0 %
10.09			$ 0	0.0 %
10.10			$ 0	0.0 %

Aetna Better Health of Kansas Inc.
Supplemental Investment Risks Interrogatories
December 31, 2022

11. Amounts and percentages of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure. ($ in Thousands)

11.01 Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 11.01 is yes, detail is not required for the remainder of interrogatory 11.

		1	2
11.02	Total admitted assets held in Canadian investments	$ 0	0.0 %
11.03	Canadian-currency-denominated investments	$ 0	0.0 %
11.04	Canadian-denominated insurance liabilities	$ 0	0.0 %
11.05	Unhedged Canadian currency exposure	$ 0	0.0 %

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions. ($ in Thousands)

12.01 Are assets held in investments with contractual sales restrictions less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 12.01 is yes, responses are not required for the remainder of Interrogatory 12.

	1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions	$ 0	0.0 %
	Largest three investments with contractual sales restrictions:		
12.03	.	$ 0	0.0 %
12.04	.	$ 0	0.0 %
12.05	.	$ 0	0.0 %

13. Amounts and percentages of admitted assets held in the ten largest equity interests. ($ in Thousands)

13.01 Are assets held in equity interests less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 13.01 is yes, detail is not required for the remainder of interrogatory 13.

	1 Issuer	2	3
13.02	.	$ 0	0.0 %
13.03	.	$ 0	0.0 %
13.04	.	$ 0	0.0 %
13.05	.	$ 0	0.0 %
13.06	.	$ 0	0.0 %
13.07	.	$ 0	0.0 %
13.08	.	$ 0	0.0 %
13.09	.	$ 0	0.0 %
13.10	.	$ 0	0.0 %
13.11	.	$ 0	0.0 %

14. Amounts and percentages of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities. ($ in Thousands)

14.01 Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 14.01 above is yes, responses are not required for 14.02 through 14.05.

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$ 0	0.0 %
	Largest three investments held in nonaffiliated, privately placed equities:		
14.03		$ 0	0.0 %
14.04		$ 0	0.0 %
14.05		$ 0	0.0 %

Ten largest fund managers:

	1 Fund Manager	2 Total Invested	3 Diversified	4 Nondiversified
14.06		$ 0	$ 0	$ 0
14.07		$ 0	$ 0	$ 0
14.08		$ 0	$ 0	$ 0
14.09		$ 0	$ 0	$ 0
14.10		$ 0	$ 0	$ 0
14.11		$ 0	$ 0	$ 0
14.12		$ 0	$ 0	$ 0
14.13		$ 0	$ 0	$ 0
14.14		$ 0	$ 0	$ 0
14.15		$ 0	$ 0	$ 0

15. Amounts and percentages of the reporting entity's total admitted assets held in general partnership interests. ($ in Thousands)

15.01 Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of Interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$ 0	0.0 %
	Largest three investments held in general partnership interests:		
15.03		$ 0	0.0 %
15.04		$ 0	0.0 %
15.05		$ 0	0.0 %

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans. ($ in Thousands)

16.01 Are mortgage loans reported in Schedule B less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of Interrogatory 16 and Interrogatory 17.

	1 Type (Residential, Commercial, Agricultural)	2	3
16.02		$ 0	0.0 %
16.03		$ 0	0.0 %
16.04		$ 0	0.0 %
16.05		$ 0	0.0 %
16.06		$ 0	0.0 %
16.07		$ 0	0.0 %
16.08		$ 0	0.0 %
16.09		$ 0	0.0 %
16.10		$ 0	0.0 %
16.11		$ 0	0.0 %

Amount and percentage of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
16.12	Construction loans	$ 0	0.0 %
16.13	Mortgage loans over 90 days past due	$ 0	0.0 %
16.14	Mortgage loans in the process of foreclosure	$ 0	0.0 %
16.15	Mortgage loans foreclosed	$ 0	0.0 %
16.16	Restructured mortgage loans	$ 0	0.0 %

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date. ($ in Thousands)

		Residential		Commercial		Agricultural	
	Loan to Value	1	2	3	4	5	6
17.01	above 95%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.02	91 to 95%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.03	81 to 90%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.04	71 to 80%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.05	below 70%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %

18. Amounts and percentages of the reporting entity's total admitted assets held in each of the five largest investments in real estate. ($ in Thousands)

18.01 Are assets held in real estate reported less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 18.01 above is yes, responses are not required for the remainder of Interrogatory 18.

Largest five investments in any one parcel or group of contiguous parcels of real estate.

	Description 1	2	3
18.02		$ 0	0.0 %
18.03		$ 0	0.0 %
18.04		$ 0	0.0 %
18.05		$ 0	0.0 %
18.06		$ 0	0.0 %

19. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments held in mezzanine real estate loans. ($ in Thousands)

19.01 Are assets held in investments held in mezzanine real estate loans less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 19.01 is yes, responses are not required for the remainder of Interrogatory 19.

	1	2	3
19.02	Aggregate statement value of investments held in mezzanine real estate loans:	$ 0	0.0 %
	Largest three investments held in mezzanine real estate loans:		
19.03		$ 0	0.0 %
19.04		$ 0	0.0 %
19.05		$ 0	0.0 %

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements. ($ in Thousands)

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
20.01	Securities lending agreements (do not include assets held as collateral for such transactions)	$ 0	0.0 %	$ 0	$ 0	$ 0
20.02	Repurchased agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.03	Reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.04	Dollar repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.05	Dollar reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors. ($ in Thousands)

		Owned		Written	
		1	2	3	4
21.01	Hedging	$ 0	0.0 %	$ 0	0.0 %
21.02	Income generation	$ 0	0.0 %	$ 0	0.0 %
21.03	Other	$ 0	0.0 %	$ 0	0.0 %

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards. ($ in Thousands)

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
22.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
22.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
22.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
22.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts. ($ in Thousands)

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
23.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
23.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
23.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
23.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

The following information regarding reinsurance contracts is presented to satisfy the disclosure requirements in SSAP No. 61R, *Life, Deposit-Type and Accident and Health Reinsurance*, which apply to reinsurance contracts entered into, renewed or amended on or after January 1, 1996 and in effect for the current period.

1. Has the Company reinsured any risk with any other entity under a reinsurance contract (or multiple contracts with the same reinsurer or its affiliates) that is subject to Appendix A-791, *Life and Health Reinsurance Agreements*, and includes a provision that limits the reinsurer's assumption of significant risks identified in Appendix A-791?

   Examples of risk-limiting features include provisions such as a deductible, a loss ratio corridor, a loss cap, an aggregate limit or other provisions that result in similar effects.

   Yes ☐ No ☑

   If yes, indicate the number of reinsurance contracts to which such provisions apply:

   If yes, indicate if deposit accounting was applied for all contracts subject to Appendix A-791 that limit significant risks.

   Yes ☐ No ☐ N/A ☑

2. Has the Company reinsured any risk with any other entity under a reinsurance contract (or multiple contracts with the same reinsurer or its affiliates) that is not subject to Appendix A-791, for which reinsurance accounting was applied and includes a provision that limits the reinsurer's assumption of risk?

   Examples of risk-limiting features include provisions such as a deductible, a loss ratio corridor, a loss cap, an aggregate limit or other provisions that result in similar effects. However, stop loss or excess of loss reinsurance agreements with deductibles or loss caps which apply to the entire contract and are not adjustable based on other features are not considered to be reinsurance contracts with a provision that limits the reinsurer's assumption of risk.

   Yes ☐ No ☑

   If yes, indicate the number of reinsurance contracts to which such provisions apply:

   If yes, indicate whether the reinsurance credit was reduced for the risk-limiting features.

   Yes ☐ No ☐ N/A ☑

3. Does the Company have any ceded reinsurance contracts (other than reinsurance contracts with a federal or state facility) that contain one or more of the following features which may result in delays in payment in form or in fact:

   (a) Provisions that permit the reporting of losses to be made less frequently than quarterly;
   (b) Provisions that permit settlements to be made less frequently than quarterly;
   (c) Provisions that permit payments due from the reinsurer to not be made in cash within ninety (90) days of the settlement date (unless there is no activity during the period); or
   (d) The existence of payment schedules, accumulating retentions from multiple years, or any features inherently designed to delay timing of the reimbursement to the ceding entity.

   Yes ☐ No ☑

4. Has the Company reflected reinsurance accounting credit for any contracts that are not subject to Appendix A-791 and not yearly renewable term reinsurance, which meet the risk transfer requirements of SSAP No. 61R?

Type of contract:	Response:	Identify reinsurance contract(s):	Has the insured event(s) triggering contract coverage been recognized?
Assumption reinsurance – new for the reporting period	Yes ☐ No ☑		N/A

5. Has the Company ceded any risk, which is not subject to Appendix A-791 and not yearly renewable term reinsurance, under any reinsurance contract (or multiple contracts with the same reinsurer or its affiliates) during the period covered by the financial statements, and either:

   (a) Accounted for that contract as reinsurance under statutory accounting principles (SAP) and as a deposit under US generally accepted accounting principles (GAAP); or

   Yes ☐ No ☑ N/A ☐

   (b) Accounted for that contract as reinsurance under US GAAP and as a deposit under SAP?

   Yes ☐ No ☑ N/A ☐

   If the answer to item (a) or item (b) is yes, include relevant information regarding US GAAP to SAP differences from the accounting policy footnote to the audited statutory-basis financial statements to explain why the contract(s) is treated differently for US GAAP and SAP below:

Aetna Better Health of Kansas Inc.

Note to Other Financial Information

December 31, 2022

Note - Basis of Presentation

The accompanying supplemental schedules present selected statutory-basis financial data as of December 31, 2022 and for the year then ended for purposes of complying with the National Association of Insurance Commissioners' Accounting Practices and Procedures Manual and agrees to or is included in the amounts reported in the Company's 2022 Statutory Annual Statement as filed with the Kansas Insurance Department.

Financial Statements - Statutory Basis

Aetna Better Health of Kansas Inc.

Years Ended December 31, 2021 and 2020
with Report of Independent Auditors

Ernst & Young LLP
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Hartford, CT 06103

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Report of Independent Auditors

Board of Directors
Aetna Better Health of Kansas Inc.

Opinion

We have audited the statutory-basis financial statements of Aetna Better Health of Kansas Inc. (the "Company"), which comprise the balance sheets as of December 31, 2021 and 2020, and the related statements of operations, changes in capital and surplus and cash flow for the years then ended, and the related notes to the financial statements (collectively referred to as the "financial statements").

Unmodified Opinion on Statutory Basis of Accounting

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2021 and 2020, and the results of its operations and its cash flows for the years then ended, on the basis of accounting described in Note 2.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the matter described in the Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles section of our report, the financial statements do not present fairly, in accordance with accounting principles generally accepted in the United States of America, the financial position of the Company at December 31, 2021 and 2020, or the results of its operations or its cash flows for the years then ended.

Basis for Opinion

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

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

As described in Note 2 to the financial statements, the Company prepared these financial statements using accounting practices prescribed or permitted by the Kansas Insurance Department, which is a basis of accounting other than accounting principles generally accepted in the United States of America. The effects on the financial statements of the variances between these statutory accounting practices described in Note 2 and accounting principles generally accepted in the United States of America, although not reasonably determinable, are presumed to be material and pervasive.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with the accounting practices prescribed or permitted by the Kansas Insurance Department.

Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for one year after the date that the financial statements are issued.

Auditor's Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with GAAS, we:

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

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

Ernst & Young LLP

April 28, 2022

Balance Sheets - Statutory Basis

(In Thousands)	December 31, 2021	2020
Admitted assets		
Cash and invested assets		
Bonds	$ 179,979	$ 186,906
Cash, cash equivalents and short-term investments	18,721	36,233
Other invested assets	3,079	—
Total cash and invested assets	201,779	223,139
Investment income due and accrued	1,682	1,705
Premiums and considerations receivable	71,516	72,744
Reinsurance recoverable	—	241
Current federal income tax recoverable	584	—
Net deferred tax asset	1,945	1,093
Health care and other amounts receivable	890	79
Total admitted assets	$ 278,396	$ 299,001

See accompanying Notes to the Statutory Financial Statements

Balance Sheets - Statutory Basis (continued)

(In Thousands)	December 31, 2021	2020
Liabilities and capital and surplus		
Liabilities:		
Claims unpaid	$ 121,201	$ 115,770
Accrued medical incentive pool and bonus amounts	1,000	—
Unpaid claims adjustment expenses	3,016	3,700
Premiums received in advance	11	5
General expenses due or accrued	4,083	5,619
Current federal income tax payable	—	1,007
Remittances and items not allocated	164	483
Amounts due to parent, subsidiaries and affiliates	6,696	44,667
Payable for securities	—	1,075
Funds held under reinsurance treaties	277	—
Liability for amounts held under uninsured plans	1,485	—
Other liabilities	448	262
Total liabilities	138,381	172,588
Capital and surplus:		
Gross paid in and contributed surplus	133,090	142,000
Unassigned surplus (deficit)	6,925	(15,587)
Total capital and surplus	140,015	126,413
Total liabilities and capital and surplus	$ 278,396	$ 299,001

See accompanying Notes to the Statutory Financial Statements

Statements of Operations - Statutory Basis

(In Thousands)	Year ended December 31, 2021	2020
Revenues		
Premium income	$ 1,133,122	$ 958,283
Total revenues	1,133,122	958,283
Benefits and expenses		
Claims	943,706	817,656
Net reinsurance recoveries	(2,567)	(821)
Claims adjustment expenses	46,795	42,730
General administrative expenses	105,308	107,456
Total benefits and expenses	1,093,242	967,021
Net underwriting gain (loss)	39,880	(8,738)
Investment gains		
Net investment income earned	6,353	4,431
Net realized capital losses less capital gains tax expense (benefit)	(464)	(914)
Total investment gains	5,889	3,517
Income (loss) before federal income taxes	45,769	(5,221)
Federal income tax expense	7,485	2,959
Net income (loss)	$ 38,284	$ (8,180)

See accompanying Notes to the Statutory Financial Statements

Statements of Changes in Capital and Surplus - Statutory Basis

(In Thousands)	Year ended December 31, 2021	2020
Capital and surplus, beginning of year	$ 126,413	$ 128,020
Net income (loss)	38,284	(8,180)
Change in net unrealized capital losses less capital gains tax benefit	(70)	(91)
Change in net deferred income tax	833	1,060
Change in nonadmitted assets	(445)	604
Capital (distribution to) contribution from parent	(8,910)	5,000
Dividends to shareholder	(16,090)	—
Net change in capital and surplus	13,602	(1,607)
Capital and surplus, end of year	$ 140,015	$ 126,413

See accompanying Notes to the Statutory Financial Statements

Statements of Cash Flow - Statutory Basis

(In Thousands)	Year ended December 31, 2021	2020
Cash from operations		
Premiums collected	$ 1,134,331	$ 949,853
Investment income received	7,769	4,325
Claims paid	(935,704)	(797,067)
General administrative expenses and other benefits and expenses paid	(152,833)	(143,846)
Federal income taxes paid	(9,190)	(1,787)
Net cash provided by operating activities	44,373	11,478
Cash from investments		
Proceeds from investments sold, matured or repaid	56,848	27,030
Cost of investments acquired	(55,908)	(124,402)
Net cash provided by (used in) investment activities	940	(97,372)
Cash from financing and miscellaneous sources		
Capital (returned to) contributed from parent	(8,910)	5,000
Dividends to shareholder	(16,090)	—
Other cash (applied) provided	(37,825)	43,336
Net cash (used in) provided by financing and miscellaneous activities	(62,825)	48,336
Change in cash, cash equivalents and short-term investments	(17,512)	(37,558)
Cash, cash equivalents and short-term investments, beginning of year	36,233	73,791
Cash, cash equivalents and short-term investments, end of year	$ 18,721	$ 36,233
Supplemental disclosures of cash flow information from non-cash transactions		
Non cash investment exchanges	$ 4,575	$ 6,791

See accompanying Notes to the Statutory Financial Statements

1. Organization and operation

Aetna Better Health of Kansas Inc. (the "Company") is a wholly-owned subsidiary of Aetna Health Holdings, LLC, whose ultimate parent is CVS Health Corporation ("CVS Health").

The Company was incorporated in the State of Kansas on July 25, 2016. Effective January 1, 2019, the Company contracts with the State of Kansas Department of Health and Human Services to provide health benefits to Medicaid, Home and Community Based waiver, and Children's Health Insurance Program ("CHIP") members. The Company's current contract with the State of Kansas runs through June 30, 2024. Effective January 1, 2021, the Company contracts Medicare Advantage policies administered by the Centers for Medicare and Medicaid Services ("CMS") within the State of Texas.

2. Summary of significant accounting policies

Accounting practices

The accompanying statutory financial statements of the Company have been prepared in conformity with accounting practices prescribed or permitted by the Kansas Insurance Department ("Kansas Department") ("Kansas Accounting Practices"). The Kansas Department recognizes statutory accounting practices prescribed or permitted by the State of Kansas for determining and reporting the financial condition and results of operations of an insurance company, which include accounting practices and procedures adopted by the National Association of Insurance Commissioners ("NAIC") and included in the Accounting Practices and Procedures Manual ("NAIC SAP").

Kansas Accounting Practices vary from U.S. generally accepted accounting principles ("GAAP"). The primary differences include the following:

- Certain assets, designated as nonadmitted assets (in part, uncollected premiums are nonadmitted in accordance with Statements of Statutory Accounting Principles ("SSAP") No. 6 - *Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers*) are not recorded as assets, but are charged to surplus. Thus, nonadmitting uncollected premiums eliminates the need for a separate allowance for doubtful accounts, which is utilized under GAAP;
- Certain assets, designated as nonadmitted assets (other receivables and prepaid capitation, which are nonadmitted in accordance with SSAP No. 4 - *Assets and Nonadmitted Assets*) are not recorded as assets, but are charged to surplus. Assets having economic value other than those which can be used to fulfill policyholder obligations, or those assets which are unavailable due to encumbrances or other third party interests are not recognized on the Balance Sheets, and are, therefore, considered nonadmitted;
- Bonds are recorded at amortized cost except for those with an NAIC designation of 3 through 6, which are reported at the lower of amortized cost or fair value. Therefore, changes in unrealized gains and losses for those securities held at amortized cost are not reflected in the financial statements. Under GAAP, bonds classified as available for sale are recorded at fair value, and related changes in unrealized gains and losses are recorded as a component of equity, net of deferred federal income taxes;
- In accordance with SSAP No. 26 - Revised - *Bonds*, an other-than-temporary impairment ("OTTI") loss is recorded as a realized loss equal to the entire difference between the bond's carrying value and its fair value at the balance sheet date of the reporting period at which the assessment is made and a new carrying value is established for prospective reporting periods. On a GAAP basis, when the Company does not intend to sell the security and it is more likely than not that the entity will not be required to sell such security before recovery of its amortized cost basis, the Company bifurcates an impairment into credit-related and non-credit related components. In evaluating whether a credit related loss exists, the Company considers a variety of factors including: the extent to which the fair value is less than the amortized cost basis; adverse conditions specifically related to the issuer of a security, an industry or geographic area; the payment structure of the security; the failure of the issuer of the security to make scheduled interest or principal payments; and any changes to the rating of the security by a rating agency. The amount of the credit-related component is recorded as an allowance for credit losses and recognized in net income, and the amount of the non-credit related component is included in other comprehensive income;
- In accordance with SSAP No. 43 - Revised - *Loan-Backed and Structured Securities* ("SSAP 43R"), OTTI on loan-backed or structured securities are recorded when fair value of the security is less than its amortized

cost basis at the balance sheet date and (1) the Company intends to sell the investment or (2) the Company does not have the intent and ability to retain the investment for the time sufficient to recover the amortized cost basis or (3) if the Company does not expect to recover the entire amortized cost basis of the security, even if it does not intend to sell the security and the Company has the intent and ability to hold. The condition in (2) above does not apply for GAAP. OTTI is recorded as the difference between the investment's amortized cost basis and the present value of cash flows expected to be collected;

- Deferred tax assets and liabilities are determined and admitted in accordance with SSAP No. 101 - *Income Taxes* ("SSAP No. 101"). Changes in net deferred tax assets and liabilities are reflected as changes in surplus, whereas under GAAP, changes in such assets and liabilities are reflected in net income. In addition, statutory accounting requires consideration of a statutory allowance adjustment in the calculation of adjusted gross deferred tax assets and an admissibility test for deferred tax assets;
- In accordance with SSAP No. 2 - Revised - *Cash, Cash Equivalents, Drafts and Short-term Investments*, certain short-term borrowings are classified as a reduction of cash, cash equivalents, and short-term investments. Under GAAP, these amounts would have been classified as liabilities; and
- Cash, cash equivalents, and short-term investments in the Statements of Cash Flow represent cash balances and investments with remaining maturities of one year or less at the time of acquisition. Under GAAP, the corresponding caption of cash and cash equivalents includes cash balances and investments with initial maturities of three months or less. The statement does not classify cash flows consistent with GAAP and a reconciliation of net earnings to net cash provided by operations is not provided.

The effects of the foregoing variances from GAAP on the accompanying statutory financial statements have not been determined but are presumed to be material.

There were no prescribed or permitted practices by the State of Kansas for the years ended December 31, 2021 and 2020.

Use of estimates in the preparation of the financial statements

The preparation of these financial statements in conformity with Kansas Accounting Practices requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and revenue and expenses. Actual results could differ from those estimates.

Significant accounting policies

The Company applies the following significant accounting policies:

Cash, cash equivalents and short-term investments

Cash, cash equivalents and short-term investments, consisting primarily of money market instruments and other debt issues with an original maturity of up to one year, are carried at amortized cost. Short-term investments consist primarily of investments purchased with an original maturity date of greater than three months but less than one year. Cash equivalents consist of highly liquid instruments, which mature within three months from the date of purchase. The carrying amount of cash, cash equivalents and short-term investments approximates fair value. Cash accounts with positive balances shall not be reported separately from cash accounts with negative balances. If in the aggregate, the reporting entity has a net negative cash balance, it shall be reported as a negative asset and shall not be recorded as a liability.

Bonds

Bonds are carried at amortized cost except for those bonds with an NAIC designation of 3 through 6, which are carried at the lower of amortized cost or fair value. Bond premiums and discounts are amortized using the scientific interest method. When quoted prices in active markets for identical assets are available, the Company uses these quoted market prices to determine the fair value of bonds. This is used primarily for U.S. government securities. In other cases where a quoted market price for identical assets in an active market is either not available or not observable, the Company estimates fair values using valuation methodologies based on available and observable market information or by using a matrix pricing model. If quoted market prices are not available, the Company

determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. The Company had no material investments where fair value was determined using broker quotes or an internal analysis of financial performance and cash flow projections at December 31, 2021 and 2020. Bonds include all investments whose maturity is greater than one year when purchased. Loan-backed and structured securities ("LB&SS") are carried at amortized cost adjusted for unamortized premiums and discounts and are accounted for using the retrospective adjustment method. Premiums and discounts on loan-backed and structured securities are amortized using the scientific interest method over the estimated remaining term of the securities, adjusted for anticipated prepayments. All adjustments between amortized cost and carrying value are reflected in unrealized capital gains and losses and are reported as direct adjustments to surplus.

Bonds are recorded as purchases or sales on the trade date.

The Company periodically reviews its bonds to determine whether a decline in fair value below the carrying value is other-than-temporary. For bonds, other than LB&SS, an OTTI shall be recorded if it is probable that the Company will be unable to collect all amounts due according to the contractual terms in effect at the date of acquisition. Declines deemed to be OTTI in the cost basis are recognized as realized capital losses. Yield-related impairments are deemed other-than-temporary when the Company intends to sell an investment at the reporting date before recovery of the cost of the investment.

For LB&SS, the Company records OTTI when the fair value of the loan-backed or structured security is less than the amortized cost basis at the balance sheet date and (1) the Company intends to sell the investment, (2) the Company does not have the intent and ability to retain the investment for the time sufficient to recover the amortized cost basis, or (3) the Company does not expect to recover the entire amortized cost basis of the security, even if it does not intend to sell the security and has the intent and ability to hold. If it is determined an OTTI has occurred because of (1) or (2), the amount of the OTTI is equal to the difference between the amortized cost and the fair value of the security at the balance sheet date and this difference is recorded as a realized capital loss. If it is determined an OTTI has occurred because of (3), the amount of the OTTI is equal to the difference between the amortized cost and the present value of cash flows expected to be collected, discounted at the loan-backed or structured security's effective interest rate and this difference is also accounted for as a realized capital loss.

The Company analyzes all relevant facts and circumstances for each investment when performing its analysis to determine whether an OTTI exists. Among the factors considered in evaluating whether a decline is other-than-temporary, management considers whether the decline in fair value results from a change in the quality of the investment security itself, whether the decline results from a downward movement in the market as a whole, the prospects for realizing the carrying value of the bond based on the investee's current and short-term prospects for recovery and other factors. The risks inherent in assessing the impairment of an investment include the risk that market factors may differ from the Company's expectations and the risk that facts and circumstances factored into its assessment may change with the passage of time. Unexpected changes to market factors and circumstances that were not present in past reporting periods may result in a current period decision to sell securities that were not other-than-temporarily impaired in prior reporting periods.

For the Company's bonds and LB&SS that provide for a prepayment penalty or acceleration fee in the event the bond or LB&SS is liquidated prior to its scheduled termination date, the Company reports such fees as investment income when earned.

Investment income due and accrued

Accrued investment income consists primarily of interest. Interest is recognized on an accrual basis and dividends are recorded as earned on the ex-dividend date. Due and accrued income is not recorded on: (a) bonds in default; and (b) bonds delinquent more than 90 days or where collection of interest is improbable. At December 31, 2021 and 2020, the Company did not have any nonadmitted investment income due and accrued.

Premiums and amounts due and unpaid

Premium revenue for health care products is recognized as income in the month in which enrollees are entitled to health care services. Premiums collected before the effective period are reported as premiums received in advance. Premiums related to unexpired contractual coverage periods are reported as unearned premiums and are included in aggregate health policy reserves in the Balance Sheets.

Nonadmitted amounts consist of all premiums due and unpaid greater than 90 days past due, with the exception of amounts due under government insured plans, which may be admitted assets under certain circumstances. In addition, for any customer for which the premiums due and unpaid greater than 90 days past due is more than a de minimus portion of the entire balance of premiums due and unpaid for that customer, the entire balance of premiums due and unpaid for that customer is nonadmitted. Management also performs a specific review of accounts and based on the results of the review, additional amounts may be nonadmitted. Uncollectible amounts are generally written-off and charged to revenue in the period in which the customer reconciliations are completed and agreed to by the customer (retroactivity) or when the account is determined to be uncollectible by the Company.

Medicare Advantage premiums and related subsidies

Through the Company's Medicare Advantage Part D annual contract with CMS, the Company receives monthly premium payments from CMS and members, as determined by the Company's annual bid process. The Company recognizes the revenue related to the CMS contract ratably over the term of its annual contract.

The CMS payment is subject to risk sharing provisions through the CMS risk corridor provision, which is accounted for as a retrospectively rated contract in accordance with SSAP No. 66 - *Retrospectively Rated Contracts*. Receivables related to the CMS risk corridor provision are included in accrued retrospective premiums and payables related to the CMS risk corridor provision are included in liability for amounts held under uninsured plans on the Balance Sheets.

Certain subsidies from CMS, including reinsurance payments, the coverage gap discount program and the cost-sharing portion of the low income subsidy, represent cost reimbursements under the Medicare Part D program for which the Company assumes no risk. Amounts received for these subsidies are not reflected as premium revenues, but rather are accounted for as deposits. Receivables for these subsidies are included in amounts receivable relating to uninsured plans and liabilities for these subsidies are included in amounts held under uninsured plans on the Balance Sheets.

Claims and claims adjustment expenses and related reserves

Claims consist principally of fee-for-service medical claims and capitation costs. Claims unpaid and aggregate health claim reserves include the Company's estimate of payments to be made on claims reported but not yet paid and for health care services rendered to enrollees but not yet reported to the Company as of the Balance Sheet date. Such estimates are developed using actuarial principles and assumptions, which consider, among other things, historical and projected claim submission and processing payment patterns, medical cost trends, historical utilization of health care services, claim inventory levels, medical inflation, changes in membership and product mix, seasonality and other relevant factors. The Company reflects changes in estimates in claims costs in the Statements of Operations in the period they are determined. Capitation costs, which are recorded in claims in the Statements of Operations, represent contractual monthly fees paid to participating physicians and other medical providers for providing medical care, regardless of the medical services provided to the enrollee.

The Company generally compensates primary care physicians through prospective compensation arrangements, which incorporate quality assessment standards, comprehensiveness of care, utilization and office status components. These components are used to adjust the capitation payments to individual physician offices and to determine the amount of additional periodic payments. The Company has prospective compensation arrangements for mental health, substance abuse, diagnostic laboratory, radiology and diagnostic imaging services, podiatric treatment, physical therapy and prescription drug dispensing. The Company has contracts that provide for all-inclusive per diem and per case hospitalization rates and fixed rates for ambulatory surgery, emergency room

services and specialist services. The Company has also entered into quality based compensation arrangements with certain hospitals, as well as agreements with certain integrated health delivery systems under which the systems are compensated on a substantially fixed prospective basis for medical services, including primary, specialist and hospital care. The arrangements described above cover the majority of medical expenses, which are recorded in claims in the Statements of Operations.

The Company uses the triangulation method to estimate reserves for claims incurred but not reported. The method of triangulation makes estimates of completion factors that are then applied to the total paid claims (net of coordination of benefits) to date for each incurral month. This provides an estimate of the total projected incurred claims and total amount outstanding or claims incurred but not reported (claims unpaid). For the most current dates of service where there is insufficient paid claim data to rely solely on the triangulation method, the Company examines cost and utilization trends as well as environmental factors, plan changes, provider contracts, changes in membership and/or benefits, and historical seasonal patterns to estimate the reserve required for these months.

Claims adjustment expenses, which include cost containment expenses, represent the costs incurred related to the claim settlement process such as costs to record, process and adjust claims. These expenses are included in the Company's management agreement with an affiliate described in Note 5.

Aggregate health policy reserves and related expenses

Premium deficiency reserves (“PDR”) are recognized when it is probable that the expected future hospital and medical costs, including maintenance costs, will exceed anticipated future premiums and reinsurance recoveries on existing contracts. Anticipated investment income is not considered in the calculation of PDR. For purposes of calculating a PDR, contracts are grouped in a manner consistent with the method of acquiring, servicing and measuring the profitability of such contracts.

The Company had no PDR at December 31, 2021 or 2020.

Fees paid to the Federal Government by health insurers

SSAP No. 106 - *Affordable Care Act Section 9010 Assessment* (“SSAP No. 106”) required (1) that the annual fee be recognized in full on January 1 of the fee year (the calendar year in which the assessment must be paid to the federal government), in the operating expense category of general administrative expenses, excluding federal income taxes and (2) that in each data year preceding a fee year a reporting entity pro-ratably accrue by reclassifying from unassigned surplus to special surplus funds an amount equal to its estimated subsequent fee year assessment. This reclassification has no impact on total capital and surplus and is reversed in full on January 1 of the fee year. On January 1, 2020, the Company was subject to the annual fee (“ACA assessment”). This annual fee was allocated to individual health insurers based on the ratio of the amount of the entity’s net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that was written during the preceding calendar year. A health insurance entity’s portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. In September 2020, the Company paid $16,483 thousand to the federal government for its portion of the annual fee. In December 2019, the annual fee was repealed beginning in 2021. As a result of this repeal, there was no annual fee payable in 2021 and thereafter, and therefore no estimated subsequent fee year assessment was required to be reclassified from unassigned funds to special surplus funds at December 31, 2021 and December 31, 2020.

Federal and state income taxes

Aetna Inc. ("Aetna") and its wholly-owned subsidiaries are included in the consolidated federal income tax return of its parent company, CVS Health, pursuant to the terms of a tax sharing agreement. In accordance with the agreement, the Company’s current federal and state income tax provisions are generally computed as if the Company were filing a separate federal and state income tax return; current income tax benefits, including those resulting from net operating losses, are recognized to the extent expected to be realized in the consolidated return. Pursuant to the agreement, the Company has the enforceable right to recoup federal and state income taxes paid in

prior years in the event of future net losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal and state income taxes.

Income taxes are accounted for under the asset and liability method. Deferred income tax assets ("DTAs") and liabilities ("DTLs") represent the expected future tax consequences of temporary differences generated by statutory accounting as defined in SSAP No. 101. DTAs and DTLs are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. DTAs and DTLs are computed by means of identifying temporary differences, which are measured using a balance sheet approach whereby statutory and tax basis balance sheets are compared. Current income tax recoverables include all current income taxes, including interest, reasonably expected to be recovered in a subsequent accounting period.

Pursuant to SSAP No. 101, gross DTAs are first reduced by a statutory valuation allowance adjustment to an amount that is more likely than not to be realized ("adjusted gross DTAs"). Adjusted gross DTAs are then admitted in an amount equal to the sum of paragraphs a., b. and c. below:

a. Federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse during a timeframe corresponding with Internal Revenue Code ("IRC") tax loss carryback provisions.

b. The amount of adjusted gross DTAs, after the application of paragraph a. above, expected to be realized within the applicable period and that is no greater than the applicable percentage as determined using the applicable Realization Threshold Limitation Table. The applicable period refers to the number of years in which the DTA will reverse in the Company's tax return and the applicable percentage refers to the percentage of the Company's statutory capital and surplus as required to be shown on the statutory balance sheet adjusted to exclude any net DTAs, electronic data processing equipment and operating system software and any net positive goodwill ("Stat Cap ExDTA").

   The Realization Threshold Limitation Tables allow DTAs to be admitted based upon either realization within 3 years and 15% of Stat Cap ExDTA, 1 year and 10% of Stat Cap ExDTA, or no DTA admitted pursuant to this paragraph b. In general, the Realization Threshold Limitation Tables allow the Company to admit more DTAs if total DTAs as reported by the Company are a smaller percentage of statutory capital and surplus.

c. The amount of gross DTAs, after the application of paragraphs a. and b. above that can be offset against existing gross DTLs. In applying this offset, the Company considers the character (i.e. ordinary versus capital) of the DTAs and DTLs such that offsetting would be permitted in the tax return under existing enacted federal income tax laws and regulations and the reversal patterns of temporary differences.

Changes in DTAs and DTLs are recognized as a separate component of gains and losses in surplus ("Change in net deferred income tax") except to the extent allocated to changes in unrealized gains and losses. Changes in DTAs and DTLs allocated to unrealized gains and losses are netted against the related changes in unrealized gains and losses and are reported as "Change in net unrealized capital gains and (losses)", also a separate component of gains and losses in surplus.

The Company is subject to state income taxes in various states. State income tax expense is recorded in general administrative expenses in the Statements of Operations.

3. Bonds and other financial instruments

The following is a summary of bonds and other financial instruments receiving bond treatment, which includes cash equivalents, at December 31, 2021 and 2020:

December 31, 2021

(In Thousands)	Amortized cost	Statutory carrying value	Gross unrealized gains	Gross unrealized losses	Fair value
U.S. government	$ 10,644	$ 10,644	$ 392	$ —	$ 11,036
All other governments	23,437	23,311	963	(106)	24,168
U.S. states, territories and possessions (direct and guaranteed)	13,046	13,046	530	(5)	13,571
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	29,874	29,874	1,322	(94)	31,102
Industrial and miscellaneous (unaffiliated)	115,198	115,106	3,589	(231)	118,464
Total	$ 192,199	$ 191,981	$ 6,796	$ (436)	$ 198,341

December 31, 2020

(In Thousands)	Amortized cost	Statutory carrying value	Gross unrealized gains	Gross unrealized losses	Fair value
U.S. government	$ 20,366	$ 20,366	$ 685	$ —	$ 21,051
All other governments	20,988	20,983	1,717	—	22,700
U.S. states, territories and possessions (direct and guaranteed)	11,957	11,957	761	—	12,718
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	1,355	1,355	26	—	1,381
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	30,656	30,656	1,401	(1)	32,056
Industrial and miscellaneous (unaffiliated)	124,397	124,273	5,691	(2)	129,962
Total	$ 209,719	$ 209,590	$ 10,281	$ (3)	$ 219,868

Summarized below are the Company's bonds and other financial instruments receiving bond treatment with unrealized losses at December 31, 2021 and 2020, along with the related fair values, aggregated by the length of time the investments have been in an unrealized loss position:

December 31, 2021

	Less than 12 months			Greater than 12 months		
(In Thousands, except number of securities)	Number of securities	Fair value	Unrealized losses	Number of securities	Fair value	Unrealized losses
All other governments	1	1,029	13	1	2,700	93
U.S. states, territories and possessions (direct and guaranteed)	1	1,327	5	—	—	—
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	5	$ 7,427	$ 94	—	$ —	$ —
Industrial and miscellaneous (unaffiliated)	17	18,833	178	1	1,945	53
Total	24	$ 28,616	$ 290	2	$ 4,645	$ 146

	Total		
(In Thousands, except number of securities)	Number of securities	Fair value	Unrealized losses
All other governments	2	3,729	106
U.S. states, territories and possessions (direct and guaranteed)	1	1,327	5
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	5	$ 7,427	$ 94
Industrial and miscellaneous (unaffiliated)	18	20,778	231
Total	26	$ 33,261	$ 436

December 31, 2020

	Less than 12 months			Greater than 12 months		
(In Thousands, except number of securities)	Number of securities	Fair value	Unrealized losses	Number of securities	Fair value	Unrealized losses
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	1	$ 749	$ 1	—	$ —	$ —
Industrial and miscellaneous (unaffiliated)	1	540	2	—	—	—
Total	2	$ 1,289	$ 3	—	$ —	$ —

	Total		
(In Thousands, except number of securities)	Number of securities	Fair value	Unrealized losses
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	1	$ 749	$ 1
Industrial and miscellaneous (unaffiliated)	1	540	2
Total	2	$ 1,289	$ 3

The Company has reviewed the investments in the tables above and has concluded that these are performing assets generating investment income to support the needs of the business. In performing this review, the Company considered factors such as the quality of the investment security based on research performed by external rating agencies and internal credit analysts and the prospects of realizing the carrying value of the security based on the investment's current prospects for recovery. Furthermore, the Company has no intention to sell the investments in the tables above at December 31, 2021 and 2020 before their cost can be recovered and for loan-backed and structured securities the Company has the ability and intent to hold these securities for a period of time sufficient to recover the amortized cost; therefore, no OTTI was determined to have occurred on these investments during the years ended December 31, 2021 and 2020. In determining if the Company needs to sell before full recovery of value, the Company considers the forecasted recovery period, expected investment returns relative to other funding sources, projected cash flow and capital requirements, regulatory obligations, and other factors. Unrealized losses at December 31, 2021 and 2020 were generally caused by the widening of market yields for these securities relative to the market yields when these securities were purchased.

The contractual or expected maturities of bonds and assets receiving bond treatment (e.g., cash equivalents and short-term investments) at December 31, 2021 were as follows:

(In Thousands)	Carrying value	Fair value
Due one year or less	$ 20,520	$ 20,540
Due after one year through five years	78,200	80,049
Due after five years through ten years	77,369	80,737
Due after ten years	15,892	17,015
Total	$ 191,981	$ 198,341

The maturity for mortgage pass-through securities, included in U.S. Government and U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions, is not based on stated maturity, but instead is based on prepayment assumptions. Prepayment assumptions are calculated utilizing published repayment factors that estimate the prepayment rates on the mortgages in the Federal National Mortgage Association and Government National Mortgage Association pools.

Proceeds from the maturities and sales of the Company's bonds and other financial instruments receiving bond treatment and the related gross realized capital gains and losses and the OTTI charges on bonds for the years ending December 31, 2021 and 2020 were as follows:

(In Thousands)	2021	2020
Proceeds from sales of bonds	$ 31,546	$ 23,054
Proceeds from maturities of bonds	25,302	2,900
Gross realized gains on sales of bonds	538	399
Gross realized losses on sales of bonds	112	1,357
OTTI charges on bonds that were in an unrealized loss position (included in net realized capital losses)	334	153

The Company conducts regular reviews of its bond investments to assess whether a decline in fair value below carrying value is an OTTI. The Company will also recognize an OTTI on bonds when the Company intends to sell a security that is in an unrealized loss position. Declines deemed to be OTTI are recognized as realized capital losses.

The Company’s unrealized loss position on loan-backed and structured securities held by the Company at December 31, 2021 and 2020 is as follows:

(In Thousands)	2021	2020
Aggregate amount of unrealized losses		
Less than 12 months	$ 83	$ 2
12 months or longer	—	—
Aggregate related fair value of securities with unrealized losses		
Less than 12 months	$ 10,114	$ 540
12 months or longer	—	—

The Company has reviewed the loan-backed and structured securities in accordance with SSAP No. 43R in the tables above and have concluded that these are performing assets generating investment income to support the needs of the business. Furthermore, the Company has no intention to sell the securities at December 31, 2021 and 2020 before their cost can be recovered and does have the intent and ability to retain the securities for the time sufficient to recover the amortized cost basis; therefore, no OTTI write-down to fair value was determined to have occurred on these securities.

4. Financial instruments

Financial instruments measured at fair value in the financial statements

The Company had no material assets and liabilities that are measured and reported at fair value as of December 31, 2021 and 2020.

The fair values of financial instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy. The following are the levels of the hierarchy and a brief description of the type of valuation information ("inputs") that qualifies a financial asset or liability for each level:

- **Level 1** – Unadjusted quoted prices for identical assets or liabilities in active markets.
- **Level 2** – Inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, inputs that are observable that are not prices (such as interest rates and credit risks) and inputs that are derived from or corroborated by observable markets.
- **Level 3** – Developed from unobservable data, reflecting the Company's own assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, the Company uses these quoted market prices to determine the fair value of financial assets and liabilities and classifies these assets and liabilities as Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, the Company estimates fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities would then be classified as Level 2. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

Transfers in and out of all levels are recognized at the end of the reporting period in which the transfer occurred.

The carrying values and estimated fair values of the Company's financial instruments at December 31, 2021 and 2020 were as follows:

December 31, 2021

(In Thousands)	Aggregate fair value	Admitted assets	(Level 1)	(Level 2)	(Level 3)
Assets					
Bonds, short term, and cash equivalents	$ 198,341	$ 191,981	$ 11,033	$ 187,308	$ —
Total	$ 198,341	$ 191,981	$ 11,033	$ 187,308	$ —

December 31, 2020

(In Thousands)	Aggregate fair value	Admitted assets	(Level 1)	(Level 2)	(Level 3)
Assets					
Bonds, short term, and cash equivalents	$ 219,868	$ 209,590	$ 19,363	$ 200,505	$ —
Total	$ 219,868	$ 209,590	$ 19,363	$ 200,505	$ —

Fair value of the Company's other invested assets was $3,079 thousand at December 31, 2021, and are classified as Level 3 financial assets.

In evaluating the Company's management of interest rate and liquidity risk and currency exposures, the fair values of all assets and liabilities should be taken into consideration, not only those presented above.

5. Information concerning parent, subsidiaries, and affiliates

As of and for the years ended December 31, 2021 and 2020, the Company had the following significant transactions with affiliates:

The Company and Aetna Medicaid Administrators LLC ("AMA") are parties to an administrative services agreement, under which AMA and certain of its affiliates provide certain administrative services, including cash management and accounting and processing of premiums and claims. Under this agreement, the Company will remit a percentage of its earned premium revenue, as applicable, to AMA as a fee. The agreement was amended effective January 1, 2020 and approved by the Kansas Department on May 18, 2020. The amendment allows other affiliates to provide services in accordance to a schedule of services and pricing. For these services, the Company was charged $90,827 thousand and $76,663 thousand in 2021 and 2020, respectively.

AMA and Aetna Health Management, LLC ("AHM"), indirectly a wholly-owned subsidiary of CVS Health, entered into a plan joinder agreement. Under this agreement, AHM has contracted with Caremark PCS Health, LLC ("Caremark"), an affiliate, to deliver pharmacy benefit management services to the Company through the Company's administrative services agreement with AMA. The Company will make payments to AMA in accordance with the administrative services agreement.

As explained in Note 2, Aetna and its wholly-owned subsidiaries, including the Company, participate in a tax sharing agreement with CVS Health. All federal income tax receivables/payables are due from/due to CVS Health.

The Company invests in Aetna Partners Diversified Fund, LLC ("APDF"), an affiliated entity, that is a fund of hedge funds. The Company records this investment as an other invested asset. The value of the Company's investment in APDF was $3,079 thousand at December 31, 2021.

At December 31, 2021 and 2020, the Company had the following amounts due to affiliates:

	December 31,	
(In Thousands)	**2021**	**2020**
Amounts due to affiliates		
Aetna Medicaid Administrators LLC	$ 6,696	$ 44,667
Total due to affiliates	$ 6,696	$ 44,667

At December 31, 2021 and 2020, the Company had no amounts due from affiliates.

The terms of settlement require that these amounts be settled within 45 days after the end of the calendar quarter.

6. Income taxes

The components of the net DTAs recognized in the Company's Balance Sheets are as follows:

	December 31, 2021		
(In Thousands)	**Ordinary**	**Capital**	**Total**
Gross DTAs	$ 1,925	$ 307	$ 2,232
Statutory valuation allowance adjustment	—	(48)	(48)
Adjusted gross DTAs	1,925	259	2,184
DTAs nonadmitted	—	—	—
Subtotal net admitted DTAs	1,925	259	2,184
DTLs	(15)	(224)	(239)
Net admitted DTAs/(DTLs)	$ 1,910	$ 35	$ 1,945

	December 31, 2020		
(In Thousands)	**Ordinary**	**Capital**	**Total**
Gross DTAs	$ 2,025	$ 69	$ 2,094
Statutory valuation allowance adjustment	(917)	(54)	(971)
Adjusted gross DTAs	1,108	15	1,123
DTAs nonadmitted	—	—	—
Subtotal net admitted DTAs	1,108	15	1,123
DTLs	(15)	(15)	(30)
Net admitted DTAs/(DTLs)	$ 1,093	$ —	$ 1,093

	Change		
(In Thousands)	**Ordinary**	**Capital**	**Total**
Gross DTAs	$ (100)	$ 238	$ 138
Statutory valuation allowance adjustment	917	6	923
Adjusted gross DTAs	817	244	1,061
DTAs nonadmitted	—	—	—
Subtotal net admitted DTAs	817	244	1,061
DTLs	—	(209)	(209)
Net admitted DTAs/(DTLs)	$ 817	$ 35	$ 852

The amount of gross DTAs admitted under each component of SSAP No. 101 is as follows:

	December 31, 2021		
(In Thousands)	**Ordinary**	**Capital**	**Total**
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$ 1,909	$ 35	$ 1,944
(b) Adjusted gross DTAs expected to be realized (excluding the amount of DTAs after application of the threshold limitations (the lesser of (b)1 and (b)2 below))	16	—	16
1. Adjusted gross DTAs expected to be realized following the balance sheet date	16	—	16
2. Adjusted gross DTAs allowed per limitation threshold	XX	XX	20,711
(c) Adjusted gross DTAs (excluding the amount of DTAs from (a) and (b) above) offset by gross DTLs	—	224	224
(d) DTAs admitted as the result of application of SSAP No. 101	$ 1,925	$ 259	$ 2,184

	December 31, 2020		
(In Thousands)	**Ordinary**	**Capital**	**Total**
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$ 1,093	$ —	$ 1,093
(b) Adjusted gross DTAs expected to be realized (excluding the amount of DTAs after application of the threshold limitations (the lesser of (b)1 and (b)2 below))	—	—	—
1. Adjusted gross DTAs expected to be realized following the balance sheet date	—	—	—
2. Adjusted gross DTAs allowed per limitation threshold	XX	XX	18,798
(c) Adjusted gross DTAs (excluding the amount of DTAs from (a) and (b) above) offset by gross DTLs	15	15	30
(d) DTAs admitted as the result of application of SSAP No. 101	$ 1,108	$ 15	$ 1,123

	Change		
(In Thousands)	**Ordinary**	**Capital**	**Total**
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$ 816	$ 35	$ 851
(b) Adjusted gross DTAs expected to be realized (excluding the amount of DTAs after application of the threshold limitations (the lesser of (b)1 and (b)2 below))	16	—	16
1. Adjusted gross DTAs expected to be realized following the balance sheet date	16	—	16
2. Adjusted gross DTAs allowed per limitation threshold	XX	XX	1,913
(c) Adjusted gross DTAs (excluding the amount of DTAs from (a) and (b) above) offset by gross DTLs	(15)	209	194
(d) DTAs admitted as the result of application of SSAP No. 101	$ 817	$ 244	$ 1,061

($ in Thousands)	**2021**	**2020**
(a) Ratio percentage used to determine recovery period and threshold limitation amount	393 %	408 %
(b) Amount of adjusted capital and surplus used to determine recovery period threshold limitation in (b)2 above	$ 138,070	$ 125,320

There were no tax planning strategies impacting the Company's ordinary or capital DTAs.

The provision (benefit) for income taxes for the years ended December 31, 2021 and 2020 were as follows:

	December 31,		
(In Thousands)	**2021**	**2020**	**Change**
Federal income tax expense on operations	$ 7,485	$ 2,959	$ 4,526
Federal income tax provision (benefit) on net capital gains (losses)	114	(197)	311
Federal income tax incurred	$ 7,599	$ 2,762	$ 4,837

The tax effects of temporary differences that gave rise to deferred tax assets and liabilities at December 31, 2021 and 2020 were as follows:

	December 31,		
(In Thousands)	**2021**	**2020**	**Change**
DTAs:			
Ordinary			
Discounting of unpaid losses	$ 1,560	$ 1,754	$ (194)
Nonadmitted assets	364	271	93
Other	1	—	1
Total ordinary DTAs	1,925	2,025	(100)
Statutory valuation allowance adjustment	—	(917)	917
Nonadmitted ordinary DTAs	—	—	—
Admitted ordinary DTAs	1,925	1,108	817
Capital			
Investments	307	69	238
Total capital DTAs	307	69	238
Statutory valuation allowance adjustment	(48)	(54)	6
Nonadmitted capital DTAs	—	—	—
Admitted capital DTAs	259	15	244
Admitted DTAs	2,184	1,123	1,061
DTLs:			
Ordinary			
Investments	15	15	—
Ordinary DTLs	15	15	—
Capital			
Investments	224	15	209
Capital DTLs	224	15	209
Total DTLs	239	30	209
Net admitted DTAs/(DTLs)	$ 1,945	$ 1,093	$ 852

The change in net deferred income taxes is comprised of the following:

	December 31,		
(In Thousands)	**2021**	**2020**	Change
Total DTAs	$ 2,184	$ 1,123	$ 1,061
Total DTLs	(239)	(30)	(209)
Net DTAs/(DTLs)	1,945	1,093	852
Tax effect of unrealized gains (losses)			(19)
Change in net deferred income tax			$ 833

The valuation allowance adjustment to gross DTAs was $48 thousand for December 31, 2021. The valuation allowance adjustment to gross DTAs was $971 thousand for December 31, 2020. The Company bases its estimates of the future realization of DTAs primarily on historic taxable income and existing DTLs.

The provision (benefit) for federal income taxes is different from that which would be obtained by applying the statutory federal income tax rate to income before income taxes. The items causing this difference are as follows:

($ in Thousands)	December 31, 2021	Effective tax rate	December 31, 2020	Effective tax rate
Provision computed at statutory rate	$ 9,635	21.0 %	$ (1,138)	21.0 %
Health insurer fee	—	— %	3,462	(63.8)%
Transfer pricing adjustment	(1,740)	(3.8)%	(1,518)	28.0 %
Tax-exempt interest	(122)	(0.3)%	(99)	1.8 %
Change in nonadmitted assets	(92)	(0.2)%	125	(2.3)%
Prior year true-up	9	— %	616	(11.4)%
Change in valuation allowance adjustment	(924)	(2.0)%	254	(4.7)%
Total	$ 6,766	14.7 %	$ 1,702	(31.4)%
Federal and foreign income tax expense incurred	$ 7,599	16.6 %	$ 2,762	(51.0)%
Change in net deferred income taxes	(833)	(1.9)%	(1,060)	19.6 %
Total statutory income taxes	$ 6,766	14.7 %	$ 1,702	(31.4)%

The transfer pricing adjustment allows taxpayers to apply different methods to price current period intercompany services at arm's length prices (i.e., prices at which unrelated entities would be willing to transact), which results in a permanent deduction for tax reporting purposes.

At December 31, 2021 and 2020, the Company had no net capital loss or net operating loss carryforwards for tax purposes.

The amount of federal income taxes incurred that is available for recoupment in the event of future net losses are:

(In Thousands)

Year	Ordinary	Capital	Total
2021	$ 7,704	$ 146	$ 7,850
2020	842	—	842
2019	N/A	101	101
Total	$ 8,546	$ 247	$ 8,793

The Company did not report any deposits as admitted assets under Internal Revenue Code Section 6603 at December 31, 2021 and 2020.

As discussed in Note 2, the Company is included in the consolidated federal income tax return of its parent, CVS Health, along with other affiliates, as of December 31, 2021 and 2020.

The Company does not have any tax loss contingencies for which it is reasonably possible that the total liability will significantly increase within twelve months of the reporting date.

The Company is subject to premium taxes in various states. These tax expenses are recorded in general administrative expenses in the Statements of Operations. The expenses for these taxes were $59,902 thousand and $54,883 thousand for the years ended December 31, 2021 and 2020, respectively. The Company's premium tax payable of $3,860 thousand and $5,432 thousand at December 31, 2021 and 2020, respectively, are included in general expenses due or accrued in the Balance Sheets.

7. Claims liabilities

The following table shows the components of the change in claims unpaid, accrued medical incentive pool and bonus amounts, and unpaid claims adjustment expenses for the years ended December 31, 2021 and 2020:

(In Thousands)	2021	2020
Balance, January 1	$ 119,470	$ 101,204
Health care receivable	(1,364)	(1,884)
Balance, January 1, net of health care receivable	118,106	99,320
Incurred related to:		
Current year	1,016,143	876,943
Prior years	(28,209)	(17,378)
Total incurred	987,934	859,565
Paid related to:		
Current year	893,181	758,109
Prior years	90,242	82,670
Total paid	983,423	840,779
Balance, December 31, net of health care receivable	122,617	118,106
Health care receivable	2,600	1,364
Balance, December 31	$ 125,217	$ 119,470

Reserves for incurred claims and claims adjustment expenses attributable to insured events of prior years decreased by $28,209 thousand in 2021 and $17,378 thousand in 2020. Changes in prior periods' estimates represent the effect of favorable development of prior period health care cost estimates on current year net income, at each financial statement date. The favorable development of these reserves in 2021 and 2020 is primarily a result of the actual claim submission times for health care claims being shorter than the Company had anticipated, as well as lower than expected health care cost trends in determining claims unpaid at the prior financial statement date. Original estimates are increased or decreased as additional information becomes known regarding individual claims.

8. Capital and surplus and shareholder's dividend restrictions

The Company had 10,000 shares of common stock authorized with no par value, with 1,000 shares issued and outstanding at December 31, 2021 and 2020.

Dividend restrictions

Dividends on the Company's common capital stock are paid as declared by its Board of Directors, from earned surplus of the Company, not including surplus arising from the sale of stock. Generally, dividends may be paid on the Company's common capital stock without obtaining regulatory approval at an amount up to the greater of: a) the prior year net gain from operations, or b) ten percent of the prior year ending capital and surplus. In addition, the minimum Risk Based Capital requirements of the NAIC and, if applicable, the Kansas Insurance Department must be maintained. Per instruction from the Kansas Insurance Department, an ordinary dividend up to ten percent of the prior year capital and surplus may be declared and paid without obtaining regulatory approval. Dividends, when paid, are not cumulative.

At December 31, 2021 and 2020, there was no portion of the Company's profits that may be paid as ordinary dividends to its shareholder without prior approval from the Kansas Department.

The Company paid $16,090 thousand as an extraordinary dividend to its parent on August 31, 2021. The Kansas Department approved this dividend on August 30, 2021.

The Company paid $8,910 thousand as a return of capital to its parent on August 31, 2021. The Kansas Department approved this dividend on August 30, 2021.

The Company received $5,000 thousand as a capital contribution from its parent on December 28, 2020.

There were no restrictions placed on the Company's surplus, including for whom the surplus was being held at December 31, 2021 and 2020, except as noted in Note 11.

9. Contingencies

Guaranty fund assessments

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers and life insurers as well as health insurers. The Company's assessments generally are based on a formula relating to the Company's health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

Litigation and regulatory proceedings

The following description of litigation and regulatory proceedings covers CVS Health and certain of its subsidiaries, including the Company. Certain of the proceedings described below may not impact the Company directly but may have an indirect impact on the Company as the Company is a member of the CVS Health holding company group (the "CVS Health Group").

The CVS Health Group has been involved or is currently involved in numerous legal proceedings, including litigation, arbitration, government investigations, audits, reviews and claims. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, the U.S. Department of Justice (the "DOJ"), state attorneys general, the U.S. Drug Enforcement Administration (the "DEA") and other governmental authorities.

Legal proceedings, in general, and securities, class action and multi-district litigation, in particular, and governmental special investigations, audits and reviews can be expensive and disruptive. Some of the litigation matters may purport or be determined to be class actions and/or involve parties seeking large and/or indeterminate amounts, including punitive or exemplary damages, and may remain unresolved for several years. The CVS Health Group also may be named from time to time in *qui tam* actions initiated by private third parties that could also be separately pursued by a governmental body. The results of legal proceedings, including government investigations, are often uncertain and difficult to predict, and the costs incurred in these matters can be substantial, regardless of the outcome.

The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and reasonably estimable, the Company does not establish an accrued liability.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and the Company is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters. The outcome of such governmental investigations or proceedings could be material to the Company.

Provider Proceedings

The CVS Health Group is named as a defendant in purported class actions and individual lawsuits arising out of its practices related to the payment of claims for services rendered to its members by providers with whom the CVS Health Group has a contract and with whom the CVS Health Group does not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that the CVS Health Group paid too little to its health plan members and/or providers for out-of-network services and/or otherwise allege that the CVS Health Group failed to timely or appropriately pay or administer out-of-network claims and benefits (including the CVS Health Group's post payment audit and collection practices and reductions in payments to providers due to sequestration). Other major health insurers are the subject of similar litigation or have settled similar litigation.

The CVS Health Group also has received subpoenas and/or requests for documents and other information from, and been investigated by, state Attorneys General and other state and/or federal regulators, legislators and agencies relating to, and the CVS Health Group is involved in other litigation regarding, its out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against one or more members of the CVS Health Group, including the Company, with respect to their respective out-of-network benefit payment and/or administration practices.

CMS Actions

CMS regularly audits the CVS Health Group's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to the Company's and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by providers. The CVS Health Group collects claim and encounter data from providers and generally relies on providers to appropriately code their submissions to the CVS Health Group and document their medical records, including the diagnosis data submitted to the CVS Health Group with claims. CMS pays increased premiums to Medicare Advantage plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to the CVS Health Group. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the CVS Health Group's plans, to validate coding practices and supporting medical record documentation maintained by providers and the resulting risk adjusted premium payments to the plans. CMS may require the CVS Health Group, including the Company, to refund premium payments if the CVS Health Group's, including the Company's, risk adjusted premiums are not properly supported by medical record data. The Office of the Inspector General of the U.S. Department of Health and Human Services ("OIG") also is auditing the CVS Health Group's risk adjustment-related data and that of other companies. The CVS Health Group expects CMS and the OIG to continue these types of audits.

In 2012, CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will extrapolate the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. For contract years prior to 2011, CMS did not extrapolate sample error rates to the entire contract. As a result, the revised methodology may increase the CVS Health Group's, including the Company's, exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of the CVS Health Group's Medicare Advantage contracts for various contract years for RADV audit, and the number of RADV audits continues to increase. The CVS Health Group is currently unable to predict which of its Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to the

CVS Health Group, or the Company, the effect of any such refunds or adjustments on the actuarial soundness of the CVS Health Group's, including the Company's, Medicare Advantage bids, or whether any RADV audit findings would require the CVS Health Group, including the Company, to change its method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in the CVS Health Group's, including the Company's, bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG or otherwise, including audits of the CVS Health Group's medical loss ratio rebates, methodology and/or reports, could be material and could adversely affect the CVS Health Group's, including the Company's, results of operations, financial condition and/or cash flows.

Medicaid

The Company's Medicaid products also are heavily regulated by CMS and state Medicaid agencies, which have the right to audit the Company's performance to determine compliance with CMS contracts and regulations. The Company's Medicaid products also are subject to complex federal and state regulations and oversight by state Medicaid agencies regarding the services the Company provides to Medicaid enrollees, payment for those services, network requirements (including mandatory inclusion of specified high-cost providers), and other aspects of these programs, and by external review organizations that audit Medicaid plans on behalf of the state Medicaid agencies. The laws, regulations and contractual requirements applicable to the Company and other participants in Medicaid programs, including requirements that the Company submit encounter data to the applicable state agency, are extensive, complex and subject to change. The Company has invested significant resources to comply with these standards, and its Medicaid program compliance efforts will continue to require significant resources. CMS and/or state Medicaid agencies may fine the Company, withhold payments to the Company, seek premium and other refunds, terminate the Company's existing contracts, elect not to award the Company new contracts or not to renew the Company's existing contracts, prohibit the Company from continuing to market and/or enroll members in or refuse to automatically assign members to one or more of the Company's Medicaid products, exclude the Company from participating in one or more Medicaid programs and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with CMS or state regulations or the Company's contractual requirements. The Company cannot predict whether pending or future federal or state legislation or court proceedings will change various aspects of the Medicaid program, nor can it predict the impact those changes will have on its business operations or financial results, but the effects could be materially adverse.

Other Legal and Regulatory Proceedings

The CVS Health Group is also a party to other legal proceedings and is subject to government investigations, inquiries and audits and has received and is cooperating with the government in response to Civil Investigative Demands ("CIDs"), subpoenas or similar process from various governmental agencies requesting information. These other legal proceedings and government actions include claims of or relating to bad faith, medical or professional malpractice, breach of fiduciary duty, claims processing, dispensing of medications, non-compliance with state and federal regulatory regimes, marketing misconduct, denial of or failure to timely or appropriately pay or administer claims and benefits, provider network structure (including the use of performance-based networks and termination of provider contracts), rescission of insurance coverage, improper disclosure or use of personal information, anticompetitive practices, general contractual matters, product liability, intellectual property litigation and employment litigation. Some of these other legal proceedings are or are purported to be class actions or derivative claims. The CVS Health Group is defending itself against the claims brought in these matters.

Awards to the Company and others of certain government contracts, particularly Medicaid contracts and other contracts with government customers in the Company's health care and related benefits businesses, frequently are subject to protests by unsuccessful bidders. These protests may result in awards to the Company being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect the Company's results of operations. The Company will continue to defend contract awards it receives.

There also continues to be a heightened level of review and/or audit by regulatory authorities and legislators of, and increased litigation regarding, the Company's and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of

medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including manufacturers' rebates, pricing, the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers).

As a leading national health solutions company, the CVS Health Group regularly is the subject of government actions of the types described above. These government actions may prevent or delay the Company from implementing planned premium rate increases and may result, and have resulted, in restrictions on the Company's businesses, changes to or clarifications of the Company's business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to the Company by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

The Company can give no assurance that its businesses, financial condition, results of operations and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iii) pending or future federal or state government investigations of one or more of the CVS Health Group's and/or the Company's businesses, one or more of the industries in which the CVS Health Group and/or the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the CVS Health Group and/or the Company; (v) adverse developments in any pending *qui tam* lawsuit against the CVS Health Group and/or the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the CVS Health Group and/or the Company; or (vi) adverse developments in pending or future legal proceedings against the CVS Health Group and/or the Company or affecting one or more of the industries in which the CVS Health Group and/or the Company competes and/or the health care industry generally.

Litigation Insurance Coverage

The Company maintains insurance coverage for certain litigation exposures in an amount it believes is reasonable.

Health Care Reform

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively, the "ACA"), made broad-based changes to the United States health care system. In June 2021, the United States Supreme Court dismissed a challenge on procedural grounds that argued the ACA is unconstitutional in its entirety and issued an opinion preserving the ACA and its consumer protections in its current form. Even though the ACA was deemed constitutional, there may nevertheless be continued efforts to invalidate, modify, repeal or replace portions of it. In addition to litigation, parts of the ACA continue to evolve through the promulgation of executive orders, legislation, regulations and guidance at the federal or state level. The Company expects the ACA, including potential changes thereto, to continue to significantly impact its business operations and operating results, including pricing, medical benefit ratios ("MBRs") and the geographies in which the Company's products are available.

10. Business concentrations

For the years ended December 31, 2021 and 2020, the Company recorded premiums under the Medicaid program of $1,019,558 thousand and $930,671 thousand, respectively, representing 90% for 2021 and 97% for 2020 of total premium revenue.

11. Minimum capital and surplus

Pursuant to the laws of the states in which the Company is licensed to do business, the Company is required to maintain a minimum surplus and capital stock as defined by the statutes and regulations of those states. At December 31, 2021 and 2020, the Company was in compliance with the minimum surplus and capital stock requirements of the states in which it is licensed to do business.

The NAIC utilizes risk-based capital ("RBC") standards for health organizations, including HMOs, that are designed to identify weakly capitalized companies by comparing each company's adjusted capital and surplus to its required capital and surplus (the "RBC Ratio"). The RBC Ratio is designed to reflect the risk profile of a company. Within certain ratio ranges, regulators have increasing authority to take action as the RBC Ratio decreases. There are four levels of regulatory action, ranging from requiring insurers to submit a comprehensive plan to the state insurance commissioner to requiring the state insurance commissioner to place the insurer under regulatory control. At December 31, 2021 and 2020, the Company had capital and surplus that exceeded the highest threshold specified by the RBC rules.

12. Retrospectively rated contracts and contracts subject to redetermination

Retrospectively rated contracts

Through annual contracts with CMS, the Company offers insurance plans for Medicare-eligible individuals through the Medicare Advantage program. Members typically receive enhanced benefits over standard Medicare fee-for-service coverage, including reduced cost-sharing for preventative care, vision and other non-Medicare services. Members also typically receive coverage for certain prescription drugs, usually subject to a deductible, co-insurance and/or co-payment. The revenues ultimately received by the Company for each member are based on that member's health status and demographic characteristics, as determined via the CMS risk adjustment process, under which the Company regularly submits risk adjustment data to CMS. As such, at December 31, 2021 the Company records a receivable for future revenues that it expects to receive from CMS in the third quarter of 2022, after the final reconciliation of risk adjustment data for contract year 2021 is complete. The Company estimates this receivable by taking into account risk adjustment data for contract year 2021 submitted to CMS prior to December 31, 2021, as well as its estimate of the impact of risk adjustment data for contract year 2021 that will be submitted prior to the appropriate regulatory deadline in early 2022. These amounts are recognized in 2021 as premium income. In addition, the Company's Medicare Advantage contracts are subject to retrospective rating provisions under which the Company and CMS share in amounts above and below agreed-upon target medical benefit ratios. These accrued retrospective premiums, if any, are recorded through premiums and are estimated based on calculations that compare the Company's expected financial results for the contract against the appropriate medical benefit ratio target.

The Company had reinsurance and low-income subsidy (cost sharing portion) and CMS coverage gap discount payables of $1,485 thousand at December 31, 2021. These amounts are recorded in the liability for amounts held under uninsured plans on the Balance Sheets as per SSAP No. 47 - *Uninsured Plans.* These items relate to the Company's Medicare product offerings.

Accrued retrospective premiums are recorded as an adjustment to earned premiums and are estimated based on calculations that compare the Company's expected financial results for the contract against the appropriate medical benefit ratio target.

The total net premiums written by the Company during the years ended 2021 and 2020 that were subject to retrospective rating features were $1,133,122 thousand and $958,283 thousand, respectively, representing 100% in 2021 and 100% in 2020 of the total net premiums written.

13. Unusual or infrequent items

The Coronavirus Disease 2019 ("COVID-19") pandemic continues to evolve. The Company believes COVID-19's impact on the Company's businesses, operating results, cash flows and/or financial condition primarily will be driven by the geographies impacted and the severity and duration of the pandemic; the pandemic's impact on the U.S. and global economies and consumer behavior and health care utilization patterns; and the timing, scope and impact of stimulus legislation as well as other federal, state and local governmental responses to the pandemic.

Those primary drivers are beyond the Company's knowledge and control. As a result, the impact COVID-19 will have on the Company's businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be adverse and material. COVID-19 also may result in legal and regulatory proceedings, investigations and claims against the Company.

14. Subsequent events

Type I - Recognized subsequent events

Subsequent events have been considered through April 28, 2022, the date on which the financial statements were available to be issued. The Company had no known reportable recognized subsequent events.

Type II - Nonrecognized subsequent events

Subsequent events have been considered through April 28, 2022, the date on which the financial statements were available to be issued. The Company had no known reportable nonrecognized subsequent events.

Financial Statements - Statutory Basis

Aetna Better Health of Kansas Inc.

Years Ended December 31, 2020 and 2019
with Report of Independent Auditors

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Report of Independent Auditors

Board of Directors
Aetna Better Health of Kansas Inc.

We have audited the accompanying statutory-basis financial statements of Aetna Better Health of Kansas Inc. (the Company), which comprise the balance sheets as of December 31, 2020 and 2019, and the related statements of operations, changes in capital and surplus and cash flow for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with accounting practices prescribed or permitted by the Kansas Insurance Department. Management also is responsible for the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

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

As described in Note 2 to the statutory-basis financial statements, the Company prepared these financial statements using accounting practices prescribed or permitted by the Kansas Insurance Department, which is a basis of accounting other than U.S. generally accepted accounting principles. The effects on the financial statements of the variances between these statutory accounting practices and U.S. generally accepted accounting principles, although not reasonably determinable, are presumed to be material.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the matter described in the Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles paragraph, the statutory-basis financial statements referred to above do not present fairly, in conformity with U.S. generally accepted accounting principles, the financial position of the Company at December 31, 2020 and 2019, or the results of its operations or its cash flows for the years then ended.

Opinion on Statutory Basis of Accounting

In our opinion, the statutory-basis financial statements referred to above present fairly, in all material respects, the financial position of the Company at December 31, 2020 and 2019, and the results of its operations and its cash flows for the years then ended, on the basis of accounting described in Note 2.

Ernst & Young LLP

May 27, 2021

Balance Sheets - Statutory Basis

(In Thousands)	December 31, 2020	2019
Admitted assets		
Cash and invested assets		
Bonds	$ 186,906	$ 90,521
Cash, cash equivalents and short-term investments	36,233	73,791
Total cash and invested assets	223,139	164,312
Investment income due and accrued	1,705	763
Premiums and considerations receivable	72,744	64,309
Reinsurance recoverable	241	1,854
Net deferred tax asset	1,093	1
Health care and other amounts receivable	79	—
State income tax receivable	—	153
Total admitted assets	$ 299,001	$ 231,392

See accompanying Notes to the Statutory Financial Statements

Balance Sheets - Statutory Basis (continued)

(In Thousands)	December 31, 2020	2019
Liabilities and capital and surplus		
Liabilities:		
Claims unpaid	$ 115,770	$ 98,136
Unpaid claims adjustment expenses	3,700	3,068
Premiums received in advance	5	—
General expenses due or accrued	5,619	59
Current federal income tax payable	1,007	33
Remittances and items not allocated	483	419
Amounts due to parent, subsidiaries and affiliates	44,667	1,657
Payable for securities	1,075	—
Other liabilities	262	—
Total liabilities	172,588	103,372
Capital and surplus:		
Gross paid in and contributed surplus	142,000	137,000
Unassigned deficit	(15,587)	(26,348)
Special surplus funds	—	17,368
Total capital and surplus	126,413	128,020
Total liabilities and capital and surplus	$ 299,001	$ 231,392

See accompanying Notes to the Statutory Financial Statements

Statements of Operations - Statutory Basis

(In Thousands)	Year ended December 31, 2020	2019
Revenues		
Premium income	$ 958,283	$ 859,300
Total revenues	958,283	859,300
Benefits and expenses		
Claims	817,656	754,004
Net reinsurance recoveries	(821)	(1,854)
Claims adjustment expenses	42,730	33,731
General administrative expenses	107,456	87,453
Total benefits and expenses	967,021	873,334
Net underwriting loss	(8,738)	(14,034)
Investment gains		
Net investment income earned	4,431	2,453
Net realized capital (losses) gains less capital gains tax (benefit) expense	(914)	352
Total investment gains	3,517	2,805
Loss before federal income taxes	(5,221)	(11,229)
Federal income taxes expense (benefit)	2,959	(4,114)
Net loss	$ (8,180)	$ (7,115)

See accompanying Notes to the Statutory Financial Statements

Statements of Changes in Capital and Surplus - Statutory Basis

(In Thousands)	Year ended December 31, 2020	2019
Capital and surplus, beginning of year	$ 128,020	$ 2,033
Net loss	(8,180)	(7,115)
Change in net unrealized capital losses less capital gains tax benefit	(91)	(11)
Change in net deferred income tax	1,060	6
Change in nonadmitted assets	604	(1,893)
Capital contribution from parent	5,000	135,000
Net change in capital and surplus	(1,607)	125,987
Capital and surplus, end of year	$ 126,413	$ 128,020

See accompanying Notes to the Statutory Financial Statements

Statements of Cash Flow - Statutory Basis

(In Thousands)	Year ended December 31, 2020	2019
Cash from operations		
Premiums collected	$ 949,853	$ 794,991
Investment income received	4,325	1,851
Claims paid	(797,067)	(657,753)
General administrative expenses and other benefits and expenses paid	(143,846)	(118,210)
Federal income taxes (paid) recovered	(1,787)	4,045
Net cash provided by operating activities	11,478	24,924
Cash from investments		
Proceeds from investments sold, matured or repaid	27,030	28,763
Cost of investments acquired	(124,402)	(115,643)
Net cash used in investment activities	(97,372)	(86,880)
Cash from financing and miscellaneous sources		
Capital contributed from parent	5,000	135,000
Other cash provided (applied)	43,336	(1,291)
Net cash provided by financing and miscellaneous activities	48,336	133,709
Change in cash, cash equivalents and short-term investments	(37,558)	71,753
Cash, cash equivalents and short-term investments, beginning of year	73,791	2,038
Cash, cash equivalents and short-term investments, end of year	$ 36,233	$ 73,791
Supplemental disclosures of cash flow information from non-cash transactions		
Non-cash exchanges	$ 6,791	$ 3,362

See accompanying Notes to the Statutory Financial Statements

1. Organization and operation

Aetna Better Health of Kansas Inc. (the "Company") is a wholly-owned subsidiary of Aetna Health Holdings, LLC, whose ultimate parent is CVS Health Corporation ("CVS Health").

The Company was incorporated in the State of Kansas on July 25, 2016. Effective January 1, 2019, the Company contracts with the State of Kansas Department of Health and Human Services to provide health benefits to Medicaid, Home and Community Based waiver, and Children's Health Insurance Program ("CHIP") members. The Company's current contract with the State of Kansas runs through June 30, 2024.

2. Summary of significant accounting policies

Accounting practices

The accompanying statutory financial statements of the Company have been prepared in conformity with accounting practices prescribed or permitted by the Kansas Insurance Department ("Kansas Department") ("Kansas Accounting Practices"). The Kansas Department recognizes statutory accounting practices prescribed or permitted by the State of Kansas for determining and reporting the financial condition and results of operations of an insurance company, which include accounting practices and procedures adopted by the National Association of Insurance Commissioners' ("NAIC") Accounting Practices and Procedures Manual ("NAIC SAP"). The Company's net income and capital and surplus as stated on a NAIC SAP basis and on the basis of practices prescribed or permitted by the State of Kansas were the same as of and for the years ended December 31, 2020 and 2019.

Kansas Accounting Practices vary from U.S. generally accepted accounting principles ("GAAP"). The primary differences include the following:

- Certain assets, designated as nonadmitted assets (in part, uncollected premiums are nonadmitted in accordance with Statements of Statutory Accounting Principles ("SSAP") No. 6 - *Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers*) are not recorded as assets, but are charged to surplus. Thus, nonadmitting uncollected premiums eliminates the need for a separate allowance for doubtful accounts, which is utilized under GAAP;
- Certain assets, designated as nonadmitted assets (other receivables and prepaid capitation, which are nonadmitted in accordance with SSAP No. 4 - *Assets and Nonadmitted Assets*) are not recorded as assets, but are charged to surplus. Assets having economic value other than those which can be used to fulfill policyholder obligations, or those assets which are unavailable due to encumbrances or other third party interests are not recognized on the Balance Sheets, and are, therefore, considered nonadmitted;
- Bonds are recorded at amortized cost except for those with an NAIC designation of 3 through 6, which are reported at the lower of amortized cost or fair value. Therefore, changes in unrealized gains and losses for those securities held at amortized cost are not reflected in the financial statements. Under GAAP, bonds classified as available for sale are recorded at fair value, and related changes in unrealized gains and losses are recorded as a component of equity, net of deferred federal income taxes;
- In accordance with SSAP No. 43 - Revised - *Loan-Backed and Structured Securities* ("SSAP 43R"), other-than-temporary impairment ("OTTI") on loan-backed or structured securities are recorded when fair value of the security is less than its amortized cost basis at the balance sheet date and (1) the Company intends to sell the investment or (2) the Company does not have the intent and ability to retain the investment for the time sufficient to recover the amortized cost basis or (3) if the Company does not expect to recover the entire amortized cost basis of the security, even if it does not intend to sell the security and the Company has the intent and ability to hold. The condition in (2) above does not apply for GAAP;
- In accordance with SSAP No. 26 - Revised - *Bonds*, an other-than-temporary impairment ("OTTI") loss is recorded as a realized loss equal to the entire difference between the bond's carrying value and its fair value at the balance sheet date of the reporting period at which the assessment is made and a new carrying value is established for prospective reporting periods. On a GAAP basis, when the Company does not intend to sell the security and it is more likely than not that the entity will not be required to sell such before recovery of its amortized costs basis, the Company bifurcates an impairment into credit-related and non-credit related components. The amount of the credit-related component is recorded as an allowance for credit

losses and recognized in net income, and the amount of the non-credit related component is included in other comprehensive income;

- Deferred tax assets and liabilities are determined and admitted in accordance with SSAP No. 101 - *Income Taxes* ("SSAP No. 101"). Changes in net deferred tax assets and liabilities are reflected as changes in surplus, whereas under GAAP, changes in such assets and liabilities are reflected in net income. In addition, statutory accounting requires consideration of a statutory allowance adjustment in the calculation of adjusted gross deferred tax assets and an admissibility test for deferred tax assets;
- In accordance with SSAP No. 2 - Revised - *Cash, Cash Equivalents, Drafts and Short-term Investments*, certain short-term borrowings are classified as a reduction of cash, cash equivalents, and short-term investments. Under GAAP, these amounts would have been classified as liabilities; and
- Cash, cash equivalents, and short-term investments in the Statements of Cash Flow represent cash balances and investments with remaining maturities of one year or less at the time of acquisition. Under GAAP, the corresponding caption of cash and cash equivalents includes cash balances and investments with initial maturities of three months or less. The statement does not classify cash flows consistent with GAAP and a reconciliation of net earnings to net cash provided by operations is not provided.

The effects of the foregoing variances from GAAP on the accompanying statutory financial statements have not been determined but are presumed to be material.

There were no prescribed or permitted practices by the State of Kansas for the years ended December 31, 2020 and 2019.

Use of estimates in the preparation of the financial statements

The preparation of these financial statements in conformity with Kansas Accounting Practices requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and revenue and expenses. Actual results could differ from those estimates.

Significant accounting policies

The Company applies the following significant accounting policies:

Cash, cash equivalents and short-term investments

Cash, cash equivalents and short-term investments, consisting primarily of money market instruments and other debt issues with an original maturity of up to one year, are carried at amortized cost. Short-term investments consist primarily of investments purchased with an original maturity date of greater than three months but less than one year. Cash equivalents consist of highly liquid instruments, which mature within three months from the date of purchase. The carrying amount of cash, cash equivalents and short-term investments approximates fair value. Cash accounts with positive balances shall not be reported separately from cash accounts with negative balances. If in the aggregate, the reporting entity has a net negative cash balance, it shall be reported as a negative asset and shall not be recorded as a liability.

Bonds

Bonds are carried at amortized cost except for those bonds with an NAIC designation of 3 through 6, which are carried at the lower of amortized cost or fair value. The amount carried at fair value is not material to the financial statements. Bond premiums and discounts are amortized using the scientific interest method. When quoted prices in active markets for identical assets are available, the Company uses these quoted market prices to determine the fair value of bonds. This is used primarily for U.S. government securities. In other cases where a quoted market price for identical assets in an active market is either not available or not observable, the Company estimates fair values using valuation methodologies based on available and observable market information or by using a matrix pricing model. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. The Company had no investments where fair value was determined using broker quotes or an internal analysis of financial performance and cash flow

projections at December 31, 2020 and 2019. Bonds include all investments whose maturity is greater than one year when purchased. Loan-backed and structured securities are carried at amortized cost adjusted for unamortized premiums and discounts and are accounted for using the retrospective adjustment method. Premiums and discounts on loan-backed and structured securities are amortized using the scientific interest method over the estimated remaining term of the securities, adjusted for anticipated prepayments. All adjustments between amortized cost and carrying value are reflected in unrealized capital gains and losses and are reported as direct adjustments to surplus.

Bonds are recorded as purchases or sales on the trade date.

The Company periodically reviews its bonds to determine whether a decline in fair value below the carrying value is other-than-temporary. For bonds, other than loan-backed and structured securities ("LB&SS"), an other-than-temporary impairment ("OTTI") shall be recorded if it is probable that the Company will be unable to collect all amounts due according to the contractual terms in effect at the date of acquisition. Declines deemed to be OTTI in the cost basis are recognized as realized capital losses. Yield-related impairments are deemed other-than-temporary when the Company intends to sell an investment at the reporting date before recovery of the cost of the investment.

For LB&SS, the Company records OTTI when the fair value of the loan-backed or structured security is less than the amortized cost basis at the balance sheet date and (1) the Company intends to sell the investment, (2) the Company does not have the intent and ability to retain the investment for the time sufficient to recover the amortized cost basis, or (3) the Company does not expect to recover the entire amortized cost basis of the security, even if it does not intend to sell the security and has the intent and ability to hold. If it is determined an OTTI has occurred because of (1) or (2), the amount of the OTTI is equal to the difference between the amortized cost and the fair value of the security at the balance sheet date and this difference is recorded as a realized capital loss. If it is determined an OTTI has occurred because of (3), the amount of the OTTI is equal to the difference between the amortized cost and the present value of cash flows expected to be collected, discounted at the loan-backed or structured security's effective interest rate and this difference is also accounted for as a realized capital loss.

The Company analyzes all relevant facts and circumstances for each investment when performing its analysis to determine whether an OTTI exists. Among the factors considered in evaluating whether a decline is other-than-temporary, management considers whether the decline in fair value results from a change in the quality of the investment security itself, whether the decline results from a downward movement in the market as a whole, the prospects for realizing the carrying value of the bond based on the investee's current and short-term prospects for recovery and other factors. The risks inherent in assessing the impairment of an investment include the risk that market factors may differ from the Company's expectations and the risk that facts and circumstances factored into its assessment may change with the passage of time. Unexpected changes to market factors and circumstances that were not present in past reporting periods may result in a current period decision to sell securities that were not other-than-temporarily impaired in prior reporting periods.

For the Company's bonds and LB&SS that provide for a prepayment penalty or acceleration fee in the event the bond or LB&SS is liquidated prior to its scheduled termination date, the Company reports such fees as investment income when earned.

Investment income due and accrued

Accrued investment income consists primarily of interest. Interest is recognized on an accrual basis and dividends are recorded as earned on the ex-dividend date. Due and accrued income is not recorded on: (a) bonds in default; and (b) bonds delinquent more than 90 days or where collection of interest is improbable. At December 31, 2020 and 2019, the Company did not have any nonadmitted investment income due and accrued.

Premiums and amounts due and unpaid

Premium revenue for health care products is recognized as income in the month in which enrollees are entitled to health care services. Premiums collected before the effective period are reported as premiums received in advance. Premiums related to unexpired contractual coverage periods are reported as unearned premiums in aggregate health policy reserves in the Balance Sheets.

Nonadmitted amounts consist of all premiums due and unpaid greater than 90 days past due, with the exception of amounts due under government insured plans, which may be admitted assets under certain circumstances. In addition, for any customer for which the premiums due and unpaid greater than 90 days past due is more than a de minimus portion of the entire balance of premiums due and unpaid for that customer, the entire balance of premiums due and unpaid for that customer is nonadmitted. Management also performs a specific review of accounts and based on the results of the review, additional amounts may be nonadmitted. Uncollectible amounts are generally written-off and charged to revenue in the period in which the customer reconciliations are completed and agreed to by the customer (retroactivity) or when the account is determined to be uncollectible by the Company.

Claims and claims adjustment expenses and related reserves

Claims consist principally of fee-for-service medical claims and capitation costs. Claims unpaid and aggregate health claim reserves include the Company's estimate of payments to be made on claims reported but not yet paid and for health care services rendered to enrollees but not yet reported to the Company as of the Balance Sheet date. Such estimates are developed using actuarial principles and assumptions, which consider, among other things, historical and projected claim submission and processing payment patterns, medical cost trends, historical utilization of health care services, claim inventory levels, medical inflation, changes in membership and product mix, seasonality and other relevant factors. The Company reflects changes in estimates in claims costs in the Statements of Operations in the period they are determined. Capitation costs, which are recorded in claims in the Statements of Operations, represent contractual monthly fees paid to participating physicians and other medical providers for providing medical care, regardless of the medical services provided to the enrollee.

The Company uses the triangulation method to estimate reserves for claims incurred but not reported. The method of triangulation makes estimates of completion factors that are then applied to the total paid claims (net of coordination of benefits) to date for each incurral month. This provides an estimate of the total projected incurred claims and total amount outstanding or claims incurred but not reported (claims unpaid). For the most current dates of service where there is insufficient paid claim data to rely solely on the triangulation method, the Company examines cost and utilization trends as well as environmental factors, plan changes, provider contracts, changes in membership and/or benefits, and historical seasonal patterns to estimate the reserve required for these months.

Claims adjustment expenses, which include cost containment expenses, represent the costs incurred related to the claim settlement process such as costs to record, process and adjust claims. These expenses are included in the Company's management agreement with an affiliate described in Note 5.

Aggregate health policy reserves and related expenses

Premium deficiency reserves (“PDR”) are recognized when it is probable that the expected future hospital and medical costs, including maintenance costs, will exceed anticipated future premiums and reinsurance recoveries on existing contracts. Anticipated investment income is not considered in the calculation of PDR. For purposes of calculating a PDR, contracts are grouped in a manner consistent with the method of acquiring, servicing and measuring the profitability of such contracts. The Company had no PDR at December 31, 2020 or 2019.

Fees paid to the Federal Government by health insurers

SSAP No. 106 - *Affordable Care Act Section 9010 Assessment* (“SSAP No. 106”) required (1) that the annual fee be recognized in full on January 1 of the fee year (the calendar year in which the assessment must be paid to the federal government), in the operating expense category of general administrative expenses, excluding federal income taxes and (2) that in each data year preceding a fee year a reporting entity pro-ratably accrue by reclassifying from unassigned surplus to special surplus funds an amount equal to its estimated subsequent fee year assessment. This reclassification has no impact on total capital and surplus and is reversed in full on January 1 of the fee year. On January 1, 2020, the Company was subject to the annual fee (“ACA assessment”). This annual fee was allocated to individual health insurers based on the ratio of the amount of the entity’s net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that was written during the preceding calendar year. A health insurance entity’s portion of the annual fee becomes payable once the entity provides health

insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. As of December 31, 2019, the Company estimated its portion of the annual fee that was payable on September 30, 2020 to be $17,368 thousand. This was estimated based on premiums written subject to the ACA assessment of $862,293 thousand. During 2020, the Company paid $16,483 thousand to the federal government for its portion of the annual fee due on September 30, 2020. In December 2019, the annual fee was repealed beginning in 2021. As a result of this repeal, there is no annual fee payable in 2021 and thereafter, and therefore no estimated subsequent fee year assessment was required to be reclassified from unassigned funds to special surplus funds at December 31, 2020.

Federal and state income taxes

Aetna Inc. ("Aetna") and its wholly-owned subsidiaries are included in the consolidated federal income tax return of its parent company, CVS Health, pursuant to the terms of a tax sharing agreement. In accordance with the agreement, the Company's current federal and state income tax provisions are generally computed as if the Company were filing a separate federal and state income tax return; current income tax benefits, including those resulting from net operating losses, are recognized to the extent expected to be realized in the consolidated return. Pursuant to the agreement, the Company has the enforceable right to recoup federal and state income taxes paid in prior years in the event of future net losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal and state income taxes.

Income taxes are accounted for under the asset and liability method. Deferred income tax assets ("DTAs") and liabilities ("DTLs") represent the expected future tax consequences of temporary differences generated by statutory accounting as defined in SSAP No. 101. DTAs and DTLs are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. DTAs and DTLs are computed by means of identifying temporary differences, which are measured using a balance sheet approach whereby statutory and tax basis balance sheets are compared. Current income tax recoverables include all current income taxes, including interest, reasonably expected to be recovered in a subsequent accounting period.

Pursuant to SSAP No. 101, gross DTAs are first reduced by a statutory valuation allowance adjustment to an amount that is more likely than not to be realized ("adjusted gross DTAs"). Adjusted gross DTAs are then admitted in an amount equal to the sum of paragraphs a. b. and c. below:

a. Federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse during a timeframe corresponding with Internal Revenue Code ("IRC") tax loss carryback provisions.

b. The amount of adjusted gross DTAs, after the application of paragraph a. above, expected to be realized within the applicable period and that is no greater than the applicable percentage as determined using the applicable Realization Threshold Limitation Table. The applicable period refers to the number of years in which the DTA will reverse in the Company's tax return and the applicable percentage refers to the percentage of the Company's statutory capital and surplus as required to be shown on the statutory balance sheet adjusted to exclude any net DTAs, electronic data processing equipment and operating system software and any net positive goodwill ("Stat Cap ExDTA").

   The Realization Threshold Limitation Tables allow DTAs to be admitted based upon either realization within 3 years and 15% of Stat Cap ExDTA, 1 year and 10% of Stat Cap ExDTA, or no DTA admitted pursuant to this paragraph b. In general, the Realization Threshold Limitation Tables allow the Company to admit more DTAs if total DTAs as reported by the Company are a smaller percentage of statutory capital and surplus.

c. The amount of gross DTAs, after the application of paragraphs a. and b. above that can be offset against existing gross DTLs. In applying this offset, the Company considers the character (i.e. ordinary versus capital) of the DTAs and DTLs such that offsetting would be permitted in the tax return under existing enacted federal income tax laws and regulations and the reversal patterns of temporary differences.

Changes in DTAs and DTLs are recognized as a separate component of gains and losses in surplus ("Change in net deferred income tax") except to the extent allocated to changes in unrealized gains and losses. Changes in DTAs and DTLs allocated to unrealized gains and losses are netted against the related changes in unrealized gains and losses and are reported as "Change in net unrealized capital gains and (losses)", also a separate component of gains and losses in surplus.

The Company is subject to state income taxes in various states. State income tax expense is recorded in general administrative expenses in the Statements of Operations.

3. Bonds and other financial instruments

The following is a summary of bonds and other financial instruments receiving bond treatment, which include special deposits, cash equivalents, and short-term investments, at December 31, 2020 and 2019:

December 31, 2020

(In Thousands)	Amortized cost	Statutory carrying value	Gross unrealized gains	Gross unrealized losses	Fair value
U.S. government	$ 20,366	$ 20,366	$ 685	$ —	$ 21,051
All other governments	20,988	20,983	1,717	—	22,700
U.S. states, territories and possessions (direct and guaranteed)	11,957	11,957	761	—	12,718
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	1,355	1,355	26	—	1,381
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	30,656	30,656	1,401	(1)	32,056
Industrial and miscellaneous (unaffiliated)	124,397	124,273	5,691	(2)	129,962
Total	$ 209,719	$ 209,590	$ 10,281	$ (3)	$ 219,868

December 31, 2019

(In Thousands)	Amortized cost	Statutory carrying value	Gross unrealized gains	Gross unrealized losses	Fair value
U.S. government	$ 17,280	$ 17,280	$ 112	$ (4)	$ 17,388
All other governments	6,601	6,599	30	(3)	6,626
U.S. states, territories and possessions (direct and guaranteed)	7,461	7,461	114	—	7,575
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	3,280	3,280	69	—	3,349
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	11,731	11,731	161	(8)	11,884
Industrial and miscellaneous (unaffiliated)	103,720	103,708	537	(55)	104,190
Total	$ 150,073	$ 150,059	$ 1,023	$ (70)	$ 151,012

Summarized below are the Company's bonds and other financial instruments receiving bond treatment with unrealized losses at December 31, 2020 and 2019, along with the related fair values, aggregated by the length of time the investments have been in an unrealized loss position:

December 31, 2020

	Less than 12 months			Greater than 12 months		
($ in Thousands)	**Number of securities**	**Fair value**	**Unrealized losses**	**Number of securities**	**Fair value**	**Unrealized losses**
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	1	$ 749	$ 1	—	$ —	$ —
Industrial and miscellaneous (unaffiliated)	1	540	2	—	—	—
Total	2	$ 1,289	$ 3	—	$ —	$ —

	Total		
($ in Thousands)	**Number of securities**	**Fair value**	**Unrealized losses**
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	1	$ 749	$ 1
Industrial and miscellaneous (unaffiliated)	1	540	2
Total	2	$ 1,289	$ 3

December 31, 2019

	Less than 12 months			Greater than 12 months		
(In Thousands)	**Number of securities**	**Fair value**	**Unrealized losses**	**Number of securities**	**Fair value**	**Unrealized losses**
U.S. government	1	$ 4,956	$ 4	—	$ —	$ —
All other governments	1	1,069	3	—	—	—
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	1	481	8	—	—	—
Industrial and miscellaneous (unaffiliated)	7	15,081	55	—	—	—
Total	10	$ 21,587	$ 70	—	$ —	$ —

	Total		
(In Thousands)	**Number of securities**	**Fair value**	**Unrealized losses**
U.S. government	1	$ 4,956	$ 4
All other governments	1	1,069	3
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	1	481	8
Industrial and miscellaneous (unaffiliated)	7	15,081	55
Total	10	$ 21,587	$ 70

The Company has reviewed the investments in the tables above and has concluded that these are performing assets generating investment income to support the needs of the business. In performing this review, the Company considered factors such as the quality of the investment security based on research performed by external rating

agencies and internal credit analysts and the prospects of realizing the carrying value of the security based on the investment's current prospects for recovery. Furthermore, the Company has no intention to sell the investments in the tables above at December 31, 2020 and 2019 before their cost can be recovered and for loan-backed and structured securities the Company has the ability and intent to hold these securities for a period of time sufficient to recover the amortized cost; therefore, no OTTI was determined to have occurred on these investments during the years ended December 31, 2020 and 2019. In determining if the Company needs to sell before full recovery of value, the Company considers the forecasted recovery period, expected investment returns relative to other funding sources, projected cash flow and capital requirements, regulatory obligations, and other factors. Unrealized losses at December 31, 2020 and 2019 were generally caused by the widening of market yields for these securities relative to the market yields when these securities were purchased.

The contractual or expected maturities of bonds and assets receiving bond treatment (e.g., cash equivalents and short-term investments) at December 31, 2020 were as follows:

(In Thousands)	Carrying Value	Fair Value
Due one year or less	$ 36,586	$ 36,768
Due after one year through five years	88,075	92,571
Due after five years through ten years	69,082	73,520
Due after ten years	15,847	17,009
Total	$ 209,590	$ 219,868

The maturity for a mortgage pass-through security, included in U.S. Government and U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions, is not based on stated maturity, but instead is based on prepayment assumptions. Prepayment assumptions are calculated utilizing published repayment factors that estimate the prepayment rates on the mortgages in the Federal National Mortgage Association and Government National Mortgage Association pools.

Proceeds from the maturities and sales of the Company's bonds and other financial instruments receiving bond treatment and the related gross realized capital gains and losses and the OTTI charges on bonds for the years ending December 31, 2020 and 2019 were as follows:

(In Thousands)	2020	2019
Proceeds from sales of bonds	$ 23,054	$ 28,763
Proceeds from maturities of bonds	2,900	—
Gross realized gains on sales of bonds	399	518
Gross realized losses on sales of bonds	1,357	35
Included in net realized capital losses (OTTI charges on bonds that were in an unrealized loss position)	153	30

The Company conducts regular reviews of its bond investments to assess whether a decline in fair value below carrying value is an OTTI. The Company will also recognize an OTTI on bonds when the Company intends to sell a security that is in an unrealized loss position. Declines deemed to be OTTI are recognized as realized capital losses.

The Company's unrealized loss position on loan-backed and structured securities held by the Company at December 31, 2020 and 2019 is as follows:

(In Thousands)	2020	2019
Aggregate amount of unrealized losses		
Less than 12 months	$ 2	$ 41
Aggregate related fair value of securities with unrealized losses		
Less than 12 months	$ 540	$ 12,606

The Company has reviewed the loan-backed and structured securities in accordance with SSAP No. 43R in the tables above and have concluded that these are performing assets generating investment income to support the needs of the business. Furthermore, the Company has no intention to sell the securities at December 31, 2020 and 2019 before their cost can be recovered and does have the intent and ability to retain the securities for the time sufficient to recover the amortized cost basis; therefore, no OTTI write-down to fair value was determined to have occurred on these securities.

4. Financial instruments

Financial instruments measured at fair value in the financial statements

The Company had no material assets and liabilities that are measured and reported at fair value as of December 31, 2020 and 2019.

The fair values of financial instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy. The following are the levels of the hierarchy and a brief description of the type of valuation information ("inputs") that qualifies a financial asset or liability for each level:

- **Level 1** – Unadjusted quoted prices for identical assets or liabilities in active markets.
- **Level 2** – Inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, inputs that are observable that are not prices (such as interest rates and credit risks) and inputs that are derived from or corroborated by observable markets.
- **Level 3** – Developed from unobservable data, reflecting the Company's own assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, the Company uses these quoted market prices to determine the fair value of financial assets and liabilities and classifies these assets and liabilities as Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, the Company estimates fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities would then be classified as Level 2. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

Transfers in and out of all levels are recognized at the end of the reporting period of which the transfer occurred.

The carrying values and estimated fair values of the Company's financial instruments at December 31, 2020 and 2019 were as follows:

December 31, 2020

(In Thousands)	Aggregate fair value	Admitted assets	(Level 1)	(Level 2)	(Level 3)
Assets					
Bonds, short term, and cash equivalents	$ 219,868	$ 209,590	$ 19,363	$ 200,505	$ —
Total	$ 219,868	$ 209,590	$ 19,363	$ 200,505	$ —

December 31, 2019

(In Thousands)	Aggregate fair value	Admitted assets	(Level 1)	(Level 2)	(Level 3)
Assets					
Bonds, short-term and cash equivalents	151,012	150,059	17,387	133,625	—
Total	151,012	150,059	17,387	133,625	—

In evaluating the Company's management of interest rate and liquidity risk and currency exposures, the fair values of all assets and liabilities should be taken into consideration, not only those presented above.

5. Information concerning parent, subsidiaries, and affiliates

As of and for the years ended December 31, 2020 and 2019, the Company had the following significant transactions with affiliates:

The Company and Aetna Medicaid Administrators LLC ("AMA") are parties to an administrative services agreement, under which AMA and certain of its affiliates provide certain administrative services, including cash management and accounting and processing of premiums and claims. Under this agreement, the Company will remit a percentage of its earned premium revenue, as applicable, to AMA as a fee. The agreement was amended effective January 1, 2020 and approved by Kansas Department on September 17, 2019. The amendment allows other affiliates to provide services in accordance to a schedule of services and pricing. For these services, the Company was charged $76,663 thousand and $68,836 thousand in 2020 and 2019, respectively.

AMA and Aetna Health Management, LLC ("AHM"), indirectly a wholly-owned subsidiary of CVS Health, entered into a plan joinder agreement. Under this agreement, AHM has contracted with Caremark PCS Health, LLC ("Caremark"), an affiliate, to deliver pharmacy benefit management services to the Company through the Company's administrative services agreement with AMA. The Company will make payments to AMA in accordance with the administrative services agreement.

As explained in Note 2, Aetna and its wholly-owned subsidiaries, including the Company, participate in a tax sharing agreement with CVS Health. All federal income tax receivables/payables are due from/due to CVS Health.

At December 31, 2020 and 2019, the Company had the following amounts due to affiliates:

	December 31,	
(In Thousands)	**2020**	**2019**
Amounts due to affiliates		
Aetna Medicaid Administrators LLC	$ 44,667	$ 772
Aetna Health Management, LLC	—	885
Total due to affiliates	$ 44,667	$ 1,657

The terms of settlement require that these amounts be settled within 45 days after the end of the calendar quarter.

6. Income taxes

The components of the net DTAs recognized in the Company's Balance Sheets are as follows:

	December 31, 2020		
(In Thousands)	**Ordinary**	**Capital**	**Total**
Gross DTAs	$ 2,025	$ 69	$ 2,094
Statutory valuation allowance adjustment	(917)	(54)	(971)
Adjusted gross DTAs	1,108	15	1,123
DTAs nonadmitted	—	—	—
Subtotal net admitted DTAs	1,108	15	1,123
DTLs	(15)	(15)	(30)
Net admitted DTAs/(DTLs)	$ 1,093	$ —	$ 1,093

	December 31, 2019		
(In Thousands)	**Ordinary**	**Capital**	**Total**
Gross DTAs	$ 720	$ 9	$ 729
Statutory valuation allowance adjustment	(718)	—	(718)
Adjusted gross DTAs	2	9	11
DTAs nonadmitted	—	(8)	(8)
Subtotal net admitted DTAs	2	1	3
DTLs	(1)	(1)	(2)
Net admitted DTAs/(DTLs)	$ 1	$ —	$ 1

	Change		
(In Thousands)	**Ordinary**	**Capital**	**Total**
Gross DTAs	$ 1,305	$ 60	$ 1,365
Statutory valuation allowance adjustment	(199)	(54)	(253)
Adjusted gross DTAs	1,106	6	1,112
DTAs nonadmitted	—	8	8
Subtotal net admitted DTAs	1,106	14	1,120
DTLs	(14)	(14)	(28)
Net admitted DTAs/(DTLs)	$ 1,092	$ —	$ 1,092

The amount of gross DTAs admitted under each component of SSAP No. 101 is as follows:

	December 31, 2020		
(In Thousands)	**Ordinary**	**Capital**	**Total**
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$ 1,093	$ —	$ 1,093
(b) Adjusted gross DTAs expected to be realized (excluding the amount of DTAs after application of the threshold limitations (the lesser of (b)1 and (b)2 below))	—	—	—
1. Adjusted gross DTAs expected to be realized following the balance sheet date	—	—	—
2. Adjusted gross DTAs allowed per limitation threshold	XX	XX	18,798
(c) Adjusted gross DTAs (excluding the amount of DTAs from (a) and (b) above) offset by gross DTLs	15	15	30
(d) DTAs admitted as the result of application of SSAP No. 101	$ 1,108	$ 15	$ 1,123

	December 31, 2019		
(In Thousands)	**Ordinary**	**Capital**	**Total**
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$ 1	$ —	$ 1
(b) Adjusted gross DTAs expected to be realized (excluding the amount of DTAs after application of the threshold limitations (the lesser of (b)1 and (b)2 below))	—	—	—
1. Adjusted gross DTAs expected to be realized following the balance sheet date	—	—	—
2. Adjusted gross DTAs allowed per limitation threshold	XX	XX	19,203
(c) Adjusted gross DTAs (excluding the amount of DTAs from (a) and (b) above) offset by gross DTLs	1	1	2
(d) DTAs admitted as the result of application of SSAP No. 101	$ 2	$ 1	$ 3

	Change		
(In Thousands)	**Ordinary**	**Capital**	**Total**
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$ 1,092	$ —	$ 1,092
(b) Adjusted gross DTAs expected to be realized (excluding the amount of DTAs after application of the threshold limitations (the lesser of (b)1 and (b)2 below))	—	—	—
1. Adjusted gross DTAs expected to be realized following the balance sheet date	—	—	—
2. Adjusted gross DTAs allowed per limitation threshold	XX	XX	(405)
(c) Adjusted gross DTAs (excluding the amount of DTAs from (a) and (b) above) offset by gross DTLs	14	14	28
(d) DTAs admitted as the result of application of SSAP No. 101	$ 1,106	$ 14	$ 1,120

($ in Thousands)	**2020**	**2019**
(a) Ratio percentage used to determine recovery period and threshold limitation amount	408 %	389 %
(b) Amount of adjusted capital and surplus used to determine recovery period threshold limitation in (b)2 above	$ 125,320	$ 128,019

There were no tax planning strategies impacting the Company's ordinary or capital DTAs.

The provision (benefit) for income taxes for the years ended December 31, 2020 and 2019 was as follows:

	December 31,		
(In Thousands)	**2020**	**2019**	**Change**
Federal income tax expense (benefit) on operations	$ 2,959	$ (4,114)	$ 7,073
Federal income tax (benefit) provision on net capital (losses) gains	(197)	101	(298)
Federal income tax incurred	$ 2,762	$ (4,013)	$ 6,775

The tax effects of temporary differences that gave rise to deferred tax assets and liabilities at December 31, 2020 and 2019 were as follows:

(In Thousands)	December 31, 2020	December 31, 2019	Change
DTAs:			
Ordinary			
Discounting of unpaid losses	$ 1,754	$ 324	$ 1,430
Nonadmitted assets	271	396	(125)
Total ordinary DTAs	2,025	720	1,305
Statutory valuation allowance adjustment	(917)	(718)	(199)
Nonadmitted ordinary DTAs	—	—	—
Admitted ordinary DTAs	1,108	2	1,106
Capital			
Bonds and other investments	69	9	60
Total capital DTAs	69	9	60
Statutory valuation allowance adjustment	(54)	—	(54)
Nonadmitted capital DTAs	—	(8)	8
Admitted capital DTAs	15	1	14
Admitted DTAs	1,123	3	1,120
DTLs:			
Ordinary			
Investments	15	1	14
Ordinary DTLs	15	1	14
Capital			
Investments	15	1	14
Capital DTLs	15	1	14
Total DTLs	30	2	28
Net admitted DTAs/(DTLs)	$ 1,093	$ 1	$ 1,092

The change in net deferred income taxes is comprised of the following:

(In Thousands)	December 31, 2020	December 31, 2019	Change
Total DTAs	$ 1,123	$ 11	$ 1,112
Total DTLs	(30)	(2)	(28)
Net DTAs/(DTLs)	1,093	9	1,084
Tax effect of unrealized gains (losses)			(24)
Change in net deferred income tax			$ 1,060

The valuation allowance adjustment to gross DTAs was $971 thousand and $718 thousand for December 31, 2020 and 2019, respectively.

The provision (benefit) for federal income taxes is different from that which would be obtained by applying the statutory federal income tax rate to income before income taxes. The items causing this difference are as follows:

($ in Thousands)	December 31, 2020	Effective Tax Rate	December 31, 2019	Effective Tax Rate
Provision computed at statutory rate	$ (1,138)	21.0 %	$ (2,337)	21.0 %
Health insurer fee	3,462	(63.8)%	—	— %
Transfer pricing adjustment	(1,518)	28.0 %	(1,975)	17.7 %
Tax-exempt interest	(99)	1.8 %	(29)	0.3 %
Change in nonadmitted assets	125	(2.3)%	(396)	3.6 %
Prior year true-up	616	(11.4)%	—	— %
Change in valuation allowance adjustment	254	(4.7)%	718	(6.5)%
Total	$ 1,702	(31.4)%	$ (4,019)	36.1 %
Federal and foreign income tax expense (benefit) incurred	$ 2,762	(51.0)%	$ (4,013)	36.0 %
Change in net deferred income taxes	(1,060)	19.6 %	(6)	0.1 %
Total statutory income taxes	$ 1,702	(31.4)%	$ (4,019)	36.1 %

The transfer pricing adjustment allows taxpayers to apply different methods to price current period intercompany services at arm's length prices (i.e., prices at which unrelated entities would be willing to transact), which results in a permanent deduction for tax reporting purposes.

At December 31, 2020 and 2019, the Company had no net capital loss or net operating loss carryforwards.

The amount of federal income taxes incurred that is available for recoupment in the event of future net losses are:

(In Thousands)

Year	Ordinary	Capital	Total
2020	$ 1,093	$ —	$ 1,093
2019	—	—	—
2018 Stub 2	N/A	—	—
Total	$ 1,093	$ —	$ 1,093

The Company did not report any deposits as admitted assets under Internal Revenue Code Section 6603 at December 31, 2020 and 2019.

As discussed in Note 2, the Company is included in the consolidated federal income tax return of its parent, CVS Health, along with other affiliates, as of December 31, 2020.

The Company does not have any tax loss contingencies for which it is reasonably possible that the total liability will significantly increase within twelve months of the reporting date.

The Company is subject to premium taxes in various states. These tax expenses are recorded in general administrative expenses in the Statements of Operations. The expenses for these taxes were $54,883 thousand and $50,058 thousand for the years ended December 31, 2020 and 2019, respectively. The Company's premium tax payable of $5,432 thousand and $58 thousand at December 31, 2020 and 2019, respectively, are included in general expenses due or accrued in the Balance Sheets.

7. Change in claims unpaid and unpaid claims adjustment expenses

The following table shows the components of the change in claims unpaid and unpaid claims adjustment expenses for the years ended December 31, 2020 and 2019:

(In Thousands)	2020	2019
Balance, January 1	$ 101,204	$ —
Health care receivable	(1,884)	—
Balance, January 1, net of health care receivable	99,320	—
Incurred related to:		
Current year	876,943	785,881
Prior years	(17,378)	—
Total incurred	859,565	785,881
Paid related to:		
Current year	758,109	686,561
Prior years	82,670	—
Total paid	840,779	686,561
Balance, December 31, net of health care receivable	118,106	99,320
Health care receivable	1,364	1,884
Balance, December 31	$ 119,470	$ 101,204

Reserves for incurred claims and claim adjustment expenses attributable to insured events of prior years decreased by $17,378 thousand in 2020. Changes in prior periods' estimates represents the effect of favorable development of prior period health care cost estimates on current year net income, at each financial statement date. The favorable development of these reserves is primarily a result of the actual claim submission times for health care claims being shorter than the Company had anticipated, as well as lower than expected health care cost trends in determining claims unpaid at prior financial statement date. Original estimates are increased or decreased, as additional information becomes known regarding individual claims.

As of December 31, 2019, there were no reserves for incurred claims and claim adjustment expenses attributable to insured events of prior years.

8. Capital and surplus and shareholder's dividend restrictions

The Company had 10,000 shares of common stock authorized with no par value, with 1,000 shares issued and outstanding at December 31, 2020 and 2019.

Dividend restrictions

According to Kansas statutes, it is unlawful for the directors, trustees, managers or officers of an insurance company organized under the laws of this state, directly or indirectly, to make or pay dividends on its capital stock, or pay any interest, bonus or other allowance in lieu of dividends except out of earned surplus as distinguished from contributed surplus. Earned surplus shall be calculated after reserving a sum equal to all liabilities of the company and may include all or part of surplus arising from unrealized capital gains or revaluation of assets. Any dividends or payments made contrary to the provisions of this section shall subject the company to a forfeiture of its charter.

At December 31, 2020 and 2019, there was no portion of the Company's profits that may be paid as ordinary dividends to its shareholder without prior approval from the Kansas Department.

The Company received $5,000 thousand as a capital contribution from its parent on December 28, 2020. The Company received $30,000 thousand, $15,000 thousand, $60,000 thousand and $30,000 thousand as a capital contribution from its parent on January 16, 2019, June 27, 2019, September 20, 2019 and December 5, 2019, respectively.

There were no restrictions placed on the Company's surplus, including for whom the surplus was being held at December 31, 2020 and 2019, except as noted in Note 12.

Changes in the balances of special surplus funds from the prior year are due to the accrual of estimated 2020 ACA health insurer fees reclassified from unassigned surplus to special surplus funds as discussed more fully in Note 2.

9. Contingencies

Guaranty fund assessments

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers and life insurers as well as health insurers. The Company's assessments generally are based on a formula relating to the Company's health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

Litigation and regulatory proceedings

The following description of litigation and regulatory proceedings covers CVS Health and certain of its subsidiaries, including the Company. Certain of the proceedings described below may not impact the Company directly but may have an indirect impact on the Company as the Company is a member of the CVS Health holding company group (the "CVS Health Group").

The CVS Health Group has been involved or is currently involved in numerous legal proceedings, including litigation, arbitration, government investigations, audits, reviews and claims. These include routine, regular and special investigations, audits and reviews by the Centers for Medicare and Medicaid Services ("CMS"), state insurance and health and welfare departments, state attorneys general, and other governmental authorities.

Legal proceedings, in general, and securities, class action and multi-district litigation, in particular, and governmental special investigations, audits and reviews can be expensive and disruptive. Some of the litigation matters may purport or be determined to be class actions and/or involve parties seeking large and/or indeterminate amounts, including punitive or exemplary damages, and may remain unresolved for several years. The CVS Health Group also may be named from time to time in qui tam actions initiated by private third parties that could also be separately pursued by a governmental body. The results of legal proceedings, including government investigations, are often uncertain and difficult to predict, and the costs incurred in these matters can be substantial, regardless of the outcome.

The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and reasonably estimable, the Company does not establish an accrued liability.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and the Company is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters. The outcome of such governmental investigations of proceedings could be material to the Company.

Provider Proceedings

The CVS Health Group is named as a defendant in purported class actions and individual lawsuits arising out of its practices related to the payment of claims for services rendered to its members by providers with whom the CVS Health Group has a contract and with whom the CVS Health Group does not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that the CVS Health Group paid too little to its health plan members and/or providers for out-of-network services and/or otherwise allege that the CVS Health Group failed to timely or appropriately pay or administer out-of-network claims and benefits (including the CVS Health Group's post payment audit and collection practices and reductions in payments to providers due to sequestration). Other major health insurers are the subject of similar litigation or have settled similar litigation.

The CVS Health Group also has received subpoenas and/or requests for documents and other information from, and been investigated by, state Attorneys General and other state and/or federal regulators, legislators and agencies relating to, and the CVS Health Group is involved in other litigation regarding, its out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against one or more members of the CVS Health Group, including the Company, with respect to their respective out-of-network benefit payment and/or administration practices.

Medicaid

The Company's Medicaid products also are heavily regulated by CMS and state Medicaid agencies, which have the right to audit the Company's performance to determine compliance with CMS contracts and regulations. The Company's Medicaid products also are subject to complex federal and state regulations and oversight by state Medicaid agencies regarding the services the Company provides to Medicaid enrollees, payment for those services, network requirements (including mandatory inclusion of specified high-cost providers), and other aspects of these programs, and by external review organizations that audit Medicaid plans on behalf of the state Medicaid agencies. The laws, regulations and contractual requirements applicable to the Company and other participants in Medicaid programs, including requirements that the Company submit encounter data to the applicable state agency, are extensive, complex and subject to change. The Company has invested significant resources to comply with these standards, and its Medicaid program compliance efforts will continue to require significant resources. CMS and/or state Medicaid agencies may fine the Company, withhold payments to the Company, seek premium and other refunds, terminate the Company's existing contracts, elect not to award the Company new contracts or not to renew the Company's existing contracts, prohibit the Company from continuing to market and/or enroll members in or refuse to automatically assign members to one or more of the Company's Medicaid products, exclude the Company from participating in one or more Medicaid programs and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with CMS or state regulations or the Company's contractual requirements. The Company cannot predict whether pending or future federal or state legislation or court proceedings will change various aspects of the Medicaid program, nor can it predict the impact those changes will have on its business operations or financial results, but the effects could be materially adverse.

Other Legal and Regulatory Proceedings

The CVS Health Group is also a party to other legal proceedings and is subject to government investigations, inquiries and audits and has received and is cooperating with the government in response to CIDs, subpoenas or similar process from various governmental agencies requesting information. These other legal proceedings and government actions include claims of or relating to bad faith, medical or professional malpractice, claims processing, dispensing of medications, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits, provider network structure (including the use of performance-based networks and termination of provider contracts), rescission of insurance coverage, improper disclosure or use of personal information, anticompetitive practices, general contractual matters, product liability, intellectual property litigation and employment litigation. Some of these other legal proceedings are or are purported to be class actions or derivative claims. The CVS Health Group is defending itself against the claims brought in these matters.

Awards to the Company and others of certain government contracts, particularly Medicaid contracts and other contracts with government customers in the Company's health care and related benefits businesses, frequently are subject to protests by unsuccessful bidders. These protests may result in awards to the Company being reversed,

delayed or modified. The loss or delay in implementation of any government contract could adversely affect the Company's results of operations. The Company will continue to defend contract awards it receives.

There also continues to be a heightened level of review and/or audit by regulatory authorities and legislators of, and increased litigation regarding, the Company's and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including manufacturers' rebates, pricing, the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers).

As a leading national health care company, the CVS Health Group regularly is the subject of government actions of the types described above. These government actions may prevent or delay the Company from implementing planned premium rate increases and may result, and have resulted, in restrictions on the Company's businesses, changes to or clarifications of the Company's business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to the Company by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

The Company can give no assurance that its businesses, financial condition, results of operations and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iii) pending or future federal or state government investigations of one or more of the CVS Health Group's and/or the Company's businesses, one or more of the industries in which the CVS Health Group and/or the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the CVS Health Group and/or the Company; (v) adverse developments in any pending *qui tam* lawsuit against the CVS Health Group and/or the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the CVS Health Group and/or the Company; or (vi) adverse developments in pending or future legal proceedings against the CVS Health Group and/or the Company or affecting one or more of the industries in which the CVS Health Group and/or the Company competes and/or the health care industry generally.

Litigation Insurance Coverage

The Company maintains insurance coverage for certain litigation exposures in an amount it believes is reasonable.

Health Care Reform

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively, the "ACA"), made broad-based changes to the United States health care system. The United States Supreme Court is expected to rule on the constitutionality of the ACA by June 2021. If the ACA is deemed unconstitutional, there will likely be significant changes to the laws and rules that govern the Company's business. If the ACA is deemed constitutional, there may nevertheless be continued efforts to invalidate, modify, repeal or replace it or portions of it, and the Company expects aspects of the ACA to continue to significantly impact its business operations and operating results, including pricing, medical benefit ratios ("MBRs") and the geographies in which the Company's products are available.

While most of the significant aspects of the ACA became effective during or prior to 2014, parts of the ACA continue to evolve through the promulgation of executive orders, legislation, regulations and guidance as well as ongoing litigation. Additional changes to the ACA and those regulations and guidance at the federal and/or state

level are likely, and those changes are likely to be significant. Growing federal and state budgetary pressures make it more likely that any changes, including changes at the state level in response to changes to, or invalidation, repeal or replacement of, the ACA and/or changes in the funding levels and/or payment mechanisms of federally supported benefit programs, will be adverse to the Company. For example, if any elements of the ACA are invalidated or repealed at the federal level, the Company expects that some states would seek to enact similar requirements, such as prohibiting pre-existing condition exclusions, prohibiting rescission of insurance coverage, requiring coverage for dependents up to age 26, requiring guaranteed renewability of insurance coverage and prohibiting lifetime limits on insurance coverage.

Potential repeal of the ACA, ongoing legislative, regulatory and administrative policy changes to the ACA, the results of federal and state level elections, pending litigation challenging the constitutionality of the ACA or funding for the law and federal budget negotiations continue to create uncertainty about the ultimate impact of the ACA. Given the inherent difficulty of foreseeing the nature and scope of future changes to the ACA and how states, businesses and individuals will respond to those changes, the Company cannot predict the impact on it of future changes to the ACA. It is reasonably possible that invalidation, repeal or replacement of or other changes to the ACA and/or states' responses to such changes, in the aggregate, could have a significant adverse effect on the Company's businesses, results of operations and cash flows.

10. Business concentrations

For the years ended December 31, 2020 and 2019, the Company recorded premiums under the Medicaid program of $930,671 thousand and $826,134 thousand, respectively, representing 97% for 2020 and 96% for 2019 of total premium revenue.

11. Contractual arrangements with providers

The Company generally compensates primary care physicians through prospective compensation arrangements which incorporate quality assessment standards, comprehensiveness of care, utilization and office status components. These components are used to adjust the capitation payments to individual physician offices and to determine the amount of additional periodic payments. The Company has prospective compensation arrangements for mental health, substance abuse, diagnostic laboratory, radiology and diagnostic imaging services, podiatric treatment, physical therapy and prescription drug dispensing. The Company has contracts that provide for all-inclusive per diem and per case hospitalization rates and fixed rates for ambulatory surgery, emergency room services and specialist services. The Company has also entered into quality based compensation arrangements with certain hospitals, as well as agreements with certain integrated health delivery systems under which the systems are compensated on a substantially fixed prospective basis for medical services, including primary, specialist and hospital care. The arrangements described above cover the majority of medical expenses.

12. Minimum capital and surplus

Pursuant to the laws of the states in which the Company is licensed to do business, the Company is required to maintain a minimum surplus and capital stock as defined by the statutes and regulations of those states. At December 31, 2020 and 2019, the Company was in compliance with the minimum surplus and capital stock requirements of the states in which it is licensed to do business.

The NAIC utilizes risk-based capital ("RBC") standards for health organizations, including HMOs, that are designed to identify weakly capitalized companies by comparing each company's adjusted capital and surplus to its required capital and surplus (the "RBC Ratio"). The RBC Ratio is designed to reflect the risk profile of a company. Within certain ratio ranges, regulators have increasing authority to take action as the RBC Ratio decreases. There are four levels of regulatory action, ranging from requiring insurers to submit a comprehensive plan to the state insurance commissioner to requiring the state insurance commissioner to place the insurer under regulatory control. At December 31, 2020 and 2019, the Company had capital and surplus that exceeded the highest threshold specified by the RBC rules.

13. Unusual or infrequent items

The Coronavirus Disease 2019 ("COVID-19") pandemic continues to evolve. The Company believes COVID-19's impact on the Company's businesses, operating results, cash flows and/or financial condition primarily will be driven by the geographies impacted and the severity and duration of the pandemic; the pandemic's impact on the U.S. and global economies and consumer behavior and health care utilization patterns; and the timing, scope and impact of stimulus legislation as well as other federal, state and local governmental responses to the pandemic. Those primary drivers are beyond the Company's knowledge and control. As a result, the impact COVID-19 will have on the Company's businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be adverse and material. COVID-19 also may result in legal and regulatory proceedings, investigations and claims against the Company.

14. Subsequent events

Type I - Recognized subsequent events

Subsequent events have been considered through May 27, 2021, the date on which the financial statements were available to be issued. The Company had no known reportable recognized subsequent events.

Type II - Nonrecognized subsequent events

Subsequent events have been considered through May 27, 2021, the date on which the financial statements were available to be issued. The Company had no known reportable non-recognized subsequent events.

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Report of Independent Auditors on Supplementary Information

Board of Directors
Aetna Better Health of Kansas Inc.

We have audited, in accordance with auditing standards generally accepted in the United States of America, the statutory-basis financial statements of Aetna Better Health of Kansas Inc. (the Company) for the years ended December 31, 2020 and 2019, and have issued an adverse opinion with respect to conformity with U.S. generally accepted accounting principles and an unmodified opinion with respect to conformity with accounting practices prescribed or permitted by the Kansas Insurance Department thereon dated May 27, 2021. Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying supplemental investment disclosures are presented to comply with the National Association of Insurance Commissioners' Annual Statement Instructions and the National Association of Insurance Commissioners' Accounting Practices and Procedures Manual and for purposes of additional analysis and are not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated, in all material respects, in relation to the statutory-basis financial statements as a whole.

This report is intended solely for the information and use of the Company and state insurance departments to whose jurisdiction the Company is subject and is not intended to be and should not be used by anyone other than these specified parties.

Ernst & Young LLP

May 27, 2021

Aetna Better Health of Kansas Inc.

Summary Investment Schedule

December 31, 2020

	($ in Thousands)	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement			
		1	2	3	4	5	6
	Investment Categories	Amount	Percentage of Column 1 Line 13	Amount	Securities Lending Reinvested Collateral Amount	Total (Col. 3 + 4) Amount	Percentage of Column 5 Line 13
1.	Long-Term Bonds (Schedule D, Part 1):						
	1.01 U.S. governments	20,366	9.126	20,366	0	20,366	9.126
	1.02 All other governments	20,983	9.403	20,983	0	20,983	9.403
	1.03 U.S. states, territories and possessions, etc. guaranteed	11,957	5.358	11,957	0	11,957	5.358
	1.04 U.S. political subdivisions of states, territories, and possessions, guaranteed	1,355	0.607	1,355	0	1,355	0.607
	1.05 U.S. special revenue and special assessment obligations, etc. non-guaranteed	30,656	13.738	30,656	0	30,656	13.738
	1.06 Industrial and miscellaneous	101,589	45.528	101,589	0	101,589	45.528
	1.07 Hybrid securities	0	0.000	0	0	0	0.000
	1.08 Parent, subsidiaries and affiliates	0	0.000	0	0	0	0.000
	1.09 SVO identified funds	0	0.000	0	0	0	0.000
	1.10 Unaffiliated Bank loans	0	0.000	0	0	0	0.000
	1.11 Total long-term bonds	186,906	83.762	186,906	0	186,906	83.762
2.	Preferred stocks (Schedule D, Part 2, Section 1):						
	2.01 Industrial and miscellaneous (Unaffiliated)	0	0.000	0	0	0	0.000
	2.02 Parent, subsidiaries and affiliates	0	0.000	0	0	0	0.000
	2.03 Total preferred stocks	0	0.000	0	0	0	0.000
3.	Common stocks (Schedule D, Part 2, Section 2):						
	3.01 Industrial and miscellaneous Publicly traded (Unaffiliated)	0	0.000	0	0	0	0.000
	3.02 Industrial and miscellaneous Other (Unaffiliated)	0	0.000	0	0	0	0.000
	3.03 Parent, subsidiaries and affiliates Publicly traded	0	0.000	0	0	0	0.000
	3.04 Parent, subsidiaries and affiliates Other	0	0.000	0	0	0	0.000
	3.05 Mutual funds	0	0.000	0	0	0	0.000
	3.06 Unit investment funds	0	0.000	0	0	0	0.000
	3.07 Closed-end funds	0	0.000	0	0	0	0.000
	3.08 Total common stocks	0	0.000	0	0	0	0.000
4.	Mortgage loans (Schedule B)						
	4.01 Farm mortgages	0	0.000	0	0	0	0.000
	4.02 Residential mortgages	0	0.000	0	0	0	0.000
	4.03 Commercial mortgages	0	0.000	0	0	0	0.000
	4.04 Mezzanine real estate loans	0	0.000	0	0	0	0.000
	4.05 Total valuation allowance	0	0.000	0	0	0	0.000
	4.06 Total mortgage loans	0	0.000	0	0	0	0.000
5.	Real estate (Schedule A)						
	5.01 Properties occupied by company	0	0.000	0	0	0	0.000
	5.02 Properties held for production of income	0	0.000	0	0	0	0.000
	5.03 Properties held for sale	0	0.000	0	0	0	0.000
	5.04 Total real estate	0	0.000	0	0	0	0.000
6.	Cash, cash equivalents and short-term investments						
	6.01 Cash (Schedule E, Part 1)	13,549	6.072	13,549	0	13,549	6.072
	6.02 Cash equivalents (Schedule E, Part 2)	22,684	10.166	22,684	0	22,684	10.166
	6.03 Short-term investments (Schedule DA)	0	0.000	0	0	0	0.000
	6.04 Total cash, cash equivalents and short-term investments	36,233	16.238	36,233	0	36,233	16.238
7.	Contract loans	0	0.000	0	0	0	0.000
8.	Derivatives (Schedule DB)	0	0.000	0	0	0	0.000
9.	Other invested assets (Schedule BA)	0	0.000	0	0	0	0.000
10.	Receivable for securities	0	0.000	0	0	0	0.000
11.	Securities Lending (Schedule DL, Part 1)	0	0.000	0	0	0	0.000
12.	Other invested assets (Page 2, Line 11)	0	0.000	0	0	0	0.000
13.	Total invested assets	223,139	100.000	223,139	0	223,139	100.000

See accompanying independent auditors' report

Aetna Better Health of Kansas Inc.
Supplemental Investment Risks Interrogatories
December 31, 2020

Of The	Aetna Better Health of Kansas Inc.				
ADDRESS (City, State and Zip Code)	Overland Park, KS 66210				
NAIC Group Code	0001	NAIC Company Code	16072	Federal Employer's Identification Number (FEIN)	81-3370401

The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by reporting the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 2 of this annual statement. ($ in Thousands) $ 299,001

2. Ten largest exposures to a single issuer/borrower/investment. ($ in Thousands)

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	CALIFORNIA STATE CONSTRUCTION BONDS	Bond	$ 10,161	3.3 %
2.02	FMC TECHNOLOGIES	Cash Equivalent	$ 6,302	2.1 %
2.03	WALGREENS BOOT ALLIANCE	Cash Equivalent	$ 5,999	2.0 %
2.04	LOS ANGELES CALIF DEPT WTR & P REF-SER B	Bond	$ 5,959	1.9 %
2.05	UNITED MEXICAN STATES SR UNSECURED	Bond	$ 4,043	1.3 %
2.06	HUMANA INC	Cash Equivalent	$ 3,999	1.3 %
2.07	CARMAX AUTO OWNER TRUST SERIES 19-4 CLASS A3	Bond	$ 3,500	1.1 %
2.08	COLGATE - PALMOLIVE CO	Cash Equivalent	$ 3,500	1.1 %
2.09	NEW YORK ST URBAN DEV CORP REF-BIDDING GROUP 3-SER A	Bond	$ 3,304	1.1 %
2.10	W PALM BEACH FL CMNTY REDEV REF CITY CENTER COMM	Bond	$ 3,220	1.1 %

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC designation. ($ in Thousands)

	Bonds	1	2		Preferred Stocks	3	4
3.01	NAIC-1	$ 125,062	40.8 %	3.07	P/RP-1	$ 0	0.0 %
3.02	NAIC-2	$ 32,983	10.8 %	3.08	P/RP-2	$ 0	0.0 %
3.03	NAIC-3	$ 39,658	12.9 %	3.09	P/RP-3	$ 0	0.0 %
3.04	NAIC-4	$ 11,885	3.9 %	3.10	P/RP-4	$ 0	0.0 %
3.05	NAIC-5	$ 0	0.0 %	3.11	P/RP-5	$ 0	0.0 %
3.06	NAIC-6	$ 0	0.0 %	3.12	P/RP-6	$ 0	0.0 %

4. Assets held in foreign investments. ($ in Thousands)

4.01 Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets? Yes [ ] No [X]

If response to 4.01 above is yes, responses are not required for interrogatories 5 - 10.

4.02	Total admitted assets held in foreign investments	$ 24,512	8.0 %
4.03	Foreign-currency-denominated investments	$ 0	0.0 %
4.04	Insurance liabilities denominated in that same foreign currency	$ 0	0.0 %

Aetna Better Health of Kansas Inc.
Supplemental Investment Risks Interrogatories
December 31, 2020

5. Aggregate foreign investment exposure categorized by NAIC sovereign designation. ($ in Thousands)

		1	2
5.01	Countries designated NAIC-1	$ 3,027	1.0 %
5.02	Countries designated NAIC-2	$ 9,912	3.2 %
5.03	Countries designated NAIC-3 or below	$ 11,573	3.8 %

6. Largest foreign investment exposures by country, categorized by the country's NAIC sovereign designation. ($ in Thousands)

			1	2
	Countries designated NAIC - 1:			
6.01	Country 1:	SAUDI ARABIA	$ 1,470	0.5 %
6.02	Country 2:	JAPAN	$ 1,000	0.3 %
	Countries designated NAIC - 2:			
6.03	Country 1:	MEXICO	$ 4,043	1.3 %
6.04	Country 2:	PANAMA	$ 2,840	0.9 %
	Countries designated NAIC - 3 or below:			
6.05	Country 1:	EGYPT	$ 3,192	1.0 %
6.06	Country 2:	SOUTH AFRICA	$ 1,668	0.5 %

		1	2
7.	Aggregate unhedged foreign currency exposure. ($ in Thousands)	$ 0	0.0 %

8. Aggregate unhedged foreign currency exposure categorized by NAIC Sovereign designation. ($ in Thousands)

		1	2
8.01	Countries designated NAIC-1	$ 0	0.0 %
8.02	Countries designated NAIC-2	$ 0	0.0 %
8.03	Countries designated NAIC-3 or below	$ 0	0.0 %

9. Largest unhedged foreign currency exposures by country, categorized by the country's NAIC sovereign designation. ($ in Thousands)

			1	2
	Countries designated NAIC - 1:			
9.01	Country 1:		$ 0	0.0 %
9.02	Country 2:		$ 0	0.0 %
	Countries designated NAIC - 2:			
9.03	Country 1:		$ 0	0.0 %
9.04	Country 2:		$ 0	0.0 %
	Countries designated NAIC - 3 or below:			
9.05	Country 1:		$ 0	0.0 %
9.06	Country 2:		$ 0	0.0 %

10. Ten largest non-sovereign (i.e. non-governmental) foreign issues. ($ in Thousands)

	1 Issuer	2 NAIC Designation	3	4
10.01	MITSUBISHI UFJ FIN GRP SR UNSECURED	1	$ 1,000	0.3 %
10.02	BANCOLOMBIA SA SR UNSECURED	2	$ 994	0.3 %
10.03	INDONESIA ASAHAN ALUMINUM SR UNSECURED	2	$ 978	0.3 %
10.04	SEAGATE HDD CAYMAN SR UNSECURED	3	$ 557	0.2 %
10.05			$ 0	0.0 %
10.06			$ 0	0.0 %
10.07			$ 0	0.0 %
10.08			$ 0	0.0 %
10.09			$ 0	0.0 %
10.10			$ 0	0.0 %

Aetna Better Health of Kansas Inc.
Supplemental Investment Risks Interrogatories
December 31, 2020

11. Amounts and percentages of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure. ($ in Thousands)

11.01 Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 11.01 is yes, detail is not required for the remainder of interrogatory 11.

		1	2
11.02	Total admitted assets held in Canadian investments	$ 0	0.0 %
11.03	Canadian-currency-denominated investments	$ 0	0.0 %
11.04	Canadian-denominated insurance liabilities	$ 0	0.0 %
11.05	Unhedged Canadian currency exposure	$ 0	0.0 %

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions. ($ in Thousands)

12.01 Are assets held in investments with contractual sales restrictions less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 12.01 is yes, responses are not required for the remainder of Interrogatory 12.

	1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions	$ 0	0.0 %
	Largest three investments with contractual sales restrictions:		
12.03		$ 0	0.0 %
12.04		$ 0	0.0 %
12.05		$ 0	0.0 %

13. Amounts and percentages of admitted assets held in the ten largest equity interests. ($ in Thousands)

13.01 Are assets held in equity interests less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 13.01 is yes, detail is not required for the remainder of interrogatory 13.

	1 Issuer	2	3
13.02		$ 0	0.0 %
13.03		$ 0	0.0 %
13.04		$ 0	0.0 %
13.05		$ 0	0.0 %
13.06		$ 0	0.0 %
13.07		$ 0	0.0 %
13.08		$ 0	0.0 %
13.09		$ 0	0.0 %
13.10		$ 0	0.0 %
13.11		$ 0	0.0 %

14. Amounts and percentages of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities. ($ in Thousands)

14.01 Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 14.01 above is yes, responses are not required for 14.02 through 14.05.

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$ 0	0.0 %
	Largest three investments held in nonaffiliated, privately placed equities:		
14.03		$ 0	0.0 %
14.04		$ 0	0.0 %
14.05		$ 0	0.0 %

Ten largest fund managers:

	1 Fund Manager	2 Total Invested	3 Diversified	4 Nondiversified
14.06		$ 0	$ 0	$ 0
14.07		$ 0	$ 0	$ 0
14.08		$ 0	$ 0	$ 0
14.09		$ 0	$ 0	$ 0
14.10		$ 0	$ 0	$ 0
14.11		$ 0	$ 0	$ 0
14.12		$ 0	$ 0	$ 0
14.13		$ 0	$ 0	$ 0
14.14		$ 0	$ 0	$ 0
14.15		$ 0	$ 0	$ 0

15. Amounts and percentages of the reporting entity's total admitted assets held in general partnership interests. ($ in Thousands)

15.01 Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of Interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$ 0	0.0 %
	Largest three investments held in general partnership interests:		
15.03		$ 0	0.0 %
15.04		$ 0	0.0 %
15.05		$ 0	0.0 %

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans. ($ in Thousands)

16.01 Are mortgage loans reported in Schedule B less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of Interrogatory 16 and Interrogatory 17.

	1 Type (Residential, Commercial, Agricultural)	2	3
16.02		$ 0	0.0 %
16.03		$ 0	0.0 %
16.04		$ 0	0.0 %
16.05		$ 0	0.0 %
16.06		$ 0	0.0 %
16.07		$ 0	0.0 %
16.08		$ 0	0.0 %
16.09		$ 0	0.0 %
16.10		$ 0	0.0 %
16.11		$ 0	0.0 %

Amount and percentage of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
16.12	Construction loans	$ 0	0.0 %
16.13	Mortgage loans over 90 days past due	$ 0	0.0 %
16.14	Mortgage loans in the process of foreclosure	$ 0	0.0 %
16.15	Mortgage loans foreclosed	$ 0	0.0 %
16.16	Restructured mortgage loans	$ 0	0.0 %

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date. ($ in Thousands)

		Residential		Commercial		Agricultural	
	Loan to Value	1	2	3	4	5	6
17.01	above 95%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.02	91 to 95%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.03	81 to 90%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.04	71 to 80%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.05	below 70%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %

18. Amounts and percentages of the reporting entity's total admitted assets held in each of the five largest investments in real estate. ($ in Thousands)

18.01 Are assets held in real estate reported less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 18.01 above is yes, responses are not required for the remainder of Interrogatory 18.

Largest five investments in any one parcel or group of contiguous parcels of real estate.

	Description 1	2	3
18.02		$ 0	0.0 %
18.03		$ 0	0.0 %
18.04		$ 0	0.0 %
18.05		$ 0	0.0 %
18.06		$ 0	0.0 %

19. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments held in mezzanine real estate loans. ($ in Thousands)

19.01 Are assets held in investments held in mezzanine real estate loans less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 19.01 is yes, responses are not required for the remainder of Interrogatory 19.

	1	2	3
19.02	Aggregate statement value of investments held in mezzanine real estate loans:	$ 0	0.0 %
	Largest three investments held in mezzanine real estate loans:		
19.03		$ 0	0.0 %
19.04		$ 0	0.0 %
19.05		$ 0	0.0 %

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements. ($ in Thousands)

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
20.01	Securities lending agreements (do not include assets held as collateral for such transactions)	$ 0	0.0 %	$ 0	$ 0	$ 0
20.02	Repurchased agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.03	Reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.04	Dollar repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.05	Dollar reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors. ($ in Thousands)

		Owned		Written	
		1	2	3	4
21.01	Hedging	$ 0	0.0 %	$ 0	0.0 %
21.02	Income generation	$ 0	0.0 %	$ 0	0.0 %
21.03	Other	$ 0	0.0 %	$ 0	0.0 %

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards. ($ in Thousands)

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
22.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
22.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
22.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
22.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

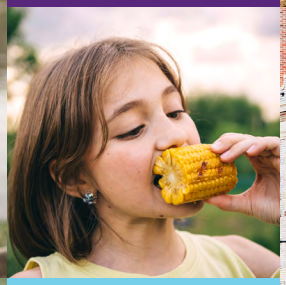
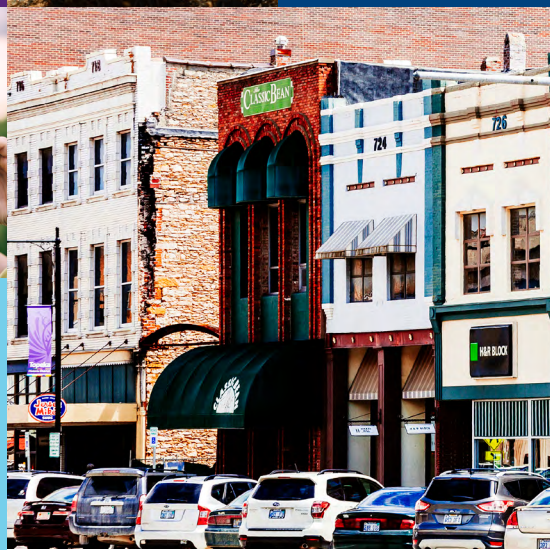
23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts. ($ in Thousands)

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
23.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
23.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
23.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
23.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

Note - Basis of Presentation

The accompanying supplemental schedules present selected statutory-basis financial data as of December 31, 2020 and for the year then ended for purposes of complying with the National Association of Insurance Commissioners' Accounting Practices and Procedures Manual and agrees to or is included in the amounts reported in the Company's 2020 Statutory Annual Statement as filed with the Kansas Insurance Department. Captions or amounts that are not applicable have been omitted.



Parent Company's Financial Statements

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

(Mark One)

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2022

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: 001-01011

CVSHealth

CVS HEALTH CORPORATION

(Exact name of registrant as specified in its charter)

Delaware	**05-0494040**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: **(401) 765-1500**

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

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, par value $0.01 per share	CVS	New York Stock Exchange

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

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act.	☒ Yes	☐ No	
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.	☐ Yes	☒ No	
Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days.	☒ Yes	☐ No	
Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files).	☒ Yes	☐ No	

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

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

If securities are registered pursuant to Section 12(b) of the Act, indicate by check mark whether the financial statements of the registrant included in the filing reflect the correction of an error to previously issued financial statements	☐ Yes	☒ No	
Indicate by check mark whether any of those error corrections are restatements that required a recovery analysis of incentive-based compensation received by any of the registrant's executive officers during the relevant recovery period pursuant to § 240.10D-1(b).	☐ Yes	☒ No	
Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act).	☐ Yes	☒ No	

The aggregate market value of the registrant's common stock held by non-affiliates was approximately $121,258,020,752 as of June 30, 2022, based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be affiliates of the registrant.

As of February 1, 2023, the registrant had 1,284,111,667 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The following materials are incorporated by reference into this Form 10-K:

Information contained in the definitive proxy statement for CVS Health Corporation's 2023 Annual Meeting of Stockholders, to be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year ended December 31, 2022 (the "Proxy Statement"), is incorporated by reference in Parts III and IV to the extent described therein.

TABLE OF CONTENTS

Unless the context otherwise requires, references to the terms "we," "our" or "us" used throughout this Annual Report on Form 10-K (this "10-K") refer to CVS Health Corporation (a Delaware corporation), together with its subsidiaries (collectively, "CVS Health" or the "Company"). References to competitors and other companies throughout this 10-K, including the information incorporated herein by reference, are for illustrative or comparison purposes only and are not identifying that these companies are the only competitors or closest competitors of the Company or any of the Company's businesses, products, or services.

CAUTIONARY STATEMENT CONCERNING FORWARD-LOOKING STATEMENTS

The Private Securities Litigation Reform Act of 1995 (the "Reform Act") provides a "safe harbor" for forward-looking statements, so long as (1) those statements are identified as forward-looking, and (2) the statements are accompanied by meaningful cautionary statements that identify important factors that could cause actual results to differ materially from those discussed in the statement. We are taking advantage of these safe harbor provisions.

Certain information contained in this 10-K is forward-looking within the meaning of the Reform Act or SEC rules. This information includes, but is not limited to: "Outlook for 2023" of Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A") included in Item 7, "Quantitative and Qualitative Disclosures About Market Risk" included in Item 7A, "Government Regulation" included in Item 1, and "Risk Factors" included in Item 1A. In addition, throughout this 10-K and our other reports and communications, we use the following words or variations or negatives of these words and similar expressions when we intend to identify forward-looking statements:

· *Anticipates*	· *Believes*	· *Can*	· *Continue*	· *Could*
· *Estimates*	· *Evaluate*	· *Expects*	· *Explore*	· *Forecast*
· *Guidance*	· *Intends*	· *Likely*	· *May*	· *Might*
· *Outlook*	· *Plans*	· *Potential*	· *Predict*	· *Probable*
· *Projects*	· *Seeks*	· *Should*	· *View*	· *Will*

All statements addressing the future operating performance of CVS Health or any segment or any subsidiary and/or future events or developments, including statements relating to the impact of coronavirus disease 2019 ("COVID-19") and any new variants or viruses on the Company's businesses, investment portfolio, operating results, cash flows and/or financial condition, statements relating to corporate strategy, statements relating to future revenue, operating income or adjusted operating income, earnings per share or adjusted earnings per share, Health Care Benefits segment business, sales results and/or trends, medical cost trends, medical membership, Medicare Part D membership, medical benefit ratios and/or operations, Pharmacy Services segment business, sales results and/or trends and/or operations, Retail/LTC segment business, sales results and/or trends and/or operations, incremental investment spending, interest expense, effective tax rate, weighted-average share count, cash flow from operations, net capital expenditures, cash available for debt repayment, statements related to possible, proposed or pending acquisitions, joint ventures, investments or combinations that involve, among other things, the timing or likelihood of receipt of regulatory approvals, the timing of completion, integration synergies, net synergies and integration risks and other costs, including those related to CVS Health's proposed acquisition of Oak Street Health, Inc. ("Oak Street Health") and pending acquisition of Signify Health, Inc. ("Signify Health"), enterprise modernization, transformation, leverage ratio, cash available for enhancing shareholder value, inventory reduction, turn rate and/or loss rate, debt ratings, the Company's ability to attract or retain customers and clients, store development and/or relocations, new product development, and the impact of industry and regulatory developments, as well as statements expressing optimism or pessimism about future operating results or events, are forward-looking statements within the meaning of the Reform Act.

Forward-looking statements rely on a number of estimates, assumptions and projections concerning future events, and are subject to a number of significant risks and uncertainties and other factors that could cause actual results to differ materially from those statements. Many of these risks and uncertainties and other factors are outside our control.

Certain of these risks and uncertainties and other factors are described under "Risk Factors" included in Item 1A of this 10-K; these are not the only risks and uncertainties we face. There can be no assurance that the Company has identified all the risks that may affect it. Additional risks and uncertainties not presently known to the Company or that the Company currently believes to be immaterial also may adversely affect the Company's businesses. If any of those risks or uncertainties develops into actual events, those events or circumstances could have a material adverse effect on the Company's businesses, operating results, cash flows, financial condition and/or stock price, among other effects.

You should not put undue reliance on forward-looking statements. Any forward-looking statement speaks only as of the date of this 10-K, and we disclaim any intention or obligation to update or revise forward-looking statements, whether as a result of new information, future events, uncertainties or otherwise.

PART I

Item 1. Business.

Overview

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health," the "Company," "we," "our" or "us"), is a leading diversified health solutions company reshaping health care to help make healthier happen for more Americans. In an increasingly connected and digital world, CVS Health is meeting people wherever they are and changing health care to meet their needs. The Company has more than 9,000 retail locations, more than 1,100 walk-in medical clinics, a leading pharmacy benefits manager with over 110 million plan members with expanding specialty pharmacy solutions and a dedicated senior pharmacy care business serving more than one million patients per year. The Company also serves an estimated 35 million people through traditional, voluntary and consumer-directed health insurance products and related services, including expanding Medicare Advantage offerings and a leading standalone Medicare Part D prescription drug plan ("PDP"). The Company believes its integrated health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

The Company has four reportable segments: Health Care Benefits, Pharmacy Services, Retail/LTC and Corporate/Other.

Business Strategy

The Company seeks to reimagine the consumer healthcare experience to make it easier and more affordable to live a healthier life. This means delivering solutions that are more personalized, simpler to use, and increasingly digital so that consumers can receive care when, where and how they desire. CVS Health is also shifting from transaction-based care to addressing holistic health – physical, emotional, social, economic – which will lead to higher quality care and lower medical costs. The Company is a leader in key segments of health care through its foundational businesses and is seeking to create new sources of value by expanding into next generation care delivery and health services, with a goal of improving satisfaction levels for both providers and consumers. The Company believes its consumer-centric strategy will drive sustainable long-term growth and deliver value for all stakeholders.

COVID-19

The COVID-19 pandemic and its emerging new variants continue to impact the U.S. and other countries around the world. Our strong local presence and scale in communities across the country has enabled us to play an indispensable role in the national response to COVID-19, as well as provide seamless support for our customers wherever they need us: in our CVS locations, in their homes, and virtually.

The Company offered COVID-19 diagnostic testing at more than 4,700 CVS pharmacy locations, at community-based testing sites in underserved areas and through its Return Ready℠ solution as of December 31, 2022. During 2021, the Company also began selling over-the-counter ("OTC") test kits in its retail locations and online. The Company began administering COVID-19 vaccinations in long-term care facilities and in certain of its retail pharmacies during December 2020 and February 2021, respectively, and began the administration of COVID-19 boosters and pediatric vaccines during the fourth quarter of 2021. The Company offered COVID-19 vaccinations at more than 9,000 CVS pharmacy locations as of December 31, 2022. During the year ended December 31, 2022, the Company administered more than 15 million COVID-19 tests and nearly 28 million COVID-19 vaccines and sold more than 63 million OTC test kits. The Company expects to continue to play a significant role in COVID-19 testing and vaccine administration in the future, while maintaining a strong commitment to testing and vaccine equity by optimizing site locations and targeting outreach initiatives to reach vulnerable populations.

The impact of COVID-19 on the Company's businesses, operating results, cash flows and financial condition in the years ended December 31, 2022, 2021 and 2020, as well as information regarding certain expected impacts of COVID-19 on the Company, is discussed throughout this 10-K.

Health Care Benefits Segment

The Health Care Benefits segment operates as one of the nation's leading diversified health care benefits providers, serving an estimated 35 million people as of December 31, 2022. The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make more informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products

and related services, including medical, pharmacy, dental and behavioral health plans, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services, and health information technology ("HIT") products and services. The Health Care Benefits segment also provided workers' compensation administrative services through its Coventry Health Care Workers' Compensation business ("Workers' Compensation business") prior to the sale of this business on July 31, 2020. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates.

Health Care Benefits Products and Services

The Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk of medical and dental care costs) as "ASC." Health Care Benefits products and services consist of the following:

- *Commercial Medical*: The Health Care Benefits segment offers point-of-service ("POS"), preferred provider organization ("PPO"), health maintenance organization ("HMO") and indemnity benefit ("Indemnity") plans. Commercial medical products also include health savings accounts ("HSAs") and consumer-directed health plans that combine traditional POS or PPO and/or dental coverage, subject to a deductible, with an accumulating benefit account (which may be funded by the plan sponsor and/or the member in the case of HSAs). With the launch of Aetna Virtual Primary Care™ in 2021, eligible members now have access to health services remotely, paired with access to in-person visits with providers in the Company's network, including at MinuteClinic® locations. Principal products and services are targeted specifically to large multi-site national, mid-sized and small employers, individual insureds and expatriates. The Company offers medical stop loss insurance coverage for certain employers who elect to self-insure their health benefits. Under medical stop loss insurance products, the Company assumes risk for costs associated with large individual claims and/or aggregate loss experience within an employer's plan above a pre-set annual threshold. The segment also has a portfolio of additional health products and services that complement its medical products such as dental plans, behavioral health and employee assistance products, provider network access and vision products.
- *Government Medical*: In select geographies, the Health Care Benefits segment offers Medicare Advantage plans, Medicare Supplement plans and prescription drug coverage for Medicare beneficiaries; participates in Medicaid and subsidized Children's Health Insurance Programs ("CHIP"); and participates in demonstration projects for members who are eligible for both Medicare and Medicaid ("Duals"). These Government Medical products are further described below:
    - *Medicare Advantage:* Through annual contracts with the U.S. Centers for Medicare & Medicaid Services ("CMS"), the Company offers HMO and PPO products for eligible individuals in certain geographic areas through the Medicare Advantage program. Members typically receive enhanced benefits over traditional fee-for-service Medicare coverage ("Original Medicare"), including reduced cost-sharing for preventive care, vision and other services. The Company offered network-based HMO and/or PPO plans in 46 states and Washington, D.C. in 2022. For certain qualifying employer groups, the Company offers Medicare PPO products nationally. When combined with the Company's PDP product, these national PPO plans form an integrated national Insured Medicare product for employers that provides medical and pharmacy benefits.
    - *Medicare PDP:* The Company is a national provider of drug benefits under the Medicare Part D prescription drug program. All Medicare eligible individuals are eligible to participate in this voluntary prescription drug plan. Members typically receive coverage for certain prescription drugs, usually subject to a deductible, co-insurance and/or co-payment. The Company offered PDP plans in all 50 states and Washington, D.C. in 2022.
    - *Medicare Supplement:* For certain Medicare eligible members, the Company offers supplemental coverage for certain health care costs not covered by Original Medicare. The products included in the Medicare Supplement portfolio help to cover some of the gaps in Original Medicare, and include coverage for Medicare deductibles and coinsurance amounts. The Company offered a wide selection of Medicare Supplement products in 49 states and Washington, D.C. in 2022.
    - *Medicaid and CHIP:* The Company offers health care management services to individuals eligible for Medicaid and CHIP under multi-year contracts with government agencies in various states that are subject to annual appropriations. CHIP are state-subsidized insurance programs that provide benefits for families with uninsured children. The Company offered these services on an Insured or ASC basis in 16 states in 2022.
    - *Duals:* The Company provides health coverage to beneficiaries who are dually eligible for both Medicare and Medicaid coverage. These members must meet certain income and resource requirements in order to qualify for this coverage. The Company coordinates 100% of the care for these members and may provide them with additional services in order to manage their health care costs.

The Company also has a portfolio of transformative products and services aimed at creating a holistic and integrated approach to individual health and wellness. These products and services complement the Commercial Medical and Government Medical products and aim to provide innovative solutions, create integrated experience offerings and enable enhanced care delivery to customers.

Health Care Benefits Provider Networks

The Company contracts with physicians, hospitals and other providers for services they provide to the Company's members. The Company uses a variety of techniques designed to help encourage appropriate utilization of medical services ("utilization") and maintain affordability of quality coverage. In addition to contracts with providers for negotiated rates of reimbursement, these techniques include creating risk sharing arrangements that align economic incentives with providers, the development and implementation of guidelines for the appropriate utilization and the provision of data to providers to enable them to improve health care quality. At December 31, 2022, the Company's underlying nationwide provider network had approximately 1.6 million participating providers. Other providers in the Company's provider networks also include laboratory, imaging, urgent care and other freestanding health facilities.

Health Care Benefits Quality Assessment

CMS uses a 5-star rating system to monitor Medicare health care and drug plans and ensure that they meet CMS's quality standards. CMS uses this rating system to provide Medicare beneficiaries with a tool that they can use to compare the overall quality of care and level of customer service of companies that provide Medicare health care and drug plans. The rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management and overall customer satisfaction. See "Health Care Benefits Pricing" below in this Item 1 for further discussion of star ratings. The Company seeks Health Plan accreditation for Aetna Inc. ("Aetna") HMO plans from the National Committee for Quality Assurance ("NCQA"), a private, not-for-profit organization that evaluates, accredits and certifies a wide range of health care organizations. Health care plans seeking accreditation must pass a rigorous, comprehensive review and must annually report on their performance.

Aetna Life Insurance Company ("ALIC"), a wholly-owned subsidiary of the Company, has received nationwide NCQA PPO Health Plan accreditation. As of December 31, 2022, all of the Company's Commercial HMO and all of ALIC's PPO members who were eligible participated in HMOs or PPOs that are accredited by the NCQA.

The Company's provider selection and credentialing/re-credentialing policies and procedures are consistent with NCQA and URAC, a health care accrediting organization that establishes quality standards for the health care industry, as well as state and federal, requirements. In addition, the Company is certified under the NCQA Credentials Verification Organization ("CVO") certification program for all certification options and has URAC CVO accreditation.

Quality assessment programs for contracted providers who participate in the Company's networks begin with the initial review of health care practitioners. Practitioners' licenses and education are verified, and their work history is collected by the Company or in some cases by the practitioner's affiliated group or organization. The Company generally requires participating hospitals to be certified by CMS or accredited by The Joint Commission, the American Osteopathic Association, or Det Norske Veritas Healthcare.

The Company also offers quality and outcome measurement programs, quality improvement programs, and health care data analysis systems to providers and purchasers of health care services.

Health Care Benefits Information Systems

The Health Care Benefits segment currently operates and supports an end-to-end suite of information technology platforms to support member engagement, enrollment, health benefit administration, care management, service operations, financial reporting and analytics. The multiple platforms are supported by an integration layer to facilitate the transfer of real-time data. There is continued focus and investment in enterprise data platforms, cloud capabilities, digital products to offer innovative solutions and a seamless experience to the Company's members through mobile and web channels. The Company is making concerted investments in emerging technology capabilities such as voice, artificial intelligence and robotics to further automate, reduce cost and improve the experience for all of its constituents. The Health Care Benefits segment is utilizing the full breadth of the Company's assets to build enterprise technology that will help guide our members through their health care

journey, provide them a high level of service, enable healthier outcomes and encourage them to take next best actions to lead healthier lives.

Health Care Benefits Customers

Medical membership is dispersed throughout the United States, and the Company also serves medical members in certain countries outside the United States. The Company offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, many of which are available nationwide. Depending on the product, the Company markets to a range of customers, including employer groups, individuals, college students, part-time and hourly workers, health plans, providers, governmental units, government-sponsored plans, labor groups and expatriates. For additional information on medical membership, see "Health Care Benefits Segment" in the Management's Discussion and Analysis of Financial Condition and Results of Operations (the "MD&A") included in Item 7 of this 10-K.

The Company markets both Commercial Insured and ASC products and services primarily to employers that sponsor the Company's products for the benefit of their employees and their employees' dependents. Frequently, larger employers offer employees a choice among coverage options from which the employee makes his or her selection during a designated annual open enrollment period. Typically, employers pay all of the monthly premiums to the Company and, through payroll deductions, obtain reimbursement from employees for a percentage of the premiums that is determined by each employer. Some Health Care Benefits products are sold directly to employees of employer groups on a fully employee-funded basis. In some cases, the Company bills the covered individual directly. In addition, effective January 2022, the Company entered the individual public health insurance exchanges ("Public Exchanges") in eight states through which it sells Insured plans directly to individual consumers. The Company entered Public Exchanges in four additional states effective January 2023.

The Company offers Insured Medicare coverage on an individual basis as well as through employer groups to their retirees. Medicaid and CHIP members are enrolled on an individual basis. The Company also offers Insured health care coverage to members who are dually-eligible for both Medicare and Medicaid.

Health Care Benefits products are sold through: the Company's sales personnel; independent brokers, agents and consultants who assist in the production and servicing of business; as well as private health insurance exchanges ("Private Exchanges") and Public Exchanges (together with Private Exchanges, "Insurance Exchanges"). For large employers or other entities that sponsor the Company's products ("plan sponsors"), independent consultants and brokers are frequently involved in employer health plan selection decisions and sales. In some instances, the Company may pay commissions, fees and other amounts to brokers, agents, consultants and sales representatives who place business with the Company. In certain cases, the customer pays the broker for services rendered, and the Company may facilitate that arrangement by collecting the funds from the customer and transmitting them to the broker. The Company supports marketing and sales efforts with an advertising program that may include television, radio, billboards, print media and social media, supplemented by market research and direct marketing efforts.

The U.S. federal government is a significant customer of the Health Care Benefits segment through contracts with CMS for coverage of Medicare-eligible individuals and federal employee-related benefit programs. Other than the contracts with CMS, the Health Care Benefits segment is not dependent upon a single customer or a few customers the loss of which would have a significant effect on the earnings of the segment. The loss of business from any one or a few independent brokers or agents would not have a material adverse effect on the earnings of the Health Care Benefits segment. In 2022, 2021 and 2020, Health Care Benefits segment revenues from the federal government accounted for 14%, 14% and 13%, respectively, of the Company's consolidated total revenues. Contracts with CMS for coverage of Medicare-eligible individuals in the Health Care Benefits segment accounted for approximately 74%, 79% and 78%, respectively, of the Company's consolidated revenues from the federal government in 2022, 2021 and 2020.

Health Care Benefits Pricing

For Commercial Insured plans, contracts containing the pricing and other terms of the relationship are generally established in advance of the policy period and typically have a duration of one year. Fees under ASC plans are generally fixed for a period of one year.

Generally, a fixed premium rate is determined at the beginning of the policy period for Commercial Insured plans. The Company typically cannot recover unanticipated increases in health care and other benefit costs in the current policy period; however, it may consider prior experience for a product in the aggregate or for a specific customer, among other factors, in determining premium rates for future policy periods. Where required by state laws, premium rates are filed and approved by

state regulators prior to contract inception. Future operating results could be adversely affected if the premium rates requested are not approved or are adjusted downward or their approval is delayed by state or federal regulators.

The Company has Medicare Advantage and PDP contracts with CMS to provide HMO, PPO and prescription drug coverage to Medicare beneficiaries in certain geographic areas. Under these annual contracts, CMS pays the Company a fixed per member (or "capitation") payment and/or a portion of the premium, both of which are based on membership and adjusted for demographic and health risk factors. CMS also considers inflation, changes in utilization patterns and average per capita fee-for-service Medicare costs in the calculation of the fixed capitation payment or premium. PDP contracts also provide a risk-sharing arrangement with CMS to limit the Company's exposure to unfavorable expenses or benefit from favorable expenses. Amounts payable to the Company under the Medicare arrangements are subject to annual revision by CMS, and the Company elects to participate in each Medicare service area or region on an annual basis. Premiums paid to the Company for Medicare products are subject to federal government reviews and audits, which can result, and have resulted, in retroactive and prospective premium adjustments and refunds to the government and/or members. In addition to payments received from CMS, some Medicare Advantage products and all PDP products require a supplemental premium to be paid by the member or sponsoring employer. In some cases, these supplemental premiums are adjusted based on the member's income and asset levels. Compared to Commercial Medical products, Medicare contracts generate higher per member per month revenues and higher health care and other benefit costs.

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA") ties a portion of each Medicare Advantage plan's reimbursement to the plan's "star ratings." Plans must have a star rating of 4 or higher (out of 5) to qualify for bonus payments. CMS released the Company's 2023 star ratings in October 2022. The Company's 2023 star ratings will be used to determine which of the Company's Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2024. Based on the Company's membership at December 31, 2022, 21% of the Company's Medicare Advantage members were in plans with 2023 star ratings of at least 4.0 stars, compared to 87% of the Company's Medicare Advantage members being in plans with 2022 star ratings of at least 4.0 stars based on the Company's membership at December 31, 2021. Refer to "Medicare Star Ratings" within the "Government Regulation" section of this Item 1 for further discussion of the decrease in the Company's star ratings.

Rates for Medicare Supplement products are regulated at the state level and vary by state and plan.

Under Insured Medicaid contracts, state government agencies pay the Company fixed monthly rates per member that vary by state, line of business and demographics; and the Company arranges, pays for and manages the health care services provided to Medicaid beneficiaries. These rates are subject to change by each state, and, in some instances, provide for adjustment for health risk factors. CMS requires these rates to be actuarially sound. The Company also receives fees from customers where it provides services under ASC Medicaid contracts. ASC Medicaid contracts generally are for periods of more than one year, and certain of them contain performance incentives and limited financial risk sharing with respect to certain medical, financial and operational metrics. Under these arrangements, performance is evaluated annually, with associated financial incentive opportunities, and financial risk share obligations are typically limited to a percentage of the fees otherwise payable to the Company. Payments to the Company under Medicaid contracts are subject to the annual appropriation process in the applicable state.

Under Duals contracts, the rate setting process is generally established by CMS in partnership with the state government agency participating in the demonstration project. Both CMS and the state government agency may seek premium and other refunds under certain circumstances, including if the Company fails to comply with CMS regulations or other contractual requirements.

The Company offers HMO and consumer-directed medical and dental plans to federal employees under the Federal Employees Health Benefits ("FEHB") Program and the Federal Employees Dental and Vision Insurance Program. Premium rates and fees for those plans are subject to federal government review and audit, which can result, and have resulted, in retroactive and prospective premium and fee adjustments and refunds to the government and/or members.

Beginning in 2014, the ACA imposed significant new industry-wide fees, assessments and taxes, including an annual levy known as the health insurer fee (the "HIF"). In December 2019, the HIF was repealed for calendar years after 2020. For additional information on the ACA fees, assessments and taxes, see Note 1 ''Significant Accounting Policies'' included in Item 8 of this 10-K. The Company's goal is to collect premiums and fees where possible, or solve for, all of the ACA-related fees, assessments and taxes.

Health Care Benefits Seasonality

The Health Care Benefits segment's quarterly operating income progression is impacted by (i) the seasonality of benefit costs which generally increase during the year as Insured members progress through their annual deductibles and out-of-pocket expense limits and (ii) the seasonality of operating expenses, which are generally the highest during the fourth quarter due primarily to spending to support readiness for the start of the upcoming plan year and marketing associated with Medicare annual enrollment.

During the year ended December 31, 2022, the impact of COVID-19 within the Health Care Benefits segment has generally stabilized as a result of the Company's ability to capture COVID-19 related medical costs in pricing, and the segment has experienced a return to a more normal seasonality pattern, as described above.

During the year ended December 31, 2021, the customary quarterly operating income progression was impacted by COVID-19. While overall medical costs in the first quarter were generally consistent with historical baseline levels in the aggregate, the segment experienced increased COVID-19 testing and treatment costs and lower Medicare risk-adjusted revenue. During the second quarter, COVID-19 testing and treatment costs persisted, however at levels significantly lower than those observed during the first quarter. Beginning in the third quarter, medical costs once again increased primarily driven by the spread of the emerging new variants of COVID-19, which resulted in increased testing and treatment costs that continued throughout the fourth quarter.

During the year ended December 31, 2020, the customary quarterly operating income progression was also impacted by COVID-19. Beginning in mid-March, the health care system experienced a significant reduction in utilization that is discretionary and the cancellation of elective medical procedures. Utilization remained below historical levels through April 2020, began to recover in May and June 2020 and reached more normal levels in the third and fourth quarters of 2020, with select geographies impacted by COVID-19 waves.

Health Care Benefits Competition

The health care benefits industry is highly competitive, primarily due to a large number of for-profit and not-for-profit competitors, competitors' marketing and pricing and a proliferation of competing products, including new products that are continually being introduced into the marketplace. New entrants into the marketplace, as well as consolidation within the industry, have contributed to and are expected to intensify the competitive environment. In addition, the rapid pace of change as the industry evolves towards a consumer-focused retail marketplace, including Insurance Exchanges, and the increased use of technology to interact with members, providers and customers, increase the risks the Company faces from new entrants and disruptive actions by existing competitors compared to prior periods.

The Company believes that the significant factors that distinguish competing health plans include the perceived overall quality (including accreditation status), quality of service, comprehensiveness of coverage, cost (including premium rates, provider discounts and member out-of-pocket costs), product design, financial stability and ratings, breadth and quality of provider networks, ability to offer different provider network options, providers available in such networks, and quality of member support and care management programs. The Company believes that it is competitive on each of these factors. The Company's ability to increase the number of persons covered by its health plans or to increase Health Care Benefits segment revenues is affected by its ability to differentiate itself from its competitors on these factors. Competition may also affect the availability of services from providers, including primary care physicians, specialists and hospitals.

Insured products compete with local and regional health care benefits plans, health care benefits and other plans sponsored by other large commercial health care benefit insurance companies, health system owned health plans, new entrants into the marketplace and numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association. The largest competitor in Medicare products is Original Medicare. Additional Health Care Benefits segment competitors include other types of medical and dental provider organizations, various specialty service providers (including pharmacy benefit management ("PBM") services providers), health care consultants, financial services companies, integrated health care delivery organizations (networks of providers who also coordinate administrative services for and assume insurance risk of their members), third party administrators ("TPAs"), HIT companies and, for certain plans, programs sponsored by the federal or state governments. Emerging competitors include start up health care benefits plans, technology companies, provider-owned health plans, new joint ventures (including not-for-profit joint ventures among firms from multiple industries), financial services firms that are distributing competing products on their proprietary Private Exchanges, and consulting firms that are distributing competing products on their proprietary Private Exchanges, as well as non-

traditional distributors such as retail companies. The Company's ability to increase the number of persons enrolled in Insured Commercial Medical products also is affected by the desire and ability of employers to self-fund their health coverage.

The Health Care Benefits segment's ASC plans compete primarily with other large commercial health care benefit companies, numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association and TPAs.

The provider solutions and HIT marketplaces and products are evolving rapidly. The Company competes for provider solutions and HIT business with other large health plans and commercial health care benefit insurance companies as well as information technology companies and companies that specialize in provider solutions and HIT. Many information technology product competitors have longer operating histories, better brand recognition, greater marketplace presence and more experience in developing innovative products.

In addition to competitive pressures affecting the Company's ability to obtain new customers or retain existing customers, the Health Care Benefits segment's medical membership has been and may continue to be adversely affected by adverse and/or uncertain economic conditions and reductions in workforce by existing customers due to adverse and/or uncertain general economic conditions, especially in the United States and industries where such membership is concentrated.

Health Care Benefits Reinsurance

The Company currently has several reinsurance agreements with non-affiliated insurers that relate to Health Care Benefits insurance policies. The Company entered into these contracts to reduce the risk of catastrophic losses which in turn reduces capital and surplus requirements. The Company frequently evaluates reinsurance opportunities and refines its reinsurance and risk management strategies on a regular basis.

Pharmacy Services Segment

The Pharmacy Services segment provides a full range of PBM solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services and mail order pharmacy. In addition, through the Pharmacy Services segment, the Company provides specialty pharmacy and infusion services, clinical services, disease management services, medical spend management and pharmacy and/or other administrative services for providers and federal 340B drug pricing program covered entities ("Covered Entities"). The Company operates a group purchasing organization that negotiates pricing for the purchase of pharmaceuticals and rebates with pharmaceutical manufacturers on behalf of its participants. The Company also provides various administrative, management and reporting services to pharmaceutical manufacturers. The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, PDPs, Medicaid managed care ("Managed Medicaid") plans, plans offered on Insurance Exchanges and other sponsors of health benefit plans throughout the United States and Covered Entities. The Pharmacy Services segment operates retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services. During the year ended December 31, 2022, the Company's PBM filled or managed 2.3 billion prescriptions on a 30-day equivalent basis.

PBM Services

The Company dispenses prescription drugs directly through its mail order dispensing and specialty mail order pharmacies and through pharmacies in its retail network. All prescriptions processed by the Company are analyzed, processed and documented by the Company's proprietary prescription management systems. These systems provide essential features and functionality to allow plan members to utilize their prescription drug benefits. These systems also streamline the process by which prescriptions are processed by staff and network pharmacists by enhancing review of various items through automation, including plan eligibility, early refills, duplicate dispensing, appropriateness of dosage, drug interactions or allergies, over-utilization and potential fraud.

Plan Design Offerings and Administration
The Company assists its PBM clients in designing pharmacy benefit plans that help improve health outcomes while minimizing the costs to the client. The Company also assists PBM clients in monitoring the effectiveness of their plans through frequent, informal communications, the use of proprietary software, as well as through formal annual, quarterly and sometimes monthly performance reviews. The Company administers pharmacy benefit plans for clients who contract with it to facilitate prescription drug coverage and claims processing for their eligible plan members. The Company also provides administrative services for Covered Entities.

The Company makes recommendations to help PBM clients design benefit plans that promote the use of lower cost, clinically appropriate drugs and helps its PBM clients control costs by recommending plan designs that encourage the use of generic equivalents of brand name drugs when such equivalents are available. Clients also have the option, through plan design, to further lower their pharmacy benefit plan costs by setting different member payment levels for different products on their drug lists or "formularies," which helps guide members to choose lower cost alternatives through appropriate financial incentives.

Formulary Management
The Company utilizes an independent panel of doctors, pharmacists and other medical experts, referred to as the CVS Caremark National Pharmacy and Therapeutics Committee, to review and approve the selection of drugs that meet the Company's standards of safety and efficacy for inclusion on one of the Company's template formularies. The Company's formularies provide recommended products in numerous drug classes to help ensure member access to clinically appropriate drugs with alternatives within a class under the client's pharmacy benefit plan, while helping to drive the lowest net cost for clients that select one of the Company's formularies. To help improve clinical outcomes for members and clients, the Company conducts ongoing, independent reviews of all drugs, including those appearing on the formularies and generic equivalent products. Many of the Company's clients choose to adopt a template formulary offering as part of their plan design. PBM clients are given capabilities to offer real time benefits information for a member's specific plan design, provided digitally at the point of prescribing, at the CVS pharmacy and directly to members.

Retail Pharmacy Network Management Services
The Company maintains a national network of approximately 66,000 retail pharmacies, consisting of approximately 40,000 chain pharmacies (which include CVS pharmacy locations) and approximately 26,000 independent pharmacies, in the United States, including Puerto Rico, the District of Columbia, Guam and the U.S. Virgin Islands. When a customer fills a prescription in a retail pharmacy, the pharmacy sends prescription data electronically to the Company from the point-of-sale. This data interfaces with the Company's proprietary prescription management systems, which verify relevant plan member data and eligibility, while also performing a drug utilization review to help evaluate clinical appropriateness and safety and confirming that the pharmacy will receive payment for the prescription.

Mail Order Pharmacy Services
The Pharmacy Services segment operates mail order dispensing pharmacies in the United States. Plan members or their prescribers submit prescriptions or refill requests, primarily for maintenance medications, to these pharmacies, and staff pharmacists review these prescriptions and refill requests with the assistance of the Company's prescription management systems. This review may involve communications with the prescriber and, with the prescriber's approval when required, can result in generic substitution, therapeutic interchange or other actions designed to help reduce cost and/or improve quality of treatment. The Company's mail order dispensing pharmacies have been awarded Mail Service Pharmacy accreditation from URAC.

Specialty Pharmacy and Infusion Services
The Pharmacy Services segment operates specialty mail order pharmacies, retail specialty pharmacy stores and branches for infusion and enteral nutrition services in the United States. The specialty mail order pharmacies are used for delivery of advanced medications to individuals with chronic or genetic diseases and disorders. The Company's specialty mail order pharmacies have been awarded Specialty Pharmacy accreditation from URAC. Substantially all of the Company's specialty mail order pharmacies also have been accredited by The Joint Commission and the Accreditation Commission for Health Care ("ACHC"), which are independent, not-for-profit organizations that accredit and certify health care programs and organizations in the United States. The ACHC accreditation includes an additional accreditation by the Pharmacy Compounding Accreditation Board, which certifies compliance with the highest level of pharmacy compounding standards.

Clinical Services
The Company offers multiple clinical programs and services to help clients manage overall pharmacy and health care costs in a clinically appropriate manner. These programs are primarily designed to promote better health outcomes and to help target inappropriate medication utilization and non-adherence to medication, each of which may result in adverse medical events that negatively affect member health and client pharmacy and medical spend. These programs include utilization management ("UM"), medication management, quality assurance, adherence and counseling programs to complement the client's plan design and clinical strategies. To help address prescription opioid abuse and misuse, the Company introduced an industry-leading UM approach that limits to seven days the supply of opioids dispensed for certain acute prescriptions for patients who are new to therapy, limits the daily dosage of opioids dispensed based on the strength of the opioid and requires the use of immediate-release formulations of opioids before extended-release opioids are dispensed. The Company's Pharmacy Advisor® program facilitates pharmacist counseling, both face-to-face and over the telephone, to help participating plan members with

certain chronic diseases, such as diabetes and cardiovascular conditions, to identify gaps in care, adhere to their prescribed medications and manage their health conditions. The Company also has digital connectivity that helps to lower drug costs for patients by providing expanded visibility to lower cost alternatives through enhanced analytics and data sharing.

Disease Management Programs
The Company's clinical programs and services utilize advanced protocols and offer clients convenience in working with providers and other third parties. The Company's care management program covers diseases such as rheumatoid arthritis, Parkinson's disease, epilepsy and multiple sclerosis and is accredited by the NCQA. The Company's UM program covers similar diseases and is accredited by the NCQA and URAC.

Medical Benefit Management
The Company's NovoLogix® online preauthorization tool helps identify and capture cost savings opportunities for specialty drugs billed under the medical benefit by identifying outliers to appropriate dosages and costs, and helps to ensure clinically appropriate use of specialty drugs.

Group Purchasing Organization Services
The Company operates a group purchasing organization that negotiates pricing for the purchase of pharmaceuticals and rebates with pharmaceutical manufacturers on behalf of its participants. The Company also provides various administrative, management and reporting services to pharmaceutical manufacturers.

Pharmacy Services Information Systems

The Pharmacy Services segment's claim adjudication platform incorporates architecture that centralizes the data generated from filling mail order prescriptions, adjudicating retail pharmacy claims and delivering other solutions to PBM clients. The Health Engagement Engine® technology and proprietary clinical algorithms help connect various parts of the enterprise and serve an essential role in cost management and health improvement, leveraging cloud-native technologies and practices. This capability transforms pharmacy data into actionable interventions at key points of care, including in retail, mail and specialty pharmacies as well as in customer care call center operations, leveraging our enterprise data platform to improve the quality of care. The technology leverages assisted artificial intelligence to deliver insights to the business and bring automation to otherwise manual tasks. Specialty services also connects with our claim adjudication platform and various health plan adjudication platforms with a centralized architecture servicing many clients and members. Operating services, such as Specialty Expedite®, provide an interconnected onboarding solution for specialty medications and branding solutions ranging from fulfillment to total patient management. These services are managed through our new innovative specialty workflow and web platform.

Pharmacy Services Clients

The Company's Pharmacy Services clients are primarily employers, insurance companies, unions, government employee groups, health plans, PDPs, Managed Medicaid plans, plans offered on Insurance Exchanges, other sponsors of health benefit plans throughout the United States and Covered Entities. Pharmaceuticals are provided to eligible members in benefit plans maintained by clients and utilize the Company's information systems, among other things, to help perform safety checks, drug interaction screening and identify opportunities for generic substitution. Substantially all of the Pharmacy Services segment's revenues are generated from dispensing and managing prescription drugs to eligible members in benefit plans maintained by clients.

Pharmacy Services Seasonality

The majority of Pharmacy Services segment revenues are not seasonal in nature.

Pharmacy Services Competition

The Company believes the primary competitive factors in the pharmacy services industry include: (i) the ability to negotiate favorable discounts from drug manufacturers as well as to negotiate favorable discounts from, and access to, retail pharmacy networks; (ii) the ability to identify and apply effective cost management programs utilizing clinical strategies, including the development and utilization of preferred formularies; (iii) the ability to market PBM products and services; (iv) the commitment to provide flexible, clinically-oriented services to clients and be responsive to clients' needs; (v) the quality, scope and costs of products and services offered to clients and their members; and (vi) operational excellence in delivering services. The Pharmacy Services segment has a significant number of competitors offering PBM services, including large, national PBM companies

(e.g., Prime Therapeutics and MedImpact), PBMs owned by large national health plans (e.g., the Express Scripts business of Cigna Corporation and the OptumRx business of UnitedHealth) and smaller standalone PBMs.

Retail/LTC Segment

The Retail/LTC segment sells prescription drugs and a wide assortment of health and wellness products and general merchandise, provides health care services through its MinuteClinic walk-in medical clinics, provides medical diagnostic testing, administers vaccinations for illnesses such as influenza, COVID-19 and shingles and conducts long-term care pharmacy ("LTC") operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to long-term care facilities and other care settings. As of December 31, 2022, the Retail/LTC segment operated more than 9,000 retail locations, more than 1,100 MinuteClinic locations as well as online retail pharmacy websites, LTC pharmacies and on-site pharmacies. During the year ended December 31, 2022, the Retail/LTC segment filled 1.6 billion prescriptions on a 30-day equivalent basis. For the year ended December 31, 2022, the Company dispensed approximately 26.8% of the total retail pharmacy prescriptions in the United States.

Retail/LTC Products and Services

A typical retail store sells prescription drugs and a wide assortment of high-quality, nationally advertised brand name and proprietary brand merchandise. Pharmacy locations may also contract with Covered Entities under the federal 340B drug pricing program. Front store categories include over-the-counter drugs, consumer health products, beauty products and personal care products. The Company purchases merchandise from numerous manufacturers and distributors. The Company believes that competitive sources are readily available for substantially all of the products carried in its retail stores and the loss of any one supplier would not likely have a material effect on the Retail/LTC segment. LTC operations include distribution of prescription drugs and related consulting and ancillary services. The Company's MinuteClinic locations offer a variety of health care services.

Retail/LTC revenues by major product group are as follows:

	Percentage of Revenues		
	2022	2021	2020
Pharmacy [1]	76.9 %	76.0 %	76.9 %
Front store and other [2]	23.1 %	24.0 %	23.1 %
	100.0 %	100.0 %	100.0 %

(1) Pharmacy includes LTC sales and sales in pharmacies within Target Corporation ("Target") and other retail stores.
(2) "Other" represents less than 12% of the "Front store and other" revenue category in all periods presented.

Pharmacy
Pharmacy revenues represented approximately three-fourths of Retail/LTC segment revenues in each of 2022, 2021 and 2020. The Company believes that retail pharmacy operations will continue to represent a critical part of the Company's business due to industry demographics, e.g., an aging American population consuming a greater number of prescription drugs, prescription drugs being used more often as the first line of defense for managing illness, the introduction of new pharmaceutical products, the need for vaccinations, including the COVID-19 vaccination, and Medicare Part D growth. The Company believes the retail pharmacy business benefits from investment in both people and technology, as well as innovative collaborations with health plans, PBMs and providers. Given the nature of prescriptions, consumers want their prescriptions filled accurately by professional pharmacists using the latest tools and technology, and ready when promised. Consumers also need medication management programs and better information to help them get the most out of their health care dollars. To assist consumers with these needs, the Company has introduced integrated pharmacy health care services that provide an earlier, easier and more effective approach to engaging consumers in behaviors that can help lower costs, improve health and save lives.

Front Store
Front store revenues reflect the Company's strategy of innovating with new and unique products and services, using innovative personalized marketing and adjusting the mix of merchandise to match customers' needs and preferences. A key component of the front store strategy is the ExtraCare® card program, which is one of the largest and most successful retail loyalty programs in the United States. The ExtraCare program allows the Company to balance marketing efforts so it can reward its best customers by providing them with automatic sale prices, customized coupons, ExtraBucks® rewards and other benefits. The Company also offers a subscription-based membership program, CarePass®, under which members are entitled to a suite of benefits delivered over the course of the subscription period, as well as a promotional reward that can be redeemed for future

goods and services. The Company continues to launch and enhance new and exclusive brands to create unmatched offerings in beauty products and deliver other unique product offerings, including a full range of high-quality proprietary brand products that are only available through CVS stores. The Company currently carries approximately 5,500 proprietary brand products, which accounted for approximately 21% of front store revenues during 2022.

MinuteClinic
As of December 31, 2022, the Company operated more than 1,100 MinuteClinic locations in the United States. The clinics are staffed by nurse practitioners and physician assistants who utilize nationally established guidelines to deliver a variety of health care services. Payors value these clinics because they provide convenient, high-quality, cost-effective care, in many cases offering an attractive alternative to more expensive sites of care. MinuteClinic also offers virtual care services to connect customers with licensed providers to provide access to health services remotely. MinuteClinic is collaborating with the Health Care Benefits and Pharmacy Services segments to help meet the needs of the Company's health plan and client plan members by offering programs that can improve member health and lower costs. MinuteClinic also maintains relationships with leading hospitals, clinics and physicians in the communities we serve to support and enhance quality, access and continuity of care.

On-site Pharmacies
The Company also operates a limited number of pharmacies located at client sites, which provide certain health plan members and customers with a convenient alternative for filling their prescriptions and receiving vaccinations, including the COVID-19 vaccination.

Medical Diagnostic Testing
The Company offers medical diagnostic testing primarily through its testing sites located at CVS pharmacy locations, in its MinuteClinic locations, at community-based testing sites in underserved areas and through its Return Ready solution.

Long-term Care Pharmacy Operations
The Retail/LTC segment provides LTC pharmacy services through the Omnicare® business. Omnicare's customers consist of skilled nursing facilities, assisted living facilities, independent living communities, hospitals, correctional facilities, and other health care service providers. The Company provides pharmacy consulting, including monthly patient drug therapy evaluations, to assist in compliance with state and federal regulations and provide proprietary clinical and health management programs. It also provides pharmaceutical case management services for retirees, employees and dependents who have drug benefits under corporate-sponsored health care programs.

Community Location Development

CVS Health's community health destinations are an integral part of its ability to meet the needs of consumers and maintain its leadership position in the changing health care landscape. When paired with its rapidly expanding digital presence, the Company's physical presence in thousands of communities across the country represents a competitive advantage by allowing it to develop deep and trusted relationships through everyday engagement in consumer health. The Company's community health destinations have played, and will continue to play, a key role in the Company's continued growth and success. During 2022, the Company opened approximately 40 new locations, relocated 4 locations and closed approximately 300 locations.

The Company's continuous assessment of its national footprint is an essential component of competing effectively in the current health care environment. On an ongoing basis, the Company evaluates changes in population, consumer buying patterns and future health needs to assess the ability of its existing stores and locations to meet the needs of its consumers and the business. During the fourth quarter of 2021, the Company completed a strategic review of its retail business and announced its plans to reduce store density in certain locations through the closure of approximately 900 retail stores between 2022 and 2024. As of December, 31, 2022, the Company has closed approximately 300 retail stores in connection with this strategic review.

Retail/LTC Information Systems

The Company has continued to invest in information systems to enable it to deliver exceptional customer service, enhance safety and quality, and expand patient care services while lowering operating costs. The proprietary WeCARE Workflow tool supports pharmacy teams by prioritizing work to meet customer expectations, facilitating prescriber outreach, and seamlessly integrating clinical programs. This solution delivers improved efficiency and enhances customer experience, as well as provides a framework to accommodate the evolution of pharmacy practice and the expansion of clinical programs. Our Health Engagement Engine technology and data science clinical algorithms enable the Company to help identify opportunities for pharmacists to deliver face-to-face counseling regarding patient health and safety matters, including medication adherence issues, gaps in care and management of certain chronic health conditions. The Company's digital strategy is to empower the

consumer to navigate their pharmacy experience and manage their condition through integrated online and mobile solutions that offer utility and convenience. The Company's LTC digital technology suite, Omniview®, improves the efficiency of customers' operations with tools that include executive dashboards, pre-admission pricing, electronic ordering of prescription refills, proof-of-delivery tracking, access to patient profiles, receipt and management of facility bills, and real-time validation of Medicare Part D coverage, among other capabilities.

Through the collaboration of its digital and technical teams, the Company has established critical tools which enable patients to schedule diagnostic testing and vaccination appointments through CVS.com and MinuteClinic.com. Key elements of the offerings include landing pages which highlight services and answer common questions, screening capabilities to determine patient eligibility, service location locator and appointment selection tools to efficiently identify the requested service on a specified date, time, and location and registration pages to collect required patient information, accelerating the administration of the test or vaccine once at the store. Once scheduled, the tools provide the user with instructions and notifications including SMS text message and email reminders, and, following administration, also provide digital results for tests and records for vaccinations, enabling patients to view and save their medical records for convenient access at a later point.

Retail/LTC Customers

The success of the Retail/LTC segment's businesses is dependent upon the Company's ability to establish and maintain contractual relationships with pharmacy benefit managers and other payors on acceptable terms. Substantially all of the Retail/LTC segment's pharmacy revenues are derived from pharmacy benefit managers, managed care organizations ("MCOs"), government funded health care programs, commercial employers and other third-party payors. No single Retail/LTC payor accounted for 10% or more of the Company's consolidated total revenues in 2022, 2021 or 2020.

Retail/LTC Seasonality

The majority of Retail/LTC segment revenues, particularly pharmacy revenues, generally are not seasonal in nature. However, front store revenues tend to be higher during the December holiday season. In addition, both pharmacy and front store revenues are affected by the timing and severity of the cough, cold and flu season. Uncharacteristic or extreme weather conditions also can adversely affect consumer shopping patterns and Retail/LTC revenues, expenses and operating results.

During the year ended December 31, 2022, the customary quarterly operating income progression in the Retail/LTC segment continued to be impacted by COVID-19. During the first quarter, the Company saw high volumes of administration of COVID-19 vaccinations, as well as demand for OTC test kits in the front store, particularly in the beginning of the year when the Omicron variant incidence was high. In addition, the Company administered the highest quarterly volume of COVID-19 diagnostic tests of 2022 during the first quarter, however a decline compared to the prior year. During the second and third quarters, the Company continued to generate earnings from the sale of OTC test kits, as customers performed more in-home testing versus diagnostic testing, in addition to earnings from the continued administration of COVID-19 diagnostic testing and vaccinations, albeit at lower levels than those experienced in the first quarter. During the fourth quarter, the Company saw an increase in COVID-19 vaccine administration from the prior quarter related to the bivalent COVID-19 booster.

During the year ended December 31, 2021, the customary quarterly operating income progression was impacted by COVID-19. During the first quarter, the Company experienced reduced customer traffic in its retail pharmacies, which reflected the impact of a weaker cough, cold and flu season, while it administered the highest quarterly volume of COVID-19 diagnostic tests. During the second quarter, the segment generated earnings from COVID-19 vaccinations and saw improved customer traffic as vaccinated customers began more actively shopping in CVS locations. During the third and fourth quarters, emerging new variants drove the continued administration of COVID-19 vaccinations (including booster shots) and diagnostic testing, while the segment also generated earnings from the sale of OTC test kits in the front store.

During the year ended December 31, 2020, the customary quarterly operating income progression was impacted by COVID-19. During March 2020, the Company experienced increased prescription volume due to the greater use of 90-day prescriptions and early refills of maintenance medications, as well as increased front store volume as consumers prepared for the COVID-19 pandemic. Beginning in the second quarter and continuing throughout the remainder of the year, the Company experienced reduced customer traffic in its retail pharmacies and MinuteClinic locations due to shelter-in-place orders as well as reduced new therapy prescriptions and decreased long-term care prescription volume as a result of the COVID-19 pandemic. Beginning in the third quarter, the Company saw an increase in diagnostic testing related to the COVID-19 pandemic and in December 2020, the Company began administering COVID-19 vaccinations in long-term care facilities.

Retail/LTC Competition

The retail pharmacy business is highly competitive. The Company believes that it competes principally on the basis of: (i) store location and convenience, (ii) customer service and satisfaction, (iii) product selection and variety, and (iv) price. In the areas it serves, the Company competes with other drugstore chains (e.g., Walgreens and Rite Aid), supermarkets, discount retailers (e.g., Walmart), independent pharmacies, restrictive pharmacy networks, internet companies (e.g., Amazon), membership clubs, retail health clinics, urgent care and primary care offices, as well as mail order dispensing pharmacies.

LTC pharmacy services are highly regional or local in nature, and within a given geographic area of operation, highly competitive. The Company's largest LTC pharmacy competitor nationally is PharMerica. The Company also competes with numerous local and regional institutional pharmacies, pharmacies owned by long-term care facilities and local retail pharmacies. Some states have enacted "freedom of choice" or "any willing provider" requirements as part of their state Medicaid programs or in separate legislation, which may increase the competition that the Company faces in providing services to long-term care facility residents in these states.

Corporate/Other Segment

The Company presents the remainder of its financial results in the Corporate/Other segment, which primarily consists of:

- Management and administrative expenses to support the Company's overall operations, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments, expenses associated with the Company's investments in its transformation and enterprise modernization programs and acquisition-related integration costs; and
- Products for which the Company no longer solicits or accepts new customers such as its large case pensions and long-term care insurance products.

Generic Sourcing Venture

The Company and Cardinal Health, Inc. ("Cardinal") each have a 50% ownership in Red Oak Sourcing, LLC ("Red Oak"), a generic pharmaceutical sourcing entity. Under this arrangement, the Company and Cardinal contributed their sourcing and supply chain expertise to Red Oak and agreed to source and negotiate generic pharmaceutical supply contracts for both companies through Red Oak. Red Oak does not own or hold inventory on behalf of either company.

Working Capital Practices

The Company funds the growth of its businesses through a combination of cash flow from operations, commercial paper and other short-term borrowings, as well as long-term borrowings. For additional information on the Company's working capital practices, see "Liquidity and Capital Resources" in the MD&A included in Item 7 of this 10-K. Employer groups, individuals, college students, part-time and hourly workers, health plans, providers, governmental units, government-sponsored plans (with the exception of Medicare Part D services, which are described below), labor groups and expatriates, which represent the vast majority of Health Care Benefits segment revenues, typically settle in less than 30 days. As a provider of Medicare Part D services, the Company contracts annually with CMS. Utilization of services each plan year results in the accumulation of either a receivable from or a payable to CMS. The timing of settlement of the receivable or payable with CMS takes several quarters, which impacts working capital from year to year. The majority of the Retail/LTC segment non-pharmacy revenues are paid in cash, or with debit or credit cards. Managed care organizations, pharmacy benefit managers, government funded health care programs, commercial employers and other third party insurance programs, which represent the vast majority of the Company's consolidated pharmacy revenues, typically settle in less than 30 days. The remainder of the Company's consolidated pharmacy revenues are paid in cash, or with debit or credit cards.

Human Capital

Overview

At CVS Health, we share a single, clear purpose: bringing our heart to every moment of your health. We devote significant time and attention to the attraction, development and retention of talent to deliver high levels of service to our customers. Our commitment to them includes a competitive rewards package and programs that support our diverse range of colleagues in rewarding and fulfilling careers. As of December 31, 2022, we employed over 300,000 colleagues primarily in the United States including in all 50 states, the District of Columbia and Puerto Rico, approximately 73% of whom were full-time.

We believe engaged colleagues produce stronger business results and are more likely to build a career with the Company. Each year we conduct an internal engagement survey that provides colleagues with an opportunity to share their opinions and experiences with respect to their role, their team and the enterprise to help CVS Health Corporation's Board of Directors (the "Board") and our management identify areas where we can improve colleague experience. The survey covers a broad range of topics including development and opportunities, diversity management, recognition, performance, well-being, compliance and continuous improvement. In 2022, greater than 80% of our colleagues participated in the engagement survey, of which greater than 75% responded that they were actively engaged.

The Board, our Chief Executive Officer ("CEO") and our Chief People Officer provide oversight of our human capital strategy, which consists of the following categories: total rewards; diversity, equity and inclusion; colleague development; and health and safety.

Total Rewards

We recognize how vital our colleagues are to our success and strive to offer comprehensive and competitive wages and benefits to meet the varying needs of our colleagues and their families. The benefits and programs include annual bonuses, 401(k) plans, stock awards, an employee stock purchase plan, health care and insurance benefits, paid time off, flexible work schedules, family leave, dependent care resources, colleague assistance programs and tuition assistance, among many others, depending on eligibility.

In recognition of the critical role that the attraction and retention of talent plays in the success of our business, during 2021, we also announced a significant investment in our employees through an increase in the Company's minimum hourly wage to $15.00 an hour effective July 2022, with incremental increases to the Company's competitive hourly rates beginning in August 2021. The new wage structure also incorporates additional increases beyond the $15.00 minimum, with higher starting hourly rates for roles such as pharmacy technicians and call center representatives. In addition, during 2021 we awarded incremental bonuses to select colleague groups in recognition of their ongoing contributions throughout the COVID-19 pandemic, the most significant of which included bonuses to our pharmacist and distribution center colleagues. In 2022, we awarded incremental bonuses to select colleague groups including our front-line retail store, pharmacy and MinuteClinic colleagues.

Diversity, Equity & Inclusion

We believe that a diverse workforce creates a healthier, stronger and more sustainable company. We aim to attract, develop, retain and support a diverse workforce that reflects the many customers, patients, members and communities we serve. Our Diversity Management Leadership Council, a cross-functional group of senior leaders appointed by our CEO, works with our Strategic Diversity Management leadership team to intentionally embed diversity across all facets of our business. For our efforts, we have been recognized as a DiversityInc Top 50 Company, one of Seramount's Best Companies for Multicultural Women and earned a 100 percent score on both the Human Rights Campaign Corporate Equality Index as well as the Disability Equality Index, meaning the company is recognized as a "Best Place to Work for Disability Inclusion." The Company discloses information on our diversity, equity and inclusion strategy and programs in our annual Environmental, Social and Governance ("ESG") Report.

As a foundation of diversity and inclusion, we continuously focus on increasing underrepresented populations across our business. In 2022, 70% of our total colleague population and 55% of our colleagues at the manager level and above self-reported as female. In addition, in 2022 our colleagues reported their race/ethnicity as: White (49%), Black/African American (18%), Hispanic/Latino (16%), Asian (11%) and Other (6%). The appendix to our ESG Report, our Strategic Diversity Management Report and our EEO-1 Employer Information Report include additional information on the diversity of our workforce.

Our diversity management strategy emphasizes workplace representation, inclusion and belonging, talent acquisition and management and a diverse marketplace. Beginning in 2021, we incorporated a diversity metric into our annual cash incentive program for our most senior leaders who have the greatest ability to influence the overall hiring, development and promotion of our colleagues. We also continued the deployment of conscious inclusion training for colleagues designed to enhance awareness of biases and rolled out our INCLUDE program to activate inclusive behaviors. Our ESG Report and Strategic Diversity Management Report include additional information with respect to our conscious inclusion training. We support 16 Colleague Resource Groups ("CRGs") that include more than 28,000 colleagues across the enterprise. These groups represent a wide range of professional, cultural, ethical and personal affinities and interests, as well as formal mentoring programs. Our

CRGs provide our colleagues with an opportunity to connect and network with one another through a particular affinity, culture or interest. Each of our CRGs is sponsored by a senior leader.

Colleague Development

The Company offers a number of resources and programs that attract, engage, develop, advance and retain colleagues. Training and development provides colleagues the support they need to perform well in their current role while planning and preparing for future roles. We offer an online orientation program that pairs new hires with seasoned colleagues and the training continues throughout a colleague's career through in-person, virtual and self-paced learning at all levels. We also provide mentoring, tools and workshops for colleagues to manage their career development. We offer a variety of management and leadership programs that develop incumbent diverse and other high potential colleagues. Our broad training practices include updated, tech-enabled tools and keep our colleagues informed of new developments in our industry that are relevant to their roles. During the year ended December 31, 2022, our colleagues invested approximately 17 million hours in learning and development courses.

Our colleague development program also promotes the importance of compliance across our business. Our colleagues demonstrate this commitment through our annual Code of Conduct training, which nearly 100% of active colleagues completed in 2022. In 2022, we launched more than 70 different training courses as part of our Enterprise Compliance Training Program.

Health & Safety

We have a strong commitment to providing a safe working environment. We have implemented an environmental health and safety management system to support adherence and monitoring of programs designed to make our various business operations compliant with applicable occupational safety and health regulations and requirements. Our Environmental Health and Safety Department oversees the implementation and adherence to programs like Powered Industrial Truck training, materials handling and storage, selection of personal protective equipment and workplace violence prevention.

We utilize Safety Service Plans to analyze data and concentrate on key areas of risk to reduce the chance of workplace incidents. We focus on identifying causes and improving performance when workplace incidents occur. We also engage leaders in promoting a culture of safety. With safety task forces in place at each distribution center, we empower leaders and safety business partners to identify policies, procedures and processes that could improve their own operations.

From the outset of the COVID-19 pandemic, we took a comprehensive approach to managing occupational health and safety challenges presented by the pandemic, including implementing facial covering requirements for our workplaces and providing face masks to colleagues, providing sick leave, implementing symptom screening measures and implementing additional protocols in accordance with applicable Occupational Safety and Health Administration ("OSHA") requirements and guidance and Centers for Disease Control and Prevention ("CDC") guidelines for workplaces. We have emphasized the importance of taking immediate steps toward full vaccination.

Environmental, Social and Governance Strategy

Overview

CVS Health believes the health of our people, communities and planet are linked to the health of our business. Our ESG strategy – *Healthy 2030* is focused on achieving our economic, environmental and social imperatives and outlines how we are shaping a more equitable and sustainable future for all – across multiple dimensions of health. Designed to use our assets to transform the health care experience and invest in community health at the local level, while working to reduce the environmental impact of our operations, *Healthy 2030* consists of four pillars: *Healthy People*, *Healthy Business*, *Healthy Community* and *Healthy Planet*. We believe this strategy is achievable without materially adversely affecting our businesses, operating results, cash flows and/or prospects.

Healthy People

Through physical and virtual assets, we provide convenient, personalized and integrated access to health care support and services. We continue to implement and expand initiatives that build on our innovative health care model, with the ultimate aim to transform the health care experience for every person we reach to improve health outcomes. These include helping to improve chronic disease prevention and management, helping to reduce and prevent prescription drug misuse, and improving the social determinants of health, which include education, transportation and behavioral health. Through our ESG strategy we

are leveraging our expertise and resources to make the health care experience simple, equitable, convenient and deeply personal for each of us.

Healthy Business

As we work to transform health care, we are committed to operating a healthy business for all our stakeholders, including our patients, customers, stockholders, clients, partners, communities and colleagues. Throughout our large operational footprint and including our supply chain, we are committed to acting responsibly with respect for human rights, privacy, information security, public policy, marketing and advertising. We focus on diversity, equity and inclusion as well as colleague development, health and safety. Through our ESG strategy, we are focused on providing people with the opportunity to be as healthy as possible by expanding community-centered solutions that advance health equity and improve outcomes.

Healthy Community

By working with community-focused organizations and through innovative programs that can be tailored to and executed across different communities, we are driving positive health outcomes and reducing overall health care costs. Our philanthropic strategy, which includes grants made through the CVS Health Foundation, Health Zones initiative and Project Health program, improves health outcomes and reduce health disparities in under-resourced communities. We are investing charitable resources, leveraging CVS Health assets, and working in partnership with non-profits to help our communities be as healthy as possible.

Healthy Planet

We are working to improve the health of our planet and make a difference in the lives of the people who live on it by advancing our sustainability commitments and addressing the environmental factors that contribute to health inequities. In October 2021, CVS Health's science-based net zero greenhouse gas ("GHG") emissions targets were validated by the Science Based Targets initiatives ("SBTi"). We continue to make meaningful progress to reduce our environmental impact across our operations and supply chain. Key priorities include the advancement of our GHG emissions-reduction targets, reduction in our energy consumption, the advancement of sustainability in transportation, logistics and our physical locations, which includes retrofitting community and corporate locations with LED lighting, exploring investments in renewable energy, reducing water use, focusing on smarter consumption through a "digital first" approach and the reduction of our use of paper and plastic.

Intellectual Property

The Company has registered and/or applied to register a variety of trademarks and service marks used throughout its businesses, as well as domain names, and relies on a combination of copyright, patent, trademark and trade secret laws, in addition to contractual restrictions, to establish and protect the Company's proprietary rights. The Company regards its intellectual property as having significant value in the Health Care Benefits, Pharmacy Services and Retail/LTC segments. The Company is not aware of any facts that could materially impact the continuing use of any of its intellectual property.

Government Regulation

Overview

The Company's operations are subject to comprehensive federal, state and local laws and regulations and comparable multiple levels of international regulation in the jurisdictions in which it does business. There also continues to be a heightened level of review and/or audit by federal, state and international regulators of the health and related benefits industry's business and reporting practices. In addition, many of the Company's PBM clients and the Company's payors in the Retail/LTC segment, including insurers, Medicare plans, Managed Medicaid plans and MCOs, are themselves subject to extensive regulations that affect the design and implementation of prescription drug benefit plans that they sponsor. Similarly, the Company's LTC clients, such as skilled nursing facilities, are subject to government regulations, including many of the same government regulations to which the Company is subject.

The laws and rules governing the Company's businesses and interpretations of those laws and rules continue to expand and become more restrictive each year and are subject to frequent change. The application of these complex legal and regulatory requirements to the detailed operation of the Company's businesses creates areas of uncertainty. Further, there are numerous proposed health care, financial services and other laws and regulations at the federal, state and international levels, some of which could adversely affect the Company's businesses if they are enacted. The Company cannot predict whether pending or future federal or state legislation or court proceedings will change aspects of how it operates in the specific markets in which it

competes or the health care industry generally, but if changes occur, the impact of any such changes could have a material adverse impact on the Company's businesses, operating results, cash flows and/or stock price. Possible regulatory or legislative changes include the federal or one or more state governments fundamentally restructuring the Commercial, Medicare or Medicaid marketplace; reducing payments to the Company in connection with Medicare, Medicaid, dual eligible or special needs programs; increasing its involvement in drug reimbursement, pricing, purchasing, and/or importation; or changing the laws governing PBMs.

The Company has internal control policies and procedures and conducts training and compliance programs for its employees to help prevent, detect and correct prohibited practices. However, if the Company's employees or agents fail to comply with applicable laws governing its international or other operations, it may face investigations, prosecutions and other legal proceedings and actions which could result in civil penalties, administrative remedies and criminal sanctions. Any failure or alleged failure to comply with applicable laws and regulations summarized below, or any adverse applications or interpretations of, or changes in, the laws and regulations affecting the Company and/or its businesses, could have a material adverse effect on the Company's operating results, financial condition, cash flows and/or stock price. See Item 3 of this 10-K, "Legal Proceedings," for further information.

The Company can give no assurance that its businesses, financial condition, operating results and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations, including the laws and regulations described in this Government Regulation section, as they may relate to one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iii) pending or future federal or state governmental investigations of one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; or (v) adverse developments in pending or future legal proceedings against or affecting the Company, including *qui tam* lawsuits, or affecting one or more of the industries in which the Company competes and/or the health care industry generally.

Laws and Regulations Related to COVID-19

In response to the COVID-19 pandemic, the U.S. Department of Health and Human Services ("HHS") put in place a public health emergency ("PHE") in January 2020 and HHS must extend it every 90 days to maintain certain health care flexibilities and waivers. The Biden administration most recently renewed the PHE on January 11, 2023 and has indicated that they intend for the PHE to expire on May 11, 2023. The Families First Coronavirus Response Act (the "Families First Act") and the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") were enacted in March 2020. Each of the Families First Act and the CARES Act requires the Company to provide coverage for COVID-19 related medical services, in many cases without member cost-sharing, in its Insured Health Care Benefits products.

The CARES Act also provides relief funding to providers to reimburse them for health care related expenses incurred in preventing, preparing for and/or responding to COVID-19 (provided no other source is obligated to reimburse those expenses) or lost health care related revenues that are attributable to COVID-19. Under the CARES Act, the Company receives reimbursement for uninsured patients in connection with COVID-19 testing and vaccination as well as monoclonal antibody treatment. Aside from such reimbursement, the Company has not requested any funding under the CARES Act. However, in the second quarter of 2020, the Company received $43 million from the CARES Act provider relief fund, all of which was returned to the HHS during the second quarter of 2020.

The CARES Act also allows for the deferral of the payment of the employer share of Social Security taxes effective March 27, 2020 by permitting them to remit the associated payments in two equal installments on or about December 31, 2021 and December 31, 2022. The Company elected to defer approximately $670 million of its Social Security tax payments during the year ended December 31, 2020. The Company paid the first of two equal installments in December 2021 and the second installment in December 2022, as required under the CARES Act.

Congress enacted the American Rescue Plan Act in March 2021. Among other changes, as a result of this legislation, Public Exchange plan premium subsidies increased for low-income individuals and became available to people with incomes higher than 400% of the federal poverty limit. In August 2022, the Inflation Reduction Act subsequently extended these subsidies through 2025, which could cause shifts in enrollment into Public Exchange plans.

In addition to the Families First Act, the CARES Act, and the American Rescue Plan Act, the Company has experienced legislation, regulation, directives, orders and other requirements from federal, state, county and municipal authorities related to

the COVID-19 pandemic. These governmental actions included, but were not limited to, requirements to waive member cost-sharing associated with COVID-19 testing and treatment, provide coverage for additional COVID-19-related services, expand the use of telemedicine, extend grace periods for payments of premiums or limit coverage termination based on non-payment of premiums or fees, modify health benefits coverage eligibility rules to help maintain employee eligibility, and facilitate, accelerate or advance payments to providers, and other requirements related to the PHE. Many of these requirements remain in effect and continue to impact different areas of our business differently and may continue for different lengths of time, and present financial implications with respect to implementing and unwinding our compliance with these requirements.

The Company has operations that fall within the scope of COVID-19 vaccine requirements for federal contractors, certain health care workers, and the requirements of certain jurisdictions such as New York City. Several of these are subject to judicial challenges. We are continuing to closely monitor and update our practices in response to developments or changes in the COVID-19 vaccination policies established by various federal agencies as well as the several state- and municipal-specific COVID-19 vaccine mandates that provide expanded exemptions, modifications, requirements or restrictions regarding employee vaccinations. We have a process for employees to request a reasonable accommodation if they are unable to get vaccinated due to a medical condition, sincerely held religious belief, or any other legally recognized exemption. Employees must apply and be approved for a reasonable accommodation in order to be exempt from the vaccination requirement.

Additionally, in January 2022, the HHS announced that commercial health insurers must cover the costs of up to eight rapid COVID-19 OTC test kits per individual per 30-day period. Coverage for COVID-19 OTC test kits has subsequently been required by Medicare and, in many states, Medicaid. These requirements may increase benefit costs in those businesses and jurisdictions, and may increase revenues in our retail business. The requirement may also result in a decrease in more expensive tests and treatments, which could partially mitigate the increase in benefit costs. These impacts will be highly dependent on the overall supply of testing products.

Some activities that were suspended during the COVID-19 pandemic, such as Medicaid eligibility redeterminations, are currently scheduled to resume later this year, and many of the requirements set forth above may change once the PHE expires. The impact of this governmental activity on the U.S. economy, consumer, customer and health care provider behavior and health care utilization patterns is beyond our knowledge and control. As a result, the financial and/or operational impact these COVID-19 related governmental actions and inactions will have on our businesses, operating results, cash flows and/or financial condition is uncertain, but the collective impact could be material and adverse.

Laws and Regulations Related to Multiple Segments of the Company's Business

Laws Related to Reimbursement by Government Programs - The Company is subject to various federal and state laws concerning its submission of claims and other information to Medicare, Medicaid and other federal and state government-sponsored health care programs. Potential sanctions for violating these laws include recoupment or reduction of government reimbursement amounts, civil penalties, treble damages, and exclusion from participation in government health care programs. Such laws include the federal False Claims Act (the "False Claims Act"), the federal anti-kickback statute (the "AKS"), state false claims acts and anti-kickback statutes in most states, the federal "Stark Law" and related state laws. In particular, the False Claims Act prohibits intentionally submitting, conspiring to submit, or causing to be submitted, false claims, records, or statements to the federal government, or intentionally failing to return overpayments, in connection with reimbursement by federal government programs. In addition, any claim for government reimbursement also violates the False Claims Act where it results from a violation of the AKS.

Both federal and state false claims laws permit private individuals to file *qui tam* or "whistleblower" lawsuits on behalf of the federal or state government. Participants in the health and related benefits industry, including the Company, frequently are subject to actions under the False Claims Act or similar state laws. The federal Stark Law generally prohibits physicians from referring Medicare or Medicaid beneficiaries for certain services, including outpatient prescription drugs, to any entity with which the physician, or an immediate family member of the physician, has a financial relationship. The Stark Law further prohibits the entity receiving a prohibited referral from presenting a claim for reimbursement by Medicare or Medicaid for services furnished pursuant to the prohibited referral. Various states have enacted similar laws.

The ACA - The ACA significantly increased federal and state oversight of health plans. Among other requirements, it specifies minimum medical loss ratios ("MLRs") for Commercial and Medicare Insured products, specifies features required to be included in commercial benefit designs, limits commercial individual and small group rating and pricing practices, encourages additional competition (including potential incentives for new participants to enter the marketplace), and includes regulations and processes that could delay or limit the Company's ability to appropriately increase its health plan premium rates. This in

turn could adversely affect the Company's ability to continue to participate in certain product lines and/or geographies that it serves today.

In June 2021, the United States Supreme Court dismissed a challenge on procedural grounds that argued the ACA is unconstitutional in its entirety and issued an opinion preserving the ACA and its consumer protections in its current form. Even though the ACA was deemed constitutional, there may nevertheless be continued efforts to invalidate, modify, repeal or replace portions of it. In addition to litigation, parts of the ACA continue to evolve through the promulgation of executive orders, legislation, regulations and guidance at the federal or state level. The Company expects the ACA, including potential changes thereto, to continue to significantly impact its business operations and operating results, including pricing, medical benefit ratios ("MBRs") and the geographies in which the Company's products are available.

In July 2022, HHS issued a new proposed rule to significantly revise the agency's prior interpretation of Section 1557 of the ACA. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, and disability in certain health programs and activities, and the proposed rule specifically includes sex stereotypes, sex characteristics, sexual orientation, gender identity and pregnancy or related conditions as bases for sex discrimination. The comment period on the proposed rule has closed but to date no final rule has been released.

Medicare Regulation - The Company's Medicare Advantage products compete directly with Original Medicare and Medicare Advantage products offered by other Medicare Advantage organizations and Medicare Supplement products offered by other insurers. The Company's Medicare PDP and Medicare Supplement products are products that Medicare beneficiaries who are enrolled in Original Medicare purchase to enhance their Original Medicare coverage.

The Company continues to expand the number of counties in which it offers Medicare products. The Company has expanded its Medicare service area and products in 2022 and is seeking to substantially grow its Medicare membership, revenue and operating results over the next several years, including through growth in Medicare Supplement products. The anticipated organic expansion of the Medicare service area and Medicare products offered and the Medicare-related provisions of the ACA significantly increase the Company's exposure to funding and regulation of, and changes in government policy with respect to and/or funding or regulation of, the various Medicare programs in which the Company participates, including changes in the amounts payable to us under those programs and/or new reforms or surcharges on existing programs. For example, the ACA requires minimum MLRs for Medicare Advantage and Medicare Part D plans of 85%. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS. Due to potential lower utilization of medical services by Medicare beneficiaries during the COVID-19 pandemic, it is possible certain Medicare Advantage contracts may not meet the 85% MLR for consecutive years.

The Company's Medicare Advantage and PDP products are heavily regulated by CMS. The regulations and contractual requirements applicable to the Company and other private participants in Medicare programs are complex, expensive to comply with and subject to change. For example, the Medicare Advantage Overpayment Rule, issued in 2014, implemented the ACA requirements that Medicare Advantage and PDP plans report and refund to CMS overpayments that those plans receive from CMS. Failure to notify overpayments to CMS could result in liability under the False Claims Act. The precise interpretation, impact and legality of this rule are subject to pending litigation. Payments the Company receives from CMS for its Medicare Advantage and Part D businesses also are subject to risk adjustment based on the health status of the individuals enrolled. Elements of that risk adjustment mechanism continue to be challenged by the U.S. Department of Justice (the "DOJ"), the Office of the Inspector General of the HHS (the "OIG") and CMS itself. Substantial changes in the risk adjustment mechanism, including changes that result from enforcement or audit actions, could materially affect the amount of the Company's Medicare reimbursement, require the Company to raise prices or reduce the benefits offered to Medicare beneficiaries, and potentially limit the Company's (and the industry's) participation in the Medicare program.

The Company has invested significant resources to comply with Medicare standards, and its Medicare compliance efforts will continue to require significant resources. CMS may seek premium and other refunds, prohibit the Company from continuing to market and/or enroll members in or refuse to passively enroll members in one or more of the Company's Medicare or Medicare-Medicaid demonstration (historically known as "dual eligible") plans, exclude us from participating in one or more Medicare, dual eligible or dual eligible special needs plan programs and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with CMS regulations or its Medicare contractual requirements. The Company's Medicare Supplement products are regulated at the state level and subject to similar significant compliance requirements and risks.

In addition, in November 2020, the HHS released the final Rebate Rule (the "Rebate Rule"), which eliminates the regulatory safe harbor from prosecution under the AKS for rebates from pharmaceutical companies to PBMs in Medicare Part D, replacing it with two far narrower safe harbors designed to directly benefit patients with high out-of-pocket costs and to change the way PBMs are compensated. The new safe harbors are (i) for rebates which are passed on to the patient at the point of sale and (ii) for flat service fee payments made to PBMs which cannot be tied to the list prices of drugs. It is unclear whether the Rebate Rule will be enforceable, whether pharmaceutical companies will respond by reducing list prices, whether list prices in the private market may also be reduced, and what the resulting impact will be to PBMs or the Company. The Pharmaceutical Care Management Association (the "PCMA"), which represents PBMs, has filed a suit in an effort to block the Rebate Rule, claiming that the Rebate Rule would lead to higher premiums in Medicare Part D and was adopted in an unlawful manner. The Bipartisan Infrastructure Act of 2021 delays the effective date of the rebate rule to January 2026, and the Inflation Reduction Act, enacted in August 2022, further delays the Rebate Rule through 2032.

In July 2022, the 2% Medicare sequester required by the Budget Control Act of 2011 resumed, meaning that Medicare claims incur a 2% reduction in Medicare payment. The sequester had been suspended during the COVID-19 pandemic.

Going forward, the Company expects CMS, the OIG, the DOJ, other federal agencies and the U.S. Congress to continue to scrutinize closely each component of the Medicare program (including Medicare Advantage, PDPs, demonstration projects such as Medicare-Medicaid plans and provider network access and adequacy), modify the terms and requirements of the program and possibly seek to recast or limit private insurers' roles. It is also possible that Congress may consider changes to Medicare Advantage payment policies due to recent recommendations by the Medicare Payment Advisory Commission and to reduce the potential added cost burden of costly new benefits, or policies that impact drug pricing such as price controls and inflationary rebates applied to pharmaceutical manufacturers.

It is not possible to predict the outcome of such regulatory or Congressional activity, any of which could materially and adversely affect the Company.

Medicare Audits - CMS regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare Advantage and PDP beneficiaries. For example, CMS conducts risk adjustment data validation ("RADV") audits of a subset of Medicare Advantage contracts for each contract year. Since 2011, CMS has selected certain of the Company's Medicare Advantage contracts for various years for RADV audit, and the number of RADV audits continues to increase. The OIG also is auditing the Company's risk adjustment data and that of other companies, and the Company expects CMS and the OIG to continue auditing risk adjustment data. The Company also has received Civil Investigative Demands ("CIDs") from, and provided documents and information to, the Civil Division of the DOJ in connection with a current investigation of its patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

On January 30, 2023, CMS released the final rule concerning Part C contract-level Risk Adjustment Data Validation Audits (the "RADV Audit Rule"). The RADV Audit Rule eliminated the application of a fee-for-service adjuster ("FFS Adjuster") in contract-level RADV audits but continued the use of extrapolation in such audits of Medicare Advantage organizations. The FFS Adjuster that was announced in 2012 was to be used by CMS to determine a permissible level of payment error. By applying the FFS Adjuster, Medicare Advantage organizations would have been liable for repayments only to the extent that their extrapolated payment errors exceeded the error rate in Original Medicare, which could have impacted the extrapolated repayments to which Medicare Advantage organizations are subject. Under the RADV Audit Rule, CMS, in most cases, will conduct RADV audits for payment year 2018 and subsequent payment years using extrapolation without the application of a FFS Adjuster. The RADV Audit Rule may have potential adverse effects, which could be material, on the Company's operating results, financial condition, and cash flows. CMS also has announced that it will not conduct RADV audits on all contracts; instead, it will only audit contracts it believes are at the highest risk for overpayments based on its statistical modeling.

Medicare Star Ratings - A portion of each Medicare Advantage plan's reimbursement is tied to the plan's "star ratings." The star rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management, compliance and overall customer satisfaction. Only Medicare Advantage plans with an overall star rating of 4 or more stars (out of 5 stars) are eligible for a quality bonus in their basic premium rates. As a result, the Company's Medicare Advantage plans' operating results in 2023 and going forward will be significantly affected by their star ratings. The Company's star ratings and past performance scores are adversely affected by any compliance issues that may have arisen each year in its Medicare operations. CMS released the Company's 2023 star ratings in October 2022. The Company's 2023 star ratings will be used to determine which of its Medicare Advantage plans have ratings of 4 stars or higher and qualify for bonus payments in 2024. Based on the 2023 star ratings, the percentage of the Company's Medicare Advantage members in 4 or more stars plans is expected to drop to 21% (based on enrollment and contract affiliation at December 31, 2022), as compared to 87%

based on the 2022 star ratings. The main driver of this decrease was a 1 star decrease in the Company's Aetna National PPO, which dropped from 4.5 to 3.5 stars, while many of the Company's other plans remain rated at 4 or more stars. The decrease in the star rating for the Aetna National PPO will mean that it will no longer be eligible for CMS' quality bonus payments related to 2024, though the Company's contract diversification efforts, which will partially mitigate certain adverse impacts associated with the decrease in the star rating for the Aetna National PPO, have received regulatory approval. CMS also gives PDPs star ratings that affect each PDP's enrollment. Medicare Advantage and PDP plans that are rated less than 3 stars for three consecutive years are subject to contract termination by CMS. CMS continues to revise its star ratings system to make it harder to achieve 4 or more stars. There can be no assurances that the Company will be successful in maintaining or improving its star ratings in future years. Accordingly, the Company's Medicare Advantage plans may not continue to be or become eligible for full level quality bonuses, which could adversely affect the benefits such plans can offer, reduce membership and/or reduce profit margins.

Medicare Payment Rates - In April 2022, CMS issued its final notice detailing final 2023 Medicare Advantage payment rates. Final 2023 Medicare Advantage rates resulted in an expected average increase in revenue for the Medicare Advantage industry of 5.00%, excluding the CMS estimate of Medicare Advantage risk score trend. On February 1, 2023, CMS issued an advance notice detailing proposed 2024 Medicare Advantage payment rates. The 2024 Medicare Advantage rates, if finalized as proposed, will result in an expected average decrease in revenue for the Medicare Advantage industry of 2.27%, excluding the CMS estimate of Medicare Advantage risk score trend. CMS intends to publish the final 2024 rate announcement no later than April 3, 2023. The federal government may seek to impose restrictions on the configuration of pharmacy or other provider networks for Medicare Advantage and/or PDP plans, or otherwise restrict the ability of these plans to alter benefits, negotiate prices or establish other terms to improve affordability or maintain viability of products. The Company currently believes that the payments it has received and will receive in the near term are adequate to justify the Company's continued participation in the Medicare Advantage and PDP programs, although there are economic and political pressures to continue to reduce spending on the program, and this outlook could change.

340B Drug Pricing Program – The 340B Drug Pricing Program allows eligible Covered Entities to purchase prescription drugs from manufacturers at a steep discount, and is overseen by the HHS and the Health Resources and Services Administration ("HRSA"). In 2020, a number of pharmaceutical manufacturers began programs that limited Covered Entities' participation in the program through contract pharmacies arrangements. In May 2021, HRSA sent enforcement letters to multiple manufacturers to curb these practices. In September 2021, HRSA forwarded the enforcement actions to the OIG for potential imposition of civil monetary penalties. Those enforcement actions are currently subject to ongoing litigation. In November 2022, HRSA issued proposed rules that would overhaul the 340B Drug Pricing Programs Administrative Dispute Resolution process. The revisions are designed to make the process more accessible by making it more expeditious and less formal, as well as more equitable by requiring fewer resources to participate. A reduction in Covered Entities' participation in contract pharmacy arrangements, as a result of the pending enforcement actions or otherwise, a reduction in the use of the Company's administrative services by Covered Entities, or a reduction in drug manufacturers' participation in the program could materially and adversely affect the Company.

Anti-Remuneration Laws - Federal law prohibits, among other things, an entity from knowingly and willfully offering, paying, soliciting or receiving, subject to certain exceptions and "safe harbors," any remuneration to induce the referral of individuals or the purchase, lease or order of items or services for which payment may be made under Medicare, Medicaid or certain other federal and state health care programs. A number of states have similar laws, some of which are not limited to services paid for with government funds. Sanctions for violating these federal and state anti-remuneration laws may include imprisonment, criminal and civil fines, and exclusion from participation in Medicare, Medicaid and other federal and state government-sponsored health care programs. Companies involved in public health care programs such as Medicare and/or Medicaid are required to maintain compliance programs to detect and deter fraud, waste and abuse, and are often the subject of fraud, waste and abuse investigations and audits. The Company has invested significant resources to comply with Medicare and Medicaid program standards. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that the Company's compliance efforts in this area will continue to require significant resources.

Antitrust and Unfair Competition - The U.S. Federal Trade Commission ("FTC") investigates and prosecutes practices that are "unfair trade practices" or "unfair methods of competition." Numerous lawsuits have been filed throughout the United States against pharmaceutical manufacturers, retail pharmacies and/or PBMs under various federal and state antitrust and unfair competition laws challenging, among other things: (i) brand name drug pricing and rebate practices of pharmaceutical manufacturers, (ii) the maintenance of retail or specialty pharmacy networks by PBMs, and (iii) various other business practices of PBMs and retail pharmacies. In July 2021, the FTC approved several resolutions that direct agency staff to use compulsory process, such as subpoenas, to investigate seven specific enforcement priorities. Priority targets include, among other businesses, health care businesses, such as pharmaceutical companies, pharmacy benefits managers and hospitals. To the extent

that the Company appears to have actual or potential market power in a relevant market or CVS pharmacy, CVS specialty or MinuteClinic plays a unique or expanded role in a Health Care Benefits or Pharmacy Services segment product offering, the Company's business arrangements and uses of confidential information may be subject to heightened scrutiny from an anti-competitive perspective and possible challenge by state and/or federal regulators and/or private parties.

Privacy and Confidentiality Requirements - Many of the Company's activities involve the receipt, use and disclosure by the Company of personally identifiable information ("PII") as permitted in accordance with applicable federal and state privacy and data security laws, which require organizations to provide appropriate privacy and security safeguards for such information. In addition to PII, the Company uses and discloses de-identified data for analytical and other purposes when permitted. Additionally, there are industry standards for handling credit card data known as the Payment Card Industry Data Security Standard, which are a set of requirements designed to help ensure that entities that process, store or transmit credit card information maintain a secure environment. Certain states have incorporated these requirements into state laws or enacted other requirements relating to the use and/or disclosure of PII.

The federal Health Insurance Portability and Accountability Act of 1996 and the regulations issued thereunder (collectively, "HIPAA"), as further modified by the American Recovery and Reinvestment Act of 2009 ("ARRA") impose extensive requirements on the way in which health plans, providers, health care clearinghouses (known as "covered entities") and their business associates use, disclose and safeguard protected health information ("PHI"). Further, ARRA requires the Company and other covered entities to report any breaches of PHI to impacted individuals and to the HHS and to notify the media in any states where 500 or more people are impacted by the unauthorized release or use of or access to PHI. Criminal penalties and civil sanctions may be imposed for failing to comply with HIPAA standards. The Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), enacted as part of ARRA, amended HIPAA to impose additional restrictions on third-party funded communications using PHI and the receipt of remuneration in exchange for PHI. The HITECH Act also extended HIPAA privacy and security requirements and penalties directly to business associates. HHS has begun to audit health plans, providers and other parties to enforce HIPAA compliance, including with respect to data security.

In addition to HIPAA, state health privacy laws apply to the extent they are more protective of individual privacy than is HIPAA, including laws that place stricter controls on the release of information relating to specific diseases or conditions and requirements to notify members of unauthorized release or use of or access to PHI. States also have adopted regulations to implement provisions of the Financial Modernization Act of 1999 (also known as the Gramm-Leach-Bliley Act ("GLBA")) which generally require insurers, including health insurers, to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a non-affiliated third party. Like HIPAA, GLBA sets a "floor" standard, allowing states to adopt more stringent requirements governing privacy protection. Complying with additional state requirements requires us to make additional investments beyond those the Company has made to comply with HIPAA and GLBA.

The Cybersecurity Information Sharing Act of 2015 encourages organizations to share cyber threat indicators with the federal government and, among other things, directs HHS to develop a set of voluntary cybersecurity best practices for organizations in the health care industry. In addition, states have begun to enact more comprehensive privacy laws and regulations addressing consumer rights to data access, deletion, protection or transparency, such as the California Consumer Privacy Act ("CCPA"). States also are starting to issue regulations and proposed regulations specifically related to cybersecurity, such as the regulations issued by the New York Department of Financial Services. Complying with conflicting cybersecurity regulations, which may differ from state to state, requires significant resources. In addition, differing approaches to state privacy and/or cyber-security regulation and varying enforcement philosophies may materially and adversely affect the Company's ability to standardize its products and services across state lines. Widely-reported large scale commercial data breaches in the United States and abroad increase the likelihood that additional data security legislation will be considered by additional states. These legislative and regulatory developments will impact the design and operation of the Company's businesses, its privacy and security strategy and its web-based and mobile assets.

Finally, each Public Exchange is required to adhere to privacy and security standards with respect to PII, and to impose privacy and security standards that are at least as protective of PII as those the Public Exchange has implemented for itself or non-Public Exchange entities, which include insurers offering plans through the Public Exchange and their designated downstream entities, including PBMs and other business associates. These standards may differ from, and be more stringent than, HIPAA.

Consumer Protection Laws - The federal government has many consumer protection laws, such as the Federal Trade Commission Act, the Federal Postal Service Act and the Consumer Product Safety Act. Most states also have similar consumer protection laws and a growing number of states regulate subscription programs. In addition, the federal government and most states have adopted laws and/or regulations requiring places of public accommodation, health care services and other goods and

services to be accessible to people with disabilities. These consumer protection and accessibility laws and regulations have been the basis for investigations, lawsuits and multistate settlements relating to, among other matters, the marketing of loyalty programs, and health care products and services, pricing accuracy, expired front store products, financial incentives provided by drug manufacturers to pharmacies in connection with therapeutic interchange programs, disclosures related to how personal data is used and protected and the accessibility of goods and services to people with disabilities. As a result of the Company's direct-to-consumer activities, including mobile and web-based solutions offered to members and to other consumers, the Company also is subject to federal and state regulations applicable to electronic communications and to other general consumer protection laws and regulations. For example, the CCPA became effective in 2020, and additional federal and state regulation of consumer privacy protection may be proposed or enacted in the future. The Company expects these new laws and regulations to impact the design of its products and services and the management and operation of its businesses and to increase its compliance costs.

Transparency in Coverage Rule - In October 2020, the HHS, the U.S. Department of Labor ("DOL") and the U.S. Internal Revenue Service ("IRS," and together with the HHS and DOL, the "Tri-Departments") released a final rule requiring health insurers to disclose negotiated prices of drugs, medical services, supplies and other covered items. The rule requires group health plans and health insurance issuers in the individual and group markets to disclose cost-sharing information upon request, to a participant, beneficiary, or enrollee and require plans and issuers to publicly disclose in-network provider rates, historical out-of-network allowed amounts and the associated billed charges, and negotiated rates and historical net prices for prescription drugs. Insurers are required to implement a consumer tool and disclose data in a machine readable file. In August 2021, the federal government delayed enforcement of the requirement to publish machine-readable files related to prescription drug pricing until further rulemaking occurs. The public disclosure of insurer- or PBM-negotiated price concessions may result in drug manufacturers lowering discounts or rebates, resulting in higher drug costs for patients and impacting the ability of the Company to negotiate drug prices and provide competitive products and services to consumers.

Additionally, the Consolidated Appropriations Act of 2021 was signed into law in December 2020 and contains further transparency provisions requiring group health plans and health insurance issuers to report certain prescription drug costs, overall spending on health services and prescription drugs, and information about premiums and the impact of rebates and other remuneration on premiums and out-of-pocket costs to the Tri-Departments. No later than 18 months after the first submission and bi-annually thereafter, the Tri-Departments will release a public report on drug pricing trends, drug reimbursement, and the impact of drug prices on premiums. The first filings of plan year data were required in December 2022 and will be required annually in June of each year on an ongoing basis.

Telemarketing and Other Outbound Contacts - Certain federal and state laws, such as the Telephone Consumer Protection Act and the Telemarketing Sales Rule, give the FTC, the Federal Communications Commission and state Attorneys General the ability to regulate, and bring enforcement actions relating to, telemarketing practices and certain automated outbound contacts such as phone calls, texts or emails. Under certain circumstances, these laws provide consumers with a private right of action. Violations of these laws could result in substantial statutory penalties and other sanctions.

Pharmacy and Professional Licensure and Regulation - The Company is subject to a variety of intersecting federal and state statutes and regulations that govern the wholesale distribution of drugs; operation of retail, specialty, infusion, LTC and mail order pharmacies; licensure of facilities and professionals, including pharmacists, technicians, nurses and other health care professionals; registration of facilities with the U.S. Drug Enforcement Administration (the "DEA") and analogous state agencies that regulate controlled substances; packaging, storing, shipping and tracking of pharmaceuticals; repackaging of drug products; labeling, medication guides and other consumer disclosures; interactions with prescribers and health care professionals; compounding of prescription medications; dispensing of controlled and non-controlled substances; counseling of patients; transfers of prescriptions; advertisement of prescription products and pharmacy services; security; inventory control; recordkeeping; reporting to Boards of Pharmacy, the U.S. Food and Drug Administration (the "FDA"), the U.S. Consumer Product Safety Commission, the DEA and related state agencies; and other elements of pharmacy practice. Pharmacies are highly regulated and have contact with a wide variety of federal, state and local agencies with various powers to investigate, inspect, audit or solicit information, including Boards of Pharmacy and Nursing, the DEA, the FDA, the DOJ, HHS and others. Many of these agencies have broad enforcement powers, conduct audits on a regular basis, can impose substantial fines and penalties, and may revoke the license, registration or program enrollment of a facility or professional.

State Insurance, HMO and Insurance Holding Company Regulation - A number of states regulate affiliated groups of insurers and HMOs such as the Company under holding company statutes. These laws may, among other things, require prior regulatory approval of dividends and material intercompany transfers of assets and transactions between the regulated companies and their affiliates, including their parent holding companies. The Company expects the states in which its insurance and HMO subsidiaries are licensed to continue to expand their regulation of the corporate governance and internal control

activities of its insurance companies and HMOs. Changes to state insurance, HMO and/or insurance holding company laws or regulations or changes to the interpretation of those laws or regulations, including due to regulators' increasing concerns regarding insurance company and/or HMO solvency due, among other things, to past and expected payor insolvencies, could negatively affect the Company's businesses in various ways, including through increases in solvency fund assessments, requirements that the Company hold greater levels of capital and/or delays in approving dividends from regulated subsidiaries.

PBM offerings of prescription drug coverage under certain risk arrangements may be subject to laws and regulations in various states. Such laws may require that the party at risk become licensed as an insurer, establish reserves or otherwise demonstrate financial viability. Laws that may apply in such cases include insurance laws and laws governing MCOs and limited prepaid health service plans. In addition, several states require that PBMs become directly registered or licensed with the department of insurance or similar government oversight agency regardless of any arrangements they have with clients. PBM licensure laws may include oversight of certain PBM activities and operations and may include auditing of those activities.

The states of domicile of the Company's regulated subsidiaries have statutory risk-based capital ("RBC") requirements for health and other insurance companies and HMOs based on the National Association of Insurance Commissioners' (the "NAIC") Risk-Based Capital for Insurers Model Act (the "RBC 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. The RBC Model Act sets forth the formula for calculating 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 company's business. 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. At December 31, 2022, the RBC level of each of the Company's insurance and HMO subsidiaries was above the level that would require regulatory action.

For information regarding restrictions on certain payments of dividends or other distributions by the Company's HMO and insurance company subsidiaries, see Note 12 ''Shareholders' Equity'' included in Item 8 of this 10-K.

The holding company laws for the states of domicile of certain of the Company's subsidiaries also restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes, without such approval (or an exemption), no person may acquire any voting security of an insurance holding company (such as the Company's ultimate parent company, CVS Health Corporation) that controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would control the insurance holding company. 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.

Certain states have laws that prohibit submitting a false claim or making a false record or statement in order to secure reimbursement from an insurance company. These state laws vary, and violation of them may lead to the imposition of civil or criminal penalties.

Government Agreements and Mandates - From time to time, the Company and/or its various affiliates are subject to certain consent decrees, settlement and other agreements, corrective action plans and corporate integrity agreements with various federal, state and local authorities relating to such matters as privacy practices, controlled substances, PDPs, expired products, environmental and safety matters, marketing and advertising practices, PBM, LTC and other pharmacy operations and various other business practices. Certain of these agreements contain ongoing reporting, monitoring and/or other compliance requirements for the Company. Failure to meet the Company's obligations under these agreements could result in civil or criminal remedies, financial penalties, administrative remedies, and/or exclusion from participation in federal health care programs.

Environmental and Safety Regulation - The Company's businesses are subject to various federal, state and local laws, regulations and other requirements pertaining to protection of the environment, public health and employee safety, including, for example, regulations governing the management of hazardous substances, the cleaning up of contaminated sites, and the maintenance of safe working conditions in the Company's retail locations, distribution centers and other facilities. Governmental agencies at the federal, state and local levels continue to focus on the retail and health care sectors' compliance with such laws and regulations, and have at times pursued enforcement activities. Any failure to comply with these regulations could result in fines or other sanctions by government authorities.

ERISA Regulation - The Employee Retirement Income Security Act of 1974 ("ERISA"), provides for comprehensive federal regulation of certain employee pension and benefit plans, including private employer and union sponsored health plans and certain other plans that contract with us to provide PBM services. In general, the Company assists plan sponsors in the

administration of their health benefit plans, including the prescription drug benefit portion of those plans, in accordance with the plan designs adopted by the plan sponsors. In addition, the Company may have fiduciary duties where it has specifically contracted with a plan sponsor to accept limited fiduciary responsibility, such as for the adjudication of initial prescription drug benefit claims and/or the appeals of denied claims under a plan. In addition to its fiduciary provisions, ERISA imposes civil and criminal liability on service providers to health plans and certain other persons if certain forms of illegal remuneration are made or received. These provisions of ERISA are broadly written and their application to specific business practices is often uncertain.

Some of the Company's health and related benefits and large case pensions products and services and related fees also are subject to potential issues raised by judicial interpretations relating to ERISA. Under those interpretations, together with DOL regulations, the Company may have ERISA fiduciary duties with respect to medical members, PBM members and/or certain general account assets held under contracts that are not guaranteed benefit policies. As a result, certain transactions related to those general account assets are subject to conflict of interest and other restrictions, and the Company must provide certain disclosures to policyholders annually. The Company must comply with these restrictions or face substantial penalties.

Preemption - ERISA generally preempts all state and local laws that relate to employee benefit plans, but the extent of the preemption continues to be reviewed by courts, including the U.S. Supreme Court. For example, in December 2020, the U.S. Supreme Court upheld an Arkansas law that, among other things, mandates a particular pricing methodology, establishes an appeals process for a pharmacy when the reimbursement is below the pharmacy's acquisition cost, permits a pharmacy to reverse and rebill if they cannot procure the drug from its wholesaler at a price equal to or less than the reimbursement rate, prohibits a PBM from reimbursing a pharmacy less than the amount it reimburses an affiliate on a per unit basis, and permits a pharmacy to decline to dispense if the reimbursement is lower than the pharmacy's acquisition cost. Subsequently, in November 2021, the U.S. Court of Appeals for the Eighth Circuit upheld a North Dakota law that regulates employer-sponsored ERISA health plans and certain PBM practices within Medicare and in April 2022 the U.S. District Court for the Western District of Oklahoma affirmed that the Oklahoma Insurance Department could enforce a state law against PBMs that contained provisions that alter and limit some of the options that an ERISA plan can use, because none of the provisions mandate that ERISA plans make any specific choices. Additional litigation has been filed in several states to challenge ERISA and Medicare Part D preemption.

Other Legislative Initiatives and Regulatory Initiatives - The U.S. federal and state governments, as well as governments in other countries where the Company does business, continue to enact and seriously consider many broad-based legislative and regulatory proposals that have had a material impact on or could materially impact various aspects of the health care and related benefits system and the Company's businesses, operating results and/or cash flows. For example:

- Under the Budget Control Act of 2011 and the American Taxpayer Relief Act of 2012 significant, automatic across-the-board budget cuts (known as sequestration) began in March 2013, including Medicare spending cuts of not more than 2% of total program costs per year through 2024. Since then, Congress has extended and modified the Medicare sequester a number of times. The CARES Act temporarily suspended the Medicare sequester and extended mandatory sequestration to 2030. In July 2022, the 2% Medicare sequester resumed. Significant uncertainty remains as to whether and how the U.S. Congress will proceed with actions that create additional federal revenue and/or with entitlement reform. The Company cannot predict future federal Medicare or federal or state Medicaid funding levels or the impact that future federal or state budget actions or entitlement program reform, if it occurs, will have on the Company's businesses, operations or operating results, but the effects could be materially adverse, particularly on the Company's Medicare and/or Medicaid revenues, MBRs and operating results.
- The European Union's ("EU's") General Data Protection Regulation ("GDPR") began to apply across the EU during 2018.
- Other significant legislative and/or regulatory measures which are or recently have been under consideration include the following:
    - Increasing the corporate tax rate.
    - Eliminating payment of manufacturer's rebates on prescription drugs to PBMs, PDPs and Managed Medicaid organizations in connection with federally funded health care programs.
    - Imposing requirements and restrictions on the design and/or administration of pharmacy benefit plans offered by the Company's and its clients' health plans and/or its PBM clients and/or the services the Company provides to those clients, including prohibiting "differential" or "spread" pricing in PBM contracts; restricting or eliminating the use of formularies for prescription drugs; restricting the Company's ability to require members to obtain drugs through a home delivery or specialty pharmacy; restricting the Company's ability to place certain specialty or other drugs in the higher cost tiers of its pharmacy formularies; restricting the Company's ability to make changes to drug formularies and/or clinical programs; limiting or eliminating rebates on pharmaceuticals; requiring the use of up front purchase price discounts on pharmaceuticals in lieu of rebates; restricting the Company's ability to

configure and reimburse its health plan and retail pharmacy provider networks, including use of CVS pharmacy locations; and restricting or eliminating the use of certain drug pricing methodologies.

- Increasing federal or state government regulation of, or involvement in, the pricing and/or purchasing of drugs.
- Restricting the Company's ability to limit providers' participation in its networks and/or remove providers from its networks by imposing network adequacy requirements or otherwise (including in its Medicare and Commercial Health Care Benefits products).
- Imposing assessments on (or to be collected by) health plans or health carriers that may or may not be passed through to their customers. These assessments may include assessments for insolvency, the uninsured, uncompensated care, Medicaid funding or defraying health care provider medical malpractice insurance costs.
- Mandating coverage by the Company's and its clients' health plans for additional conditions and/or specified procedures, drugs or devices (e.g., high cost pharmaceuticals, experimental pharmaceuticals and oral chemotherapy regimens).
- Regulating electronic connectivity.
- Mandating or regulating the disclosure of provider fee schedules, manufacturer's rebates and other data about the Company's payments to providers and/or payments the Company receives from pharmaceutical manufacturers.
- Mandating or regulating disclosure of provider outcome and/or efficiency information.
- Prescribing or limiting members' financial responsibility for health care or other covered services they utilize, including restricting "surprise" bills by providers and by specifying procedures for resolving "surprise" bills.
- Prescribing payment levels for health care and other covered services rendered to the Company's members by providers who do not have contracts with the Company.
- Assessing the medical device status of home infusion therapy products and/or solutions, mobile consumer wellness tools and clinical decision support tools, which may require compliance with FDA requirements in relation to some of these products, solutions and/or tools.
- Restricting the ability of employers and/or health plans to establish or impose member financial responsibility.
- Proposals to expand benefits under Original Medicare.
- Amending or supplementing ERISA to impose greater requirements on PBMs or the administration of employer-funded benefit plans or limit the scope of current ERISA pre-emption, which would among other things expose the Company and other health plans to expanded liability for punitive and other extra-contractual damages and additional state regulation.

It is uncertain whether the Company can counter the potential adverse effects of such potential legislation or regulation on its operating results or cash flows, including whether it can recoup, through higher premium rates, expanded membership or other measures, the increased costs of mandated coverage or benefits, assessments, fees, taxes or other increased costs, including the cost of modifying its systems to implement any enacted legislation or regulations.

The Company's businesses also may be affected by other legislation and regulations. The Dodd-Frank Wall Street Reform and Consumer Protection Act creates incentives for whistleblowers to speak directly to the government rather than utilizing internal compliance programs and reduces the burden of proof under the Foreign Corrupt Practices Act of 1977 (the "FCPA"). There also are laws and regulations that set standards for the escheatment of funds to states.

Health savings accounts, health reimbursement arrangements and flexible spending accounts and certain of the tax, fee and subsidy provisions of the ACA also are regulated by the U.S. Department of the Treasury and the IRS.

The Company also may be adversely affected by court and regulatory decisions that expand or revise the interpretations of existing statutes and regulations or impose medical malpractice or bad faith liability. Federal and state courts, including the U.S. Supreme Court, continue to consider cases, and federal and state regulators continue to issue regulations and interpretations, addressing bad faith liability for denial of medical claims, the scope of ERISA's fiduciary duty requirements, the scope of the False Claims Act and the pre-emptive effect of ERISA and Medicare Part D on state laws.

Contract Audits - The Company is subject to audits of many of its contracts, including its PBM client contracts, its PBM rebate contracts, its PBM network contracts, its contracts relating to Medicare Advantage and/or Medicare Part D, the agreements the Company's pharmacies enter into with other payors, its Medicaid contracts and its customer contracts. Because some of the Company's contracts are with state or federal governments or with entities contracted with state or federal agencies, audits of these contracts are often regulated by the federal or state agencies responsible for administering federal or state

benefits programs, including those which operate Medicaid fee for service plans, Managed Medicaid plans, Medicare Part D plans or Medicare Advantage organizations.

Federal Employee Health Benefits Program - The Company's subsidiaries contract with the Office of Personnel Management (the "OPM") to provide managed health care services under the FEHB program in their service areas. These contracts with the OPM and applicable government regulations establish premium rating arrangements for this program. In addition to other requirements, such as the Transparency in Coverage Rule note above, OPM regulations require that community-rated FEHB plans meet a FEHB program-specific minimum MLR by plan code and market. Managing to these rules is complicated by the simultaneous application of the minimum MLR standards and associated premium rebate requirements of the ACA. The Company also has a contractual arrangement with carriers for the FEHB program, such as the BlueCross BlueShield Association, to provide pharmacy services to federal employees, postal workers, annuitants, and their dependents under the Government-wide Service Benefit Plan, as authorized by the FEHB Act and as part of the FEHB program. Additionally, the Company manages certain FEHB plans on a "cost-plus" basis. These arrangements subject the Company to certain aspects of the FEHB Act, and other federal regulations, such as the FEHB Acquisition Regulation, that otherwise would not be applicable to the Company. The OPM also is auditing the Company and its other contractors to, among other things, verify that plans meet their applicable FEHB program-specific MLR and the premiums established under the OPM's Insured contracts and costs allocated pursuant to the OPM's cost-based contracts are in compliance with the requirements of the applicable FEHB program. The OPM may seek premium refunds or institute other sanctions against the Company if it fails to comply with the FEHB program requirements.

Clinical Services Regulation - The Company provides clinical services to health plans, PBMs and providers for a variety of complex and common medical conditions, including arranging for certain members to participate in disease management programs. State laws regulate the practice of medicine, the practice of pharmacy, the practice of nursing and certain other clinical activities. Clinicians engaged in a professional practice in connection with the provision of clinical services must satisfy applicable state licensing requirements and must act within their scope of practice.

Third Party Administration and Other State Licensure Laws - Many states have licensure or registration laws governing certain types of administrative organizations, such as PPOs, TPAs and companies that provide utilization review services. Several states also have licensure or registration laws governing the organizations that provide or administer consumer card programs (also known as cash card or discount card programs).

International Regulation - The Company has insurance licenses in several foreign jurisdictions and does business directly or through local affiliations in numerous countries around the world. The Company has taken steps to be able to continue to serve customers in the European Economic Area following the United Kingdom's exit from the EU ("Brexit").

The Company's international operations are subject to different, and sometimes more stringent, legal and regulatory requirements, which vary widely by jurisdiction, including anti-corruption laws; economic sanctions laws; various privacy, insurance, tax, tariff and trade laws and regulations; corporate governance, privacy, data protection (including the EU's General Data Protection Regulation which began to apply across the EU during 2018), data mining, data transfer, labor and employment, intellectual property, consumer protection and investment laws and regulations; discriminatory licensing procedures; compulsory cessions of reinsurance; required localization of records and funds; higher premium and income taxes; limitations on dividends and repatriation of capital; and requirements for local participation in an insurer's ownership. In addition, the presence of operations in foreign countries potentially increases the Company's exposure to the anti-bribery, anti-corruption and anti-money laundering provisions of U.S. law, including the FCPA, and corresponding foreign laws, including the U.K. Bribery Act 2010 (the "UK Bribery Act").

Anti-Corruption Laws - The FCPA prohibits offering, promising or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage. The Company also is subject to applicable anti-corruption laws of the jurisdictions in which it operates. In many countries outside the United States, health care professionals are employed by the government. Therefore, the Company's dealings with them are subject to regulation under the FCPA. Violations of the FCPA and other anti-corruption laws may result in severe criminal and civil sanctions as well as other penalties, and there continues to be a heightened level of FCPA enforcement activity by the U.S. Securities and Exchange Commission (the "SEC") and the DOJ. The UK Bribery Act is an anti-corruption law that is broader in scope than the FCPA and applies to all companies with a nexus to the United Kingdom. Disclosures of FCPA violations may be shared with the UK authorities, thus potentially exposing companies to liability and potential penalties in multiple jurisdictions.

Anti-Money Laundering Regulations - Certain lines of the Company's businesses are subject to Treasury anti-money laundering regulations. Those lines of business have implemented anti-money laundering policies designed to ensure their

compliance with the regulations. The Company also is subject to anti-money laundering laws in non-U.S. jurisdictions where it operates.

Office of Foreign Assets Control - The Company also is subject to regulation by the Office of Foreign Assets Control of the U.S. Department of Treasury ("OFAC"). OFAC administers and enforces economic and trade sanctions based on U.S. foreign policy and national security goals against targeted foreign countries and regimes, terrorists, international narcotics traffickers, those engaged in activities related to the proliferation of weapons of mass destruction, and other threats to the national security, foreign policy or economy of the United States. In addition, the Company is subject to similar regulations in the non-U.S. jurisdictions in which it operates.

FDA Regulation - The FDA regulates the Company's compounding pharmacy and clinical research operations. The FDA also generally has authority to, among other things, regulate the manufacture, distribution, sale and labeling of medical devices (including hemodialysis devices such as the device the Company is developing and mobile medical devices) and many products sold through retail pharmacies, including prescription drugs, over-the-counter medications, cosmetics, dietary supplements and certain food items. In addition, the FDA regulates the Company's activities as a distributor of store brand products.

Laws and Regulations Related to the Health Care Benefits Segment

In addition to the laws and regulations discussed above that may affect multiple segments of the Company's business, the Company is subject to federal, state, local and international statutes and regulations governing its Health Care Benefits segment specifically.

Overview - Differing approaches to state insurance regulation and varying enforcement philosophies may materially and adversely affect the Company's ability to standardize its Health Care Benefits products and services across state lines. These laws and regulations, including the ACA, restrict how the Company conducts its business and result in additional burdens and costs to the Company. Significant areas of governmental regulation include premium rates and rating methodologies, underwriting rules and procedures, required benefits, sales and marketing activities, provider rates of payment, restrictions on health plans' ability to limit providers' participation in their networks and/or remove providers from their networks and financial condition (including reserves and minimum capital or risk based capital requirements). These laws and regulations are different in each jurisdiction and vary from product to product.

Each health insurer and HMO must file periodic financial and operating reports with the states in which it does business. In addition, health insurers and HMOs are subject to state examination and periodic license renewal. Applicable laws also restrict the ability of the Company's regulated subsidiaries to pay dividends, and certain dividends require prior regulatory approval. In addition, some of the Company's businesses and related activities may be subject to PPO, MCO, utilization review or TPA-related licensure requirements and regulations. These licensure requirements and regulations differ from state to state, but may contain provider network, contracting, product and rate, financial and reporting requirements. There also are laws and regulations that set specific standards for the Company's delivery of services, payment of claims, fraud prevention, protection of consumer health information, and payment for covered benefits and services.

Required Regulatory Approvals - The Company must obtain and maintain regulatory approvals to price, market and administer many of its Health Care Benefits products. Supervisory agencies, including CMS, the Center for Consumer Information and Insurance Oversight and the DOL, as well as state health, insurance, managed care and Medicaid agencies, have broad authority to take one or more of the following actions:

- Grant, suspend and revoke the Company's licenses to transact business;
- Suspend or exclude the Company from participation in government programs;
- Suspend or limit the Company's authority to market products;
- Regulate many aspects of the products and services the Company offers, including the pricing and underwriting of many of its products and services;
- Assess damages, fines and/or penalties;
- Terminate the Company's contract with the government agency and/or withhold payments from the government agency to the Company;
- Impose retroactive adjustments to premiums and require the Company to pay refunds to the government, customers and/or members;
- Restrict the Company's ability to conduct acquisitions or dispositions;

- Require the Company to maintain minimum capital levels in its subsidiaries and monitor its solvency and reserve adequacy;
- Regulate the Company's investment activities on the basis of quality, diversification and other quantitative criteria; and/or
- Exclude the Company's plans from participating in Public Exchanges if they are deemed to have a history of "unreasonable" premium rate increases or fail to meet other criteria set by HHS or the applicable state.

The Company's operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time the Company receives subpoenas and other requests for information from, federal, state and international supervisory and enforcement agencies, Attorneys General and other state, federal and international governmental authorities and legislators.

Commercial Product Pricing and Underwriting Restrictions - Pricing and underwriting regulation by states limits the Company's underwriting and rating practices and those of other health insurers, particularly for small employer groups, and varies by state. In general, these limitations apply to certain customer segments and limit the Company's ability to set prices for new or renewing groups, or both, based on specific characteristics of the group or the group's prior claim experience. In some states, these laws and regulations restrict the Company's ability to price for the risk it assumes and/or reflect reasonable costs in the Company's pricing.

The ACA expanded the premium rate review process by, among other things, requiring the Company's Commercial Insured rates to be reviewed for "reasonableness" at either the state or the federal level. HHS established a federal premium rate review process that generally applies to proposed premium rate increases equal to or exceeding a federally (or lower state) specified threshold. HHS's rate review process imposes additional public disclosure requirements as well as additional review on filings requesting premium rate increases equal to or exceeding this "reasonableness" threshold. These combined state and federal review requirements may prevent, further delay or otherwise affect the Company's ability to price for the risk it assumes, which could adversely affect its MBRs and operating results, particularly during periods of increased utilization of medical services and/or medical cost trend or when such utilization and/or trend exceeds the Company's projections.

The ACA also specifies minimum MLRs of 85% for large group Commercial products and 80% for individual and small group Commercial products. Because the ACA minimum MLRs are structured as "floors" for many of their requirements, states have the latitude to enact more stringent rules governing these restrictions. For Commercial products, states have and may adopt higher minimum MLR requirements, use more stringent definitions of "medical loss ratio," incorporate minimum MLR requirements into prospective premium rate filings, require prior approval of premium rates or impose other requirements related to minimum MLR. Minimum MLR requirements and similar actions further limit the level of margin the Company can earn in its Insured Commercial products while leaving the Company exposed to medical costs that are higher than those reflected in its pricing. The Company also may be subject to significant fines, penalties, premium refunds and litigation if it fails to comply with minimum MLR laws and regulations.

In addition, the Company requested increases in its premium rates in its Commercial Health Care Benefits business for 2023 and expects to request future increases in those rates in order to adequately price for projected medical cost trends, required expansions of coverage and rating limits, and significant assessments, fees and taxes imposed by the federal and state governments, including as a result of the ACA. The Company's rates also must be adequate to reflect adverse selection in its products, particularly in small group Commercial products. These rate increases may be significant and thus heighten the risks of adverse publicity, adverse regulatory action and adverse selection and the likelihood that the Company's requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.

Many of the laws and regulations governing the Company's pricing and underwriting practices also limit the differentials in premium rates insurers and other carriers may charge between new and renewal business, and/or between groups based on differing characteristics. They may also require that carriers disclose to customers the basis on which the carrier establishes new business and renewal premium rates and limit the ability of a carrier to terminate customers' coverage.

Medicaid Regulation - The Company is seeking to substantially grow its Medicaid, dual eligible and dual eligible special needs plan businesses over the next several years. As a result, the Company also is increasing its exposure to changes in government policy with respect to and/or regulation of the various Medicaid, dual eligible and dual eligible special needs plan programs in which the Company participates, including changes in the amounts payable to the Company under those programs.

In addition to a quality rating system that applies to Medicaid and Managed Medicaid plans, federal regulations give states the option to choose to establish a minimum MLR of at least 85% for their Managed Medicaid plans, including those offered by the Company. Regardless of whether a state establishes a minimum MLR, it must use plan-reported MLR data to set future

payment rates for managed care, so that its plans will "reasonably achieve" an MLR of at least 85%. For Managed Medicaid products, states may use more stringent definitions of "medical loss ratio", use discretion in choosing a quantitative standard for determining provider network adequacy, or impose other requirements related to minimum MLR. Minimum MLR requirements and similar actions further limit the level of margin the Company can earn in its Insured Medicaid products while leaving the Company exposed to medical costs that are higher than those reflected in its pricing. The Company also may be subject to significant fines, penalties, premium refunds and litigation if it fails to comply with minimum MLR laws and regulations.

States continue to consider Medicaid expansion; however, to date 12 states have not expanded, which will drop to 11 states once South Dakota's expansion takes effect in July 2023. States may opt out of the elements of the ACA requiring expansion of Medicaid coverage without losing their current federal Medicaid funding. In addition, the election of new Governors and/or state legislatures may impact states' previous decisions regarding Medicaid expansion. Although Congress enacted incentives for states that had not yet done so to expand Medicaid, this incentive alone may not persuade holdout states to expand.

In 2021, Medicaid MCOs faced new requirements and state flexibility that were finalized in the 2020 Medicaid managed care final rule. States now have flexibility related to rate setting and provider network adequacy that could adversely or positively impact our Medicaid plans. Other changes related to managed care operations include beneficiary communications, appeals and grievances, and provider directories.

The economic aspects of the Medicaid, dual eligible and dual eligible special needs plan business vary from state to state and are subject to frequent change. Medicaid premiums are paid by each state and differ from state to state. The federal government and certain states also are considering proposals and legislation for Medicaid and dual eligible program reforms or redesigns, including restrictions on the collection of manufacturer's rebates on pharmaceuticals by Medicaid MCOs and their contracted PBMs, further program, population and/or geographic expansions of risk-based managed care, increasing beneficiary cost-sharing or payment levels, and changes to benefits, reimbursement, eligibility criteria, provider network adequacy requirements (including requiring the inclusion of specified high cost providers in the Company's networks) and program structure. In some states, current Medicaid and dual eligible funding and premium revenue may not be adequate for the Company to continue program participation. The Company's Medicaid and dual eligible contracts with states (or sponsors of Medicaid managed care plans) are subject to cancellation by the state (or the sponsors of the managed care plans) after a short notice period without cause (e.g., when a state discontinues a managed care program) or in the event of insufficient state funding.

The Company's Medicaid, dual eligible and dual eligible special needs plan products also are heavily regulated by CMS and state Medicaid agencies, which have the right to audit the Company's performance to determine compliance with CMS contracts and regulations. The Company's Medicaid products, dual eligible products and CHIP contracts also are subject to complex federal and state regulations and oversight by state Medicaid agencies regarding the services provided to Medicaid enrollees, payment for those services, network requirements (including mandatory inclusion of specified high-cost providers), and other aspects of these programs, and by external review organizations which audit Medicaid plans on behalf of state Medicaid agencies. The laws, regulations and contractual requirements applicable to the Company and other participants in Medicaid and dual eligible programs, including requirements that the Company submit encounter data to the applicable state agency, are extensive, complex and subject to change. The Company has invested significant resources to comply with these standards, and its Medicaid and dual eligible program compliance efforts will continue to require significant resources. CMS and/or state Medicaid agencies may fine the Company, withhold payments to the Company, seek premium and other refunds, terminate the Company's existing contracts, elect not to award the Company new contracts or not to renew the Company's existing contracts, prohibit the Company from continuing to market and/or enroll members in or refuse to automatically assign members to one or more of the Company's Medicaid or dual eligible products, exclude the Company from participating in one or more Medicaid or dual eligible programs and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with CMS or state regulations or contractual requirements.

The Company cannot predict whether pending or future federal or state legislation or court proceedings will change various aspects of the Medicaid program, nor can it predict the impact those changes will have on its business operations or operating results, but the effects could be materially adverse.

Federal and State Reporting - The Company is subject to extensive financial and business reporting requirements, including penalties for inaccuracies and/or omissions, at both the federal and state level. The Company's ability to comply with certain of these requirements depends on receipt of information from third parties that may not be readily available or reliably provided in all instances. The Company is and will continue to be required to modify its information systems, dedicate significant resources and incur significant expenses to comply with these requirements. However, the Company cannot eliminate the risks of unavailability of or errors in its reports.

Product Design and Administration and Sales Practices - State and/or federal regulatory scrutiny of health care benefit product design and administration and marketing and advertising practices, including the filing of insurance policy forms, the adequacy of provider networks, the accuracy of provider directories, and the adequacy of disclosure regarding products and their administration, is increasing as are the penalties being imposed for inappropriate practices. Medicare, Medicaid and dual eligible products and products offering more limited benefits in particular continue to attract increased regulatory scrutiny.

Guaranty Fund Assessments/Solvency Protection - Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. The Company's assessments generally are based on a formula relating to the Company's health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer governed health plans established under the ACA. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that limit future offsets.

Laws and Regulations Related to the Pharmacy Services Segment

In addition to the laws and regulations discussed above that may affect multiple segments of the Company's business, the Company is subject to federal, state and local statutes and regulations governing the operation of its Pharmacy Services segment specifically. Among these are the following:

PBM Laws and Regulation - Legislation and/or regulations seeking to regulate PBM activities in a comprehensive manner have been proposed or enacted in a majority of states. This legislation could adversely affect the Company's ability to conduct business on commercially reasonable terms in states where the legislation is in effect and the Company's ability to standardize its PBM products and services across state lines. In addition, certain quasi-regulatory organizations, including the National Association of Boards of Pharmacy and the National Council of Insurance Legislators, have issued model regulations or may propose future regulations concerning PBMs and/or PBM activities. Similarly, credentialing organizations such as URAC have established voluntary standards regarding PBM, mail order pharmacy and/or specialty pharmacy activities. While the actions of these quasi-regulatory or standard-setting organizations do not have the force of law, they may influence states to adopt their requirements or recommendations and influence client requirements for PBM, mail order pharmacy and/or specialty pharmacy services. Moreover, any standards established by these organizations could also impact the Company's health plan clients and/or the services provided to those clients and/or the Company's health plans.

The Company's PBM activities also are regulated directly and indirectly at the federal and state levels, including being subject to the False Claims Act and state false claims acts and the AKS and state anti-kickback laws. These laws and regulations govern, and proposed legislation and regulations may govern and/or further restrict, critical PBM practices, including disclosure, receipt and retention of rebates and other payments received from pharmaceutical manufacturers; use of, administration of and/or changes to drug formularies, maximum allowable cost ("MAC") list pricing, average wholesale prices ("AWP") and/or clinical programs; the offering to plan sponsors of pricing that includes retail network "differential" or "spread" (i.e., a difference between the drug price charged to the plan sponsor by a PBM and the price paid by the PBM to the dispensing provider); reconciliation to pricing guarantees; disclosure of data to third parties; drug UM practices; the level of duty a PBM owes its customers; configuration of pharmacy networks; the operations of the Company's pharmacies (including audits of its pharmacies); disclosure of negotiated provider reimbursement rates; disclosure of fees associated with administrative service agreements and patient care programs that are attributable to members' drug utilization; and registration or licensing of PBMs. Failure by the Company or one of its PBM services suppliers to comply with these laws or regulations could result in material fines and/or sanctions and could have a material adverse effect on the Company's operating results and/or cash flows.

The Company's PBM service contracts, including those in which the Company assumes certain risks under performance guarantees or similar arrangements, are generally not subject to insurance regulation by the states. However, state departments of insurance are increasing their oversight of PBM activities due to legislation passing in a number of states requiring PBMs to register or obtain a license with the department, including through market conduct examinations and other audits our licensed entities. In addition, rulemaking is either underway or has already taken place in a number of states with the areas of focus including licensure requirements, pharmacy reimbursement, network design, cost sharing and pharmacy audits - most of which fall under the state insurance code.

Pharmacy Network Access Legislation - Medicare Part D and a majority of states now have some form of legislation affecting the Company's (and its health plans' and its health plan clients') ability to limit access to a pharmacy provider network or remove pharmacy network providers. For example, certain "any willing provider" legislation may require the Company or its clients to admit a nonparticipating pharmacy if such pharmacy is willing and able to meet the plan's price and other applicable terms and conditions for network participation. These laws could negatively affect the services and economic benefits achievable through a limited pharmacy provider network. Also, a majority of states now have some form of legislation affecting the Company's ability (and the Company's and its client health plans' ability) to conduct audits of network pharmacies regarding claims submitted to the Company for payment. These laws could negatively affect the Company's ability to recover overpayments of claims submitted by network pharmacies that the Company identifies through pharmacy audits. Finally, several states have passed legislation that limits the ability of PBMs and health insurers to provide special benefit structures for use with affiliated pharmacies, which could result in reduced savings to clients and consumers.

Pharmacy Pricing Legislation - A number of states have passed legislation regulating the Company's ability to manage and establish MACs for generic prescription drugs. MAC methodology is a common cost management practice used by private and public payors (including CMS) to pay pharmacies for dispensing generic prescription drugs. MAC prices specify the allowable reimbursement by a PBM for a particular strength and dosage of a generic drug that is available from multiple manufacturers but sold at different prices. State legislation can regulate the disclosure of MAC prices and MAC price methodologies, the kinds of drugs that a PBM can pay for at a MAC price, and the rights of pharmacies to appeal a MAC price established by a PBM. These laws could negatively affect the Company's ability to establish MAC prices for generic drugs. Additionally, some states have passed legislation that would restrict certain types of retroactive reconciliation or recoupment from pharmacies in the network or create a reimbursement benchmark mandate, such as the national average drug acquisition cost and/or the wholesale acquisition cost ("WAC"), plus a set dispensing fee, for pharmacies in the network.

Formulary and Plan Design Regulation - A number of government entities regulate the administration of prescription drug benefits. HHS regulates how Medicare Part D formularies are developed and administered, including requiring the inclusion of all drugs in certain classes and categories, subject to limited exceptions. Under the ACA, CMS imposes drug coverage requirements for health plans required to cover essential health benefits, including plans offered through federal or state Public Exchanges. Additionally, the NAIC and health care accreditation agencies like NCQA and URAC have developed model acts and standards for formulary development that are often incorporated into government requirements. Many states regulate the scope of prescription drug coverage, as well as the delivery channels to receive prescriptions, for insurers, MCOs and Medicaid managed care plans. The increasing government regulation of formularies could significantly affect the Company's ability to develop and administer formularies, pharmacy networks and other plan design features. Similarly, some states prohibit health plan sponsors from implementing certain restrictive pharmacy benefit plan design features. This regulation could limit or preclude (i) limited networks, (ii) a requirement to use particular providers, (iii) copayment differentials among providers and (iv) formulary tiering practices.

Laws and Regulations Related to the Retail/LTC Segment

In addition to the laws and regulations discussed above that may affect multiple segments of the Company's business, the Company is subject to federal, state and local statutes and regulations governing the operation of its Retail/LTC segment specifically. Among these are the following:

Retail Medical Clinics - States regulate retail medical clinics operated by nurse practitioners or physician assistants through physician oversight, clinic and lab licensure requirements and the prohibition of the corporate practice of medicine. A number of states have implemented or proposed laws or regulations that impact certain components of retail medical clinic operations such as physician oversight, signage, third party contracting requirements, bathroom facilities, and scope of services. These laws and regulations may affect the operation and expansion of the Company's owned and managed retail medical clinics.

Other Laws - Other federal, state and local laws and regulations also impact the Company's retail operations, including laws and regulations that limit the sale of alcohol, mandate a minimum wage, govern the practices of optometry or audiology, or impact the provision of dietician services and the sale of durable medical equipment, contact lenses, eyeglasses and hearing aids.

Available Information

CVS Health Corporation was incorporated in Delaware in 1996. The corporate office is located at One CVS Drive, Woonsocket, Rhode Island 02895, telephone (401) 765-1500. CVS Health Corporation's common stock is listed on the New York Stock Exchange under the trading symbol "CVS." General information about the Company is available through the

Company's website at *http://www.cvshealth.com*. The Company's financial press releases and filings with the SEC are available free of charge within the Investors section of the Company's website at *http://investors.cvshealth.com*. In addition, the SEC maintains an internet site that contains reports, proxy and information statements and other information regarding issuers, such as the Company, that file electronically with the SEC. The address of that website is *http://www.sec.gov.* The information on or linked to the Company's website is neither a part of nor incorporated by reference in this 10-K or any of the Company's other SEC filings.

In accordance with guidance provided by the SEC regarding use by a company of its websites and social media channels as a means to disclose material information to investors and to comply with its disclosure obligations under SEC Regulation FD, CVS Health Corporation (the "Registrant") hereby notifies investors, the media and other interested parties that it intends to continue to use its media and investor relations website (*http://investors.cvshealth.com/*) and its Twitter feed (@CVSHealthIR) to publish important information about the Registrant, including information that may be deemed material to investors. The list of social media channels that the Registrant uses may be updated on its media and investor relations website from time to time. The Registrant encourages investors, the media, and other interested parties to review the information the Registrant posts on its website and social media channels as described above, in addition to information announced by the Registrant through its SEC filings, press releases and public conference calls and webcasts.

Item 1A. Risk Factors.

You should carefully consider each of the following risks and uncertainties and all of the other information set forth in this 10-K. These risks and uncertainties and other factors may affect forward-looking statements, including those we make in this 10-K or elsewhere, such as in news releases or investor or analyst calls, meetings or presentations, on our websites or through our social media channels. The risks and uncertainties described below are not the only ones we face. There can be no assurance that we have identified all the risks that affect us. Additional risks and uncertainties not presently known to us or that we currently believe to be immaterial also may adversely affect our businesses. Any of these risks or uncertainties could cause our actual results to differ materially from our expectations and the expected results discussed in our forward-looking statements. You should not consider past results to be an indication of future performance.

If any of the following risks or uncertainties develops into actual events or if the circumstances described in the risks or uncertainties occur or continue to occur, those events or circumstances could have a material adverse effect on our businesses, operating results, cash flows, financial condition and/or stock price, among other effects on us. You should read the following section in conjunction with the MD&A, included in Item 7 of this 10-K, our consolidated financial statements and the related notes, included in Item 8 of this 10-K, and our "Cautionary Statement Concerning Forward-Looking Statements" in this 10-K.

Summary

The following is a summary of the principal risks we face that could negatively impact our businesses, operating results, cash flows and/or financial condition:

Risks Relating to Our Businesses

- The impact COVID-19 will have on our businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be material and adverse.
- We may not be able to accurately forecast health care and other benefit costs.
- Adverse economic conditions in the U.S. and abroad can materially and adversely impact our businesses, operating results, cash flows and financial condition.
- Each of our segments operates in a highly competitive and evolving business environment.
- A change in our Health Care Benefits product mix may adversely affect our profit margins.
- We can provide no assurance that we will be able to compete successfully and profitably on Public Exchanges.
- Negative public perception of the industries in which we operate can adversely affect our businesses, operating results, cash flows and prospects.
- We must maintain and improve our relationships with our customers and increase the demand for our products and services.
- We face risks relating to the availability, pricing and safety profiles of prescription drugs that we purchase and sell.

- The reserves we hold for expected claims in our Insured Health Care Benefits products are based on estimates that involve an extensive degree of judgment and are inherently variable, and any reserve, including a premium deficiency reserve, may be insufficient.
- We are exposed to risks relating to the solvency of other insurers.

Risks From Changes in Public Policy and Other Legal and Regulatory Risks

- We are subject to potential changes in public policy, laws and regulations, including reform of the U.S. health care system and entitlement programs.
- If we fail to comply with applicable laws and regulations, or fail to change our operations in line with any new legal or regulatory requirements, we could be subject to significant adverse regulatory actions.
- If our compliance or other systems and processes fail or are deemed inadequate, we may suffer brand and reputational harm and become subject to regulatory actions and/or litigation.
- We routinely are subject to litigation and other adverse legal proceedings, including class actions and *qui tam* actions. Many of these proceedings seek substantial damages which may not be covered by insurance.
- We frequently are subject to regular and special governmental audits, investigations and reviews that could result in changes to our business practices and also could result in material refunds, fines, penalties, civil liabilities, criminal liabilities and other sanctions.
- Our litigation and regulatory risk profiles are changing as we offer new products and services and expand in business areas beyond our historical core businesses.
- We face unique regulatory and other challenges in our Public Exchange, Medicare and Medicaid businesses.
- Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues.
- We may not be able to obtain adequate premium rate increases in our Insured Health Care Benefits products, MBRs and operating results which could magnify the adverse impact of increases in health care and other benefit costs and of ACA assessments, fees and taxes.
- Minimum MLR rebate requirements limit the level of margin we can earn in our Insured Health Care Benefits products while leaving us exposed to higher than expected medical costs. Challenges to our minimum MLR rebate methodology and/or reports could adversely affect our operating results.
- Our operating results may be adversely affected by changes in laws and policies governing employers and by union organizing activity.

Risks Associated with Mergers, Acquisitions, and Divestitures

- We may be unable to successfully integrate companies we acquire.
- We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities, which may be unsuccessful, cause us to assume unanticipated liabilities, disrupt our existing businesses, be dilutive or lead us to assume significant debt, among other things.

Risks Related to Our Operations

- Failure to meet customer and investor expectations, including with respect to environmental, social and governance goals, may harm our brand and reputation, our ability to retain and grow our customer base and membership.
- We and our vendors have experienced and continue to experience information security incidents. We can provide no assurance that we or our vendors will be able to contain detect or prevent incident.
- Data governance failures or the failure or disruption of our information technology or infrastructure can adversely affect our reputation, businesses and prospects. Our use and disclosure of members', customers' and other constituents' sensitive information is subject to complex regulations.
- Product liability, product recall or personal injury issues could damage our reputation.
- We face significant competition in attracting and retaining talented employees. Further, managing succession for, and retention of, key executives is critical to our success.
- Sales of our products and services are dependent on our ability to attract and motivate internal sales personnel and independent third-party brokers, consultants and agents. We may be subject to penalties or other regulatory actions as a result of the marketing practices of brokers and agents selling our products.

- Failure of our businesses to effectively collaborate could prevent us from maximizing our operating results.
- Pursuing multiple information technology improvement initiatives simultaneously could make continued development and implementation significantly more challenging.
- We are subject to payment-related risks that could increase our operating costs, expose us to fraud or theft, subject us to potential liability and disrupt our business operations.
- Both our and our vendors' operations are subject to a variety of business continuity hazards and risks that could interrupt our operations or otherwise adversely affect our performance and operating results.

Financial Risks

- We would be adversely affected by downgrades or potential downgrades in our credit ratings, should they occur, or if we do not effectively deploy our capital.
- Goodwill and other intangible assets could, in the future, become impaired.
- Adverse conditions in the U.S. and global capital markets can significantly and adversely affect the value of our investments in debt and equity securities, mortgage loans, alternative instruments and other investments.

Risks Related to Our Relationships with Manufacturers, Providers, Suppliers and Vendors

- We face risks relating to the market availability, pricing, suppliers and safety profiles of prescription drugs and other products that we purchase and sell.
- We need to be able to maintain our ability to contract with providers on competitive terms and develop and maintain attractive networks with high quality providers.
- If our suppliers or service providers fail to meet their contractual obligations to us or to comply with applicable laws or regulations, we may be exposed to brand and reputational harm, litigation and/or regulatory action.
- We may experience increased medical and other benefit costs, litigation risk and customer and member dissatisfaction when providers that do not have contracts with us render services to our Health Care Benefits members.
- Continuing consolidation and integration among providers and other suppliers may increase our costs and increase competition.

Risks Relating to Our Businesses

The impact of COVID-19 underscores and amplifies certain risks we face.

COVID-19 has spread to every state in the U.S., has been declared a pandemic by the World Health Organization and has severely impacted the economies of the U.S. and other countries around the world. Although certain of the economic impacts of COVID-19 have moderated and the restrictions imposed as a result of COVID-19 have eased, a rise in infection rates, the development of new variants or viruses could result in, among other things, a return of the following: a reduction in discretionary utilization, the cancellation of elective medical procedures, reduced customer traffic and front store sales in our retail pharmacies, our customers being ordered to close or severely curtail their operations, the adoption of work-from-home policies and a reduction in diagnostic reporting due to reductions in health care provider visits and restrictions on our access to providers' medical records, all of which have had a negative impact on our businesses. In addition, as a result of legislative and/or regulatory responses to a rise in infection rates or the development of new variants or viruses, the premiums we charge in our Insured Health Care Benefits products may prove to be insufficient to cover the cost of medical services delivered to our insured medical members, which may increase significantly as a result of higher utilization rates of medical facilities and services and other increases in associated hospital and pharmaceutical costs.

Over the course of the COVID-19 pandemic, we implemented various initiatives, such as COVID-19 related support programs for our customers, medical members and colleagues. If there is a rise in infection rates or the development of new variants or viruses, we may have to re-institute, extend or expand these initiatives, which could adversely impact our businesses, operating results, cash flows and/or financial condition. In addition, measures that were imposed to limit the spread of COVID-19 may also be re-instituted, which may lead to impacts including, but not limited to, complete or partial facility closures, labor shortages, financial difficulties of third-party providers, supply chain disruptions and re-introduction of remote work arrangements. If any of the foregoing materializes, the Company's ability to operate its businesses effectively may be adversely affected and other risks to the Company, such as the risk of cybersecurity attacks, may be amplified, and the impact on our businesses, operating results, cash flows and/or financial condition would be uncertain but could be adverse and material. COVID-19 also may result in legal and regulatory proceedings, investigations and claims against us.

We believe COVID-19's continuing impact on our businesses, operating results, cash flows and/or financial condition primarily will be driven by vaccination rates; the severity of any new COVID-19 variants and the continued effectiveness of vaccines; and whether federal, state and local governments reinstitute and/or intensify policies and initiatives designed to reduce the transmission of COVID-19, including new and existing variants, and to address the financial impacts of a pandemic through additional legislation and other support programs. These primary drivers are beyond our knowledge and control.

We may not be able to accurately forecast health care and other benefit costs, which could adversely affect our Health Care Benefits segment's operating results. There can be no assurance that future health care and other benefits costs will not exceed our projections.

COVID-19 has caused and may continue to cause unanticipated and significant volatility in our health care and other benefits costs, including COVID-19 related testing and vaccination and post-acute care skilled nursing facility and behavioral health costs. In January 2021, the President of the United States issued an executive order to support government efforts to expand access, availability and use of COVID-19 diagnostic, screening and surveillance and addressed the cost of COVID-19 testing by facilitating COVID-19 testing free of charge to those who lack comprehensive health insurance and clarifying group health plans' and health insurance issuers' obligations to provide coverage for COVID-19 testing. In January 2022, the HHS announced that commercial health insurers must cover the cost of up to eight rapid COVID-19 OTC test kits per individual per 30-day period. In addition, the timing of vaccine administration to the general public and related costs as well as the identification of new, more infectious strains of the COVID-19 virus and whether the vaccines will be effective against such new strains are uncertain and may impact our MBR.

Premiums for our Insured Health Care Benefits products, which comprised 93% of our Health Care Benefits revenues for 2022, are priced in advance based on our forecasts of health care and other benefit costs during a fixed premium period, which is generally twelve months. These forecasts are typically developed several months before the fixed premium period begins, are influenced by historical data (and recent historical data in particular), are dependent on our ability to anticipate and detect medical cost trends and changes in our members' behavior and health care utilization patterns and medical claim submission patterns and require a significant degree of judgment. For example, our revenue on Medicare policies is based on bids submitted in June of the year before the contract year. Cost increases in excess of our projections cannot be recovered in the fixed premium period through higher premiums. As a result, our profits are particularly sensitive to the accuracy of our forecasts of the increases in health care and other benefit costs that we expect to occur and our ability to anticipate and detect medical cost trends. For 2023, those forecasts include adjustments made to pricing based on prospective expectations for liabilities due to testing, vaccines, direct COVID-19 treatment and deferred care. Risk-adjusted revenue has been adjusted for deferred care, and forecasted enrollment considers assumptions about the economic environment, though COVID-19 related impacts remain uncertain. During periods when health care and other benefit costs, utilization and/or medical costs trends experience significant volatility and medical claim submission patterns are changing rapidly as a result of COVID-19, accurately detecting, forecasting, managing, reserving and pricing for our (and our self-insured customers') medical cost trends and incurred and future health care and other benefits costs is more challenging. There can be no assurance regarding the accuracy of the health care or other benefit cost projections reflected in our pricing, and whether our health care and other benefit costs (including COVID-19 related testing and vaccination and post-acute care skilled nursing facility and behavioral health costs) will be affected by COVID-19 or other variants or viruses and other external events over which we have no control. Even relatively small differences between predicted and actual health care and other benefit costs as a percentage of premium revenues can result in significant adverse changes in our Health Care Benefits segment's operating results.

A number of factors contribute to rising health care and other benefit costs, including COVID-19 or other variants or viruses, previously uninsured members entering the health care system, changes in members' behavior and health care utilization patterns, turnover in our membership, additional government mandated benefits or other regulatory changes (including under the Families First Act, the CARES Act, and the American Rescue Plan Act), changes in the health status of our members, the aging of the population and other changing demographic characteristics, advances in medical technology, increases in the number and cost of prescription drugs (including specialty pharmacy drugs and ultra-high cost drugs and therapies), direct-to-consumer marketing by drug manufacturers, the increasing influence of social media on our members' health care utilization and other behaviors, changes in health care practices and general economic conditions (such as inflation and employment levels). In addition, government-imposed limitations on Medicare and Medicaid reimbursements to health plans and providers have caused the private sector to bear a greater share of increasing health care and other benefits costs over time, and future amendments to the ACA that increase the uninsured population may amplify this issue. Other factors that affect our health care and other benefit costs include epidemics or other pandemics, changes as a result of the ACA, changes to the ACA and other changes in the regulatory environment, the evolution toward a consumer driven business model, new technologies, influenza-related health care costs (which may be substantial and higher than we expected), clusters of high-cost cases, health care

provider and member fraud, and numerous other factors that are or may be beyond our control. For example, the 2020-2021 influenza season was impacted by efforts taken to reduce the spread of COVID-19; and the 2019-2020 influenza season had an earlier than average start and had a higher incidence of influenza than the 2018-2019 influenza season.

Our Health Care Benefits segment's operating results and competitiveness depend in large part on our ability to appropriately manage future health care and other benefit costs through underwriting criteria, product design, provider network configuration, negotiation of favorable provider contracts and medical management programs. Our medical cost management programs may not be successful and may have a smaller impact on health care and benefit costs than we expect. The factors described above may adversely affect our ability to predict and manage health care and other benefit costs, which can adversely affect our competitiveness and operating results.

Furthermore, if we are not able to accurately and promptly anticipate and detect medical cost trends or accurately estimate the cost of incurred but not yet reported claims or reported claims that have not been paid, our ability to take timely corrective actions to limit future health care costs and reflect our current benefit cost experience in our pricing process may be limited, which would further amplify the extent of any adverse impact on our operating results. These risks are particularly acute during periods when health care and other benefit costs, utilization and/or medical cost trends experience significant volatility and medical claim submission patterns are changing rapidly as a result of COVID-19. Such risks are further magnified by the ACA and other existing and future legislation and regulations that limit our ability to price for our projected and/or experienced increases in utilization and/or medical cost trends.

Many of the requirements set forth above may change once the PHE expires. The Biden administration recently renewed the PHE on January 11, 2023 and has indicated that they intend for the PHE to expire on May 11, 2023. There can be no assurance that future health care and other benefits costs will not exceed our projections.

Adverse economic conditions in the U.S. and abroad can materially and adversely impact our businesses, operating results, cash flows and financial condition, and we do not expect these conditions to improve in the near future.

Adverse economic conditions in the U.S. and abroad, including those caused by inflation, high interest rates, supply chain disruptions and COVID-19, can materially and adversely impact our businesses, operating results, cash flows and financial condition, including:

- In our Pharmacy Services segment, by causing drug utilization to decline, reducing demand for PBM services and adversely affecting the financial health of our PBM clients.
- In our Retail/LTC segment, by causing drug utilization to decline, changing consumer purchasing power, preferences and/or spending patterns leading to reduced consumer demand for products sold in our stores, potentially increasing levels of theft at our retail locations and adversely affecting the financial health of our LTC pharmacy customers.
- By causing our existing customers to reduce workforces (including due to business failures), which would reduce our revenues, the number of covered lives in our PBM clients and/or the number of members our Health Care Benefits segment serves.
- By causing our clients and customers and potential clients and customers, particularly those with the most employees or members, and state and local governments, to force us to compete more vigorously on factors such as price and service, including service, discount and other performance guarantees, to retain or obtain their business.
- By causing customers and potential customers of our Health Care Benefits and Retail/LTC segments to purchase fewer products and/or products that generate less profit for us than the ones they currently purchase or otherwise would have purchased.
- By causing customers and potential customers of our Health Care Benefits segment, particularly smaller employers and individuals, to forego obtaining or renewing their health and other coverage with us.
- In our Health Care Benefits segment, by causing unanticipated increases and volatility in utilization of medical and other covered services, including COVID-19 related testing, vaccination and behavioral health services, by our medical members, changes in medical claim submission patterns and/or increases in medical unit costs and/or provider behavior, each of which would increase our costs and limit our ability to accurately detect, forecast, manage, reserve and price for our (and our self-insured customers') medical cost trends and incurred and future health care and other benefits costs.
- By increasing medical unit costs and causing changes in provider behavior in our Health Care Benefits segment as hospitals and other providers attempt to maintain revenue levels in their efforts to adjust to their own economic challenges.
- By weakening the ability or perceived ability of the issuers and/or guarantors of the debt or other securities we hold in our investment portfolio to perform on their obligations to us, which could result in defaults in those securities and has reduced,

and may further reduce, the value of those securities and has created, and may continue to create, net realized capital losses for us that reduce our operating results.

- By weakening the ability of our customers, including self-insured customers in our Health Care Benefits segment, medical providers and the other companies with which we do business as well as our medical members to perform their obligations to us or causing them not to perform those obligations, either of which could reduce our operating results.
- By weakening the ability of our former subsidiaries and/or their purchasers to satisfy their lease obligations that we have guaranteed and causing the Company to be required to satisfy those obligations.
- By weakening the financial condition of other insurers, including long-term care insurers and life insurers, which increases the risk that we will receive significant assessments for obligations of insolvent insurers to policyholders and claimants.
- By continuing to cause, over time, inflation that could cause interest rates to further increase and thereby further increase our interest expense and reduce our operating results, as well as further decrease the value of the debt securities we hold in our investment portfolio, which would further reduce our operating results and/or adversely affect our financial condition.

Furthermore, reductions in workforce by our customers can cause unanticipated increases in the health care and other benefits costs of our Health Care Benefits segment. For example, our business associated with members who have elected to receive benefits under Consolidated Omnibus Budget Reconciliation Act (known as "COBRA") typically has an MBR that is significantly higher than our overall Commercial MBR.

Each of our segments operates in a highly competitive and evolving business environment; and operating income in the industries in which we compete may decline.

Each of our segments, Health Care Benefits, Pharmacy Services, which includes our PBM business, and Retail/LTC, operates in a highly competitive and evolving business environment. Specifically:

- As competition increases in the geographies in which we operate, including competition from new entrants, a significant increase in price compression and/or reimbursement pressures could occur, and this could require us to reevaluate our pricing structures to remain competitive.
- In our Health Care Benefits segment, we are seeking to substantially grow our Medicaid, dual eligible and dual eligible special needs plan membership over the next several years. In many instances, to acquire and retain our government customers' business, we must bid against our competitors in a highly competitive environment. Winning bids often are challenged successfully by unsuccessful bidders, and may also be withdrawn or cancelled by the issuing agency.
- Customer contracts in our Health Care Benefits segment are generally for a period of one year, and our customers have considerable flexibility in moving between us and our competitors. We may lose members to competitors with more favorable pricing, or our customers may purchase different types of products from us that are less profitable, adversely affecting our revenues and operating results. In addition, our Medicare, Medicaid and CHIP products are subject to termination without cause, periodic re-bid, rate adjustment and program redesign, as customers seek to contain their benefit costs, particularly in an uncertain economy, and our exposure to this risk is increasing as we grow our Government products membership. These actions may adversely affect our membership, revenues and operating results.
- We requested increases in our premium rates in our Commercial Health Care Benefits business for 2023 and expect to request future increases in those rates in order to adequately price for projected medical cost trends, required expansions of coverage and rating limits, and significant assessments, fees and taxes imposed by federal and state governments, including as a result of the ACA. Our rates also must be adequate to reflect the risk that our products will be selected by people with a higher risk profile or utilization rate than the pool of participants we anticipated when we established pricing for the applicable products (also known as "adverse selection"), particularly in small group Commercial products. These rate increases may be significant and thus heighten the risks of adverse publicity, adverse regulatory action and adverse selection and the likelihood that our requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.
- The competitive success of our Pharmacy Services segment is dependent on our ability to establish and maintain contractual relationships with network pharmacies.
- The competitive success of our Retail/LTC segment and our specialty pharmacy operations is dependent on our ability to establish and maintain contractual relationships with PBMs and other payors on acceptable terms as the payors' clients evaluate adopting narrow or restricted retail pharmacy networks.
- In our PBM business, we maintain contractual relationships with brand name drug manufacturers that provide for purchase discounts and/or rebates on drugs dispensed by pharmacies in our retail network and by our specialty and mail order pharmacies (all or a portion of which may be passed on to clients). Manufacturer's rebates often depend on a PBM's ability to meet contractual requirements, including the placement of a manufacturer's products on the PBM's formularies. If we

lose our relationship with one or more drug manufacturers, or if the discounts or rebates provided by drug manufacturers decline, our operating results, cash flows and/or prospects could be adversely affected.

- If laws or regulations are promulgated that limit the number of PBMs available in a particular business or geography, competition in those businesses and geographies could be amplified and could adversely affect our revenues and operating results.
- The PBM industry has been experiencing price compression as a result of competitive pressures and increased client demands for lower prices, increased revenue sharing, including sharing in a larger portion of rebates received from drug manufacturers, enhanced service offerings and/or higher service levels. Marketplace dynamics and regulatory changes also have adversely affected our ability to offer plan sponsors pricing that includes the use of retail "differential" or "spread," which could adversely affect our future profitability, and we expect these trends to continue.
- Our retail pharmacy, specialty pharmacy and LTC pharmacy operations have been affected by reimbursement pressure caused by competition, including client demands for lower prices, generic drug pricing, earlier than expected generic drug introductions and network reimbursement pressure. If we are unable to increase our prices to reflect, or otherwise mitigate the impact of, increasing costs, our profitability will be adversely affected. If we are unable to limit our price increases, we may lose customers to competitors with more favorable pricing, adversely affecting our revenues and operating results.
- A shift in the mix of our pharmacy prescription volume towards programs offering lower reimbursement rates as a result of competition or otherwise could adversely affect our margins, including the ongoing shift in pharmacy mix towards 90-day prescriptions at retail and the ongoing shift in pharmacy mix towards Medicare Part D prescriptions.
- PBM client contracts often are for a period of approximately three years. However, PBM clients may require early or periodic re-negotiation of pricing prior to contract expiration. PBM clients are generally well informed, can move between us and our competitors and often seek competing bids prior to expiration of their contracts. We are therefore under pressure to contain price increases despite being faced with increasing drug costs and increasing operating costs. If we are unable to increase our prices to reflect, or otherwise mitigate the impact of, increasing costs, our profitability will be adversely affected. If we are unable to limit our price increases, we may lose customers to competitors with more favorable pricing, adversely affecting our revenues and operating results.
- The operating results and margins of our LTC business are further affected by the increased efforts of health care payors to negotiate reduced or capitated pricing arrangements and by the financial health of, and purchases and sales of, our LTC customers.

In addition, competitors in each of our businesses may offer services and pricing terms that we may not be willing or able to offer. Competition also may come from new entrants and other sources in the future. Unless we can demonstrate enhanced value to our clients through innovative product and service offerings in the rapidly changing health care industry, we may be unable to remain competitive.

Disruptive innovation by existing or new competitors could alter the competitive landscape in the future and require us to accurately identify and assess such alterations and make timely and effective changes to our strategies and business model to compete effectively. For example, decisions to buy our Health Care Benefits and Pharmacy Services products and services increasingly are made or influenced by consumers, either through direct purchasing (e.g., Medicare Advantage plans and PDPs) or through Public Exchanges and private health insurance exchanges that allow individual choice. Consumers also are increasingly seeking to access consumer goods and health care products and services locally and through other direct channels such as mobile devices and websites. To compete effectively in the consumer-driven marketplace, we will be required to develop or acquire new capabilities, attract new talent and develop new service and distribution relationships that respond to consumer needs and preferences.

Changes in marketplace dynamics or the actions of competitors or manufacturers, including industry consolidation, the emergence of new competitors and strategic alliances, and decisions to exclude us from new narrow or restricted retail pharmacy networks could materially and adversely affect our businesses, operating results, cash flows and/or prospects.

We can provide no assurance that we will be able to compete successfully on Public Exchanges or that our pricing or other actions will result in the profitability of our Public Exchange products.

In January 2022, we entered into the Public Exchanges in eight states and further expanded to a total of twelve states in January 2023. To compete effectively on Public Exchanges, we have developed or acquired the technology, systems, tools and talent necessary to interact with Public Exchanges and engage Public Exchange consumers through enhanced consumer-focused sales, marketing channels and customer interfaces. We have also created new customer service programs and product offerings. While participating on the Public Exchanges, we will have to respond to pricing and other actions taken by existing competitors and regulators as well as potentially disruptive new entrants, which could reduce our profit margins. Due to the price transparency

provided by Public Exchanges, when we market products we face competitive pressures from existing and new competitors who may have lower cost structures. Our competitors may bring their Public Exchange and other consumer products to market more quickly, have greater experience marketing to consumers and/or may be targeting the higher margin portions of our business. We can provide no assurance that we will be able to compete successfully or profitably on Public Exchanges or that we will be able to benefit from any opportunities presented by Public Exchanges.

In addition, there can be no assurance that our pricing or other actions will result in the profitability of our Public Exchange products in 2023 or any future year. We have set 2023 premium rates for our Public Exchange products based on our projections, including as to the health status and quantity of membership and utilization of medical and/or other covered services by members. The accuracy of the projections reflected in our pricing may be impacted by (i) adverse selection among individuals who require or utilize more expensive medical and/or other covered services, (ii) other plans' withdrawals from participation in the Public Exchanges we serve, (iii) a rapid increase or decline in membership, including as a result of individuals losing Medicaid eligibility as redeterminations resume after being suspended during the COVID-19 pandemic, and (iv) legislation, regulations, enforcement activity and/or judicial decisions that cause Public Exchanges to operate in a manner different than what we projected in setting our premium rates.

A change in our Health Care Benefits product mix may adversely affect our profit margins.

Our Insured Health Care Benefits products that involve greater potential risk generally tend to be more profitable than our ASC products. Historically, smaller employer groups have been more likely to purchase Insured Health Care Benefits products because such purchasers are generally unable or unwilling to bear greater liability for health care expenditures, although over the last several years even relatively small employers have moved to ASC products. We also serve, and expect to grow our business with, government-sponsored programs, including Medicare and Medicaid, that are subject to competitive bids and have lower profit margins than our Commercial Insured Health Care Benefits products. A shift of enrollees from more profitable products to less profitable products could have a material adverse effect on the Health Care Benefits segment's operating results.

Negative public perception of the industries in which we operate, or of our industries' or our practices, can adversely affect our businesses, operating results, cash flows and prospects.

Our brand and reputation are two of our most important assets, and the industries in which we operate have been and are negatively perceived by the public from time to time. Negative publicity may come as a result of adverse media coverage, litigation against us and other industry participants, the ongoing public debates over drug pricing, PBMs, government involvement in drug pricing and purchasing, changes to the ACA, "surprise" medical bills, governmental hearings and/or investigations, actual or perceived shortfalls regarding our industries' or our own products and/or business practices (including PBM operations, drug pricing and insurance coverage determinations) and social media and other media relations activities. Negative publicity also may come from a failure to meet customer expectations for consistent, high quality and accessible care. This risk may increase as we continue to offer products and services that make greater use of data and as our business model becomes more focused on delivering health care to consumers.

In addition, by working with the U.S. government in the distribution and administration of the COVID-19 vaccine, the Company may be subject to negative publicity related to the government's actions in response to COVID-19 that are outside of the ability of the Company to control.

Negative public perception and/or publicity of our industries in general, or of us or our key vendors, brokers or product distribution networks in particular, can further increase our costs of doing business and adversely affect our operating results and our stock price by:

- adversely affecting our brand and reputation;
- adversely affecting our ability to market and sell our products and/or services and/or retain our existing customers and members;
- requiring us to change our products and/or services;
- reducing or restricting the revenue we can receive for our products and/or services; and/or
- increasing or significantly changing the regulatory and legislative requirements with which we must comply.

We must maintain and improve our relationships with our retail and specialty pharmacy customers and increase the demand for our products and services, including proprietary brands.

The success of our businesses depends in part on customer loyalty, superior customer service and our ability to persuade customers to frequent our retail stores and online sites and to purchase products in additional categories and our proprietary brands. Failure to timely identify or effectively respond to changing consumer preferences and spending patterns, and evolving demographic mixes in the communities we serve, an inability to expand the products being purchased by our clients and customers, or the failure or inability to obtain or offer particular categories of products could adversely affect our relationship with our customers and clients and the demand for our products and services and could result in excess inventories of products.

We offer our retail customers proprietary brand products that are available exclusively at our retail stores and through our online retail sites. The sale of proprietary products subjects us to unique risks including potential product liability risks, mandatory or voluntary product recalls, potential supply chain and distribution chain disruptions for raw materials and finished products, our ability to successfully protect our intellectual property rights and the rights of applicable third parties, and other risks generally encountered by entities that source, market and sell private-label products. We also face similar risks for the other products we sell in our retail operations, including supply chain and distribution chain disruption risk. Any failure to adequately address some or all of these risks could have an adverse effect on our retail business, operating results, cash flows and/or financial condition. Additionally, an increase in the sales of our proprietary brands may adversely affect our sales of products owned by our suppliers and adversely impact certain of our supplier relationships. Our ability to locate qualified, economically stable suppliers who satisfy our requirements, and to acquire sufficient products in a timely and effective manner, is critical to ensuring, among other things, that customer confidence is not diminished. Any failure to develop sourcing relationships with a broad and deep supplier base could adversely affect our operating results and erode customer loyalty.

We also could be adversely affected if we fail to identify or effectively respond to changes in marketplace dynamics. For example, specialty pharmacy represents a significant and growing proportion of prescription drug spending in the U.S., a significant portion of which is dispensed outside of traditional retail pharmacies. Because our specialty pharmacy business focuses on complex and high-cost medications, many of which are made available by manufacturers to a limited number of pharmacies (so-called limited distribution drugs) that serve a relatively limited universe of patients, the future growth of our specialty pharmacy business depends largely upon expanding our access to key drugs and penetration in certain treatment categories. Any contraction of our base of patients or reduction in demand for the prescriptions we currently dispense could have an adverse effect on our specialty pharmacy business, operating results and cash flows.

We face risks relating to the availability, pricing and safety profiles of prescription drugs that we purchase and sell.

The profitability of our Retail/LTC and Pharmacy Services segments is dependent upon the utilization of prescription drug products. We dispense significant volumes of brand name and generic drugs from our retail, LTC, specialty and mail order pharmacies, and the retail pharmacies in our PBM's network also dispense significant volumes of brand name and generic drugs. Our revenues, operating results and cash flows may decline if physicians cease writing prescriptions for drugs or the utilization of drugs is reduced, including due to:

- increased safety risk profiles or regulatory restrictions;
- manufacturing or other supply issues;
- a reduction in drug manufacturers' participation in federal programs;
- certain products being withdrawn by their manufacturers or transitioned to over-the-counter products;
- future FDA rulings restricting the supply or increasing the cost of products;
- the introduction of new and successful prescription drugs or lower-priced generic alternatives to existing brand name products; or
- inflation in the price of drugs.

In addition, increased utilization of generic drugs (which normally yield a higher gross profit rate than equivalent brand name drugs) has resulted in pressure to decrease reimbursement payments to retail, mail order, specialty and LTC pharmacies for generic drugs, causing a reduction in our margins on sales of generic drugs. Consolidation within the generic drug manufacturing industry and other external factors may enhance the ability of manufacturers to sustain or increase pricing of generic drugs and diminish our ability to negotiate reduced generic drug acquisition costs. Any inability to offset increased brand name or generic prescription drug acquisition costs or to modify our activities to lessen the financial impact of such increased costs could have a significant adverse effect on our operating results.

The reserves we hold for expected claims in our Insured Health Care Benefits products are based on estimates that involve an extensive degree of judgment and are inherently variable. Any reserve, including a premium deficiency reserve, may be

insufficient. If actual claims exceed our estimates, our operating results could be materially adversely affected, and our ability to take timely corrective actions to limit future costs may be limited.

A large portion of health care claims are not submitted to us until after the end of the quarter in which services are rendered by providers to our members. Our reported health care costs payable for any particular period reflect our estimates of the ultimate cost of such claims as well as claims that have been reported to us but not yet paid. We also must estimate the amount of rebates payable under the MLR rules of the ACA, CMS and the OPM and the amounts payable by us to, and receivable by us from, the United States federal government under the ACA's remaining premium stabilization program.

Our estimates of health care costs payable are based on a number of factors, including those derived from historical claim experience, but this estimation process also makes use of extensive judgment. Considerable variability is inherent in such estimates, and the accuracy of the estimates is highly sensitive to changes in medical claims submission and processing patterns and/or procedures, turnover and other changes in membership, changes in product mix, changes in the utilization of medical and/or other covered services, including prescription drugs, changes in medical cost trends, changes in our medical management practices and the introduction of new benefits and products. We estimate health care costs payable periodically, and any resulting adjustments, including premium deficiency reserves, are reflected in current-period operating results within benefit costs. For example, as of December 31, 2021, we established a premium deficiency reserve of $16 million related to Medicaid products in the Health Care Benefits segment, but did not establish a premium deficiency reserve as of December 31, 2022. A worsening (or improvement) of health care cost trend rates or changes in claim payment patterns from those that we assumed in estimating health care costs payable as of December 31, 2022 would cause these estimates to change in the near term, and such a change could be material.

Furthermore, if we are not able to accurately and promptly anticipate and detect medical cost trends or accurately estimate the cost of incurred but not yet reported claims or reported claims that have not been paid, our ability to take timely corrective actions to limit future health care costs and reflect our current benefit cost experience in our pricing process may be limited, which would further exacerbate the extent of any adverse impact on our operating results. These risks are particularly acute during and following periods when utilization of medical and/or other covered services and/or medical cost trends are below recent historical levels and in products where there is significant turnover in our membership each year, and such risks are further magnified by the ACA and other legislation and regulations that limit our ability to price for our projected and/or experienced increases in utilization and/or medical cost trends.

Our operating results are affected by the health of the economy in general and in the communities we serve.

The U.S. financial markets have been experiencing, and may continue to experience, volatility and disruptions, including diminished liquidity and credit availability, inflation, declines in consumer confidence and economic growth and increases in unemployment rates, all of which have resulted in uncertainty about economic stability. Our businesses are affected by economic instability and declines in consumer confidence in general and in the communities we serve, and various other economic factors, including inflation and changes in consumer purchasing power, preferences and/or spending patterns. An unfavorable, uncertain or volatile economic environment, as we have experienced recently as a result of inflation, rising interest rates, supply chain disruptions and COVID-19, has caused and could cause a decline in drug utilization, an increase in health care utilization, a dampening demand for PBM services and retail products, and an increase in theft or other crime that could impact our retail locations.

If our customers' operating and financial performance deteriorates, or they are unable to make scheduled payments or obtain adequate financing, as a result of adverse economic conditions or otherwise, our customers may not be able to pay timely, or may delay payment of, amounts owed to us. Any inability of our customers to pay us for our products and services may adversely affect our businesses, operating results and cash flows. In addition, both state and federal government sponsored payers, as a result of budget deficits or spending reductions, may suspend payments or seek to reduce their health care expenditures resulting in our customers delaying payments to us or renegotiating their contracts with us.

The adverse impacts on our businesses of an uncertain economic environment may be further exacerbated by the increasing prevalence of high deductible health plans and health plan designs favoring co-insurance over co-payments as members and other consumers may decide to postpone, or not to seek, medical treatment which may lead them to incur more expensive medical treatment in the future and/or decrease our prescription volumes.

Further, economic conditions including interest rate fluctuations, changes in capital market conditions and regulatory changes may affect our ability to obtain necessary financing on acceptable terms, our ability to secure suitable store locations under

acceptable terms, our ability to execute sale-leaseback transactions under acceptable terms and the value of our investment portfolio.

In addition, our Health Care Benefits membership remains concentrated in certain U.S. geographies and in certain industries. Unfavorable changes in health care or other benefit costs or reimbursement rates or increased competition in those geographic areas where our membership is concentrated could therefore have a disproportionately adverse effect on our Health Care Benefits segment's operating results. Our Health Care Benefits membership has been and may continue to be affected by workforce reductions by our customers due to adverse and/or uncertain general economic conditions, especially in the U.S. geographies and industries where our membership is concentrated. As a result, we may not be able to profitably grow and diversify our Health Care Benefits membership geographically, by product type or by customer industry, and our revenues and operating results may be disproportionately affected by adverse changes affecting our customers.

Adverse changes in the U.S. economy, consumer confidence and economic conditions could have an adverse effect on our businesses and financial results.

We are exposed to risks relating to the solvency of other insurers.

We are subject to assessments under guaranty fund laws existing in all states for obligations of insolvent insurance companies (including long-term care insurers), HMOs, ACA co-ops and other payors to policyholders and claimants. For example, in the first quarter of 2017, Aetna recorded a discounted estimated liability expense of $231 million pretax for our estimated share of future assessments for long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries. Guaranty funds are maintained by state insurance commissioners to protect policyholders and claimants in the event that an insurer, HMO, ACA co-op and/or other payor becomes insolvent or is unable to meet its financial obligations. These funds are usually financed by assessments against insurers regulated by a state. Future assessments may have an adverse effect on our operating results and cash flows.

Extreme events, or the threat of extreme events, could materially impact our businesses and health care (including behavioral health) costs.

Nuclear, biological or other attacks, or other acts of violence, including active shooter situations, whether as a result of war or terrorism or otherwise; other man-made disasters; natural disasters, such as hurricanes, tropical storms, floods, fires, earthquakes, tsunamis, cyclones, typhoons or extreme weather conditions such as major or extended winter storms, droughts and tornados, whether as a result of climate change or otherwise; epidemics; pandemics and other extreme events can affect the U.S. economy in general, our industries and us specifically. In particular, such extreme events or the threat of such extreme events could result in significant health care (including behavioral health) costs, which also would be affected by the government's actions and the responsiveness of public health agencies and other insurers. Such extreme events or the threat of such extreme events also could disrupt our supply chains and/or our distribution chains for the products we sell. In addition, our employees and those of our vendors are concentrated in certain large, metropolitan areas which may be particularly exposed to these events. Such events could adversely affect our businesses, operating results and cash flows, and, in the event of extreme circumstances, our financial condition or viability, particularly if our responses to such events are less adequate than those of our competitors.

We may be unable to achieve our environmental, social and governance goals.

We are dedicated to corporate social responsibility and sustainability and we established certain goals as part of our ESG strategy. We face pressures from our colleagues, customers, and stockholders to meet our goals and to make significant advancements in environmental, social and governance matters. Achievement of our goals is subject to risks and uncertainties, many of which are outside of our control, and it is possible that we may fail to achieve these goals or that our colleagues, customers, or stockholders may not be satisfied with the goals we set or our efforts to achieve them. These risks and uncertainties include, but are not limited to: our ability to set and execute on our operational strategies and achieve our goals within the currently projected costs and the expected timeframes; the availability and cost of technological advancements, renewable energy and other materials necessary to meet our goals and expectations; compliance with, and changes or additions to, global and regional regulations, taxes, charges, mandates or requirements relating to climate-related goals; labor-related regulations and requirements that restrict or prohibit our ability to impose requirements on third party contractors; the actions of competitors and competitive pressures; an acquisition of or merger with another company that has not adopted similar goals or whose progress towards reaching its goals is not as advanced as ours; and the pace of regional and global recovery from the COVID-19 pandemic. A failure to meet our goals could adversely affect public perception of our business, employee morale or customer or stockholder support.

Further, an increasing percentage of colleagues, customers, and stockholders considers sustainability factors in making employment, consumer health care and investment decisions. If we are unable to meet our goals, we may lose colleagues, have difficulty recruiting new colleagues, and be unable to attract investors, customers, or partners, our stock price may be negatively impacted, our reputation may be negatively affected, and it may be more difficult for us to compete effectively, all of which would have an adverse effect on our business, operating results, and financial condition.

Risks From Changes in Public Policy and Other Legal and Regulatory Risks

We are subject to potential changes in public policy, laws and regulations, including reform of the U.S. health care system, which can adversely affect our businesses. Entitlement program reform, if it occurs, could have a material adverse effect on our businesses, operations and/or operating results.

The political environment in which we operate remains uncertain. It is reasonably possible that our business operations and operating results could be materially adversely affected by legislative, enforcement, regulatory and public policy changes at the federal or state level, increased government involvement in drug reimbursement, pricing, purchasing and/or importation and/or increased regulation of PBMs, including: changes to the regulatory environment for health care and related benefits, including Medicare, the ACA, and related Public Exchange regulations; changes to laws or regulations governing drug reimbursement and/or pricing; changes to the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs; changes to laws and/or regulations governing drug manufacturers' rebates; changes to laws and/or regulations governing reimbursements paid to pharmacists by and/or reporting required by PBMs; changes to immigration policies and/or other public policy initiatives. It is not possible to predict whether or when any such changes will occur or what form any such changes may take (including through the use of U.S. Presidential Executive Orders or executive orders by Governors or key regulators). Other significant changes to health care and related benefits system legislation or regulation as well as changes with respect to tax and trade policies, tariffs and other government regulations affecting trade between the United States and other countries also are possible and could adversely affect our businesses. If we fail to respond adequately to such changes, including by implementing strategic and operational initiatives, or do not respond as effectively as our competitors, our businesses, operations and operating results may be materially adversely affected.

Efforts to amend the ACA and related regulations are possible. It is also possible that federal and state governments will continue to enact and seriously consider many broad-based legislative and regulatory proposals that will or could materially impact various aspects of the health care and related benefits system and our businesses. Further changes to federal health care and related benefits laws, including the ACA, drug reimbursement and pricing laws, laws governing PBMs and/or laws governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, are probable. We cannot predict the effect, if any, that new health care and related benefits legislation, future changes to the ACA or the implementation of or failure to implement the outstanding provisions of ACA, may have on our Health Care Benefits, Pharmacy Services and/or retail pharmacy, LTC pharmacy operations and/or operating results. The federal and many state governments also are considering changes in the interpretation, enforcement and/or application of existing programs, laws and regulations, including changes to payments under and funding of Medicare and Medicaid programs and increased regulation of PBMs.

Further, changes in existing federal or state laws or regulations or the adoption of new laws or regulations relating to additional regulation of PBMs (including network restrictions, formulary management, affiliate reimbursement, contractual guarantees and reconciliations, reimbursement mandates or other PBM services), drug pricing or purchasing, patent term extensions and/or purchase discount and/or rebate arrangements with drug manufacturers also could reduce the discounts or rebates we receive. Changes in existing federal or state laws or regulations or the adoption of new laws or regulations relating to claims processing and billing also could adversely affect our profitability.

In addition, in November 2020, the HHS released the Rebate Rule, which eliminates the regulatory safe harbor from prosecution under the AKS for rebates from pharmaceutical companies to PBMs in Medicare Part D and in Medicaid MCOs, replacing it with two far narrower safe harbors designed to directly benefit patients with high out-of-pocket costs and to change the way PBMs are compensated. The new safe harbors are (i) for rebates which are passed on to the patient at the point of sale and (ii) for flat service fee payments made to PBMs which cannot be tied to the list prices of drugs. The PCMA, which represents PBMs, has filed a suit in an effort to block the Rebate Rule, claiming that the Rebate Rule would lead to higher premiums in Medicare Part D and was adopted in an unlawful manner. It is unclear whether the Rebate Rule will be enforceable, whether pharmaceutical companies will respond by reducing list prices, whether list prices in the private market may also be reduced, and what the resulting impact will be to PBMs or the Company. The Bipartisan Infrastructure Act of 2021

delays the effective date of the rebate rule to January 2026, and the Inflation Reduction Act, enacted in August 2022, further delays the Rebate Rule through 2032.

Additionally, the Consolidated Appropriations Act of 2021 was signed into law in December 2020 and contains transparency provisions requiring group health plans and health insurance issuers to report certain prescription drug costs, overall spending on health services and prescription drugs, and information about premiums and the impact of rebates and other remuneration on premiums and out-of-pocket costs to the Tri-Departments. No later than 18 months after the first submission and bi-annually thereafter, the Tri-Departments will release a public report on drug pricing trends, drug reimbursement, and the impact of drug prices on premiums. The first filings of plan year data were required in December 2022 and will be required annually in June of each year on an ongoing basis.

We cannot predict the enactment or content of new legislation or regulations or changes to existing laws or regulations or their enforcement, interpretation or application, or the effect they will have on our business operations or operating results, which could be materially adverse. Even if we could predict such matters, it is not possible to eliminate the adverse impact of public policy changes that would fundamentally change the dynamics of one or more of the industries in which we compete. Examples of such changes include: the federal or one or more state governments fundamentally restructuring or reducing the funding available for Medicare, Medicaid, dual eligible or dual eligible special needs plan programs, increasing its involvement in drug reimbursement, pricing, purchasing and/or importation, changing the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, changing the tax treatment of health or related benefits, or significantly altering the ACA. The likelihood of adverse changes remains high due to state and federal budgetary pressures, and our businesses and operating results could be materially and adversely affected by such changes, even if we correctly predict their occurrence.

For more information on these matters, see "Government Regulation" included in Item 1 of this 10-K.

If we fail to comply with applicable laws and regulations, many of which are highly complex, we could be subject to significant adverse regulatory actions, including monetary penalties, or suffer brand and reputational harm.

Our businesses are subject to extensive regulation and oversight by state, federal and international governmental authorities. The laws and regulations governing our operations and interpretations of those laws and regulations, including those related to human capital and climate change, are increasing in number and complexity, change frequently and can be inconsistent or conflict with one another. In general, these laws and regulations are designed to benefit and protect customers, members and providers rather than us or our investors. In addition, the governmental authorities that regulate our businesses have broad latitude to make, interpret and enforce the laws and regulations that govern us and continue to interpret and enforce those laws and regulations more strictly and more aggressively each year. We also must follow various restrictions on certain of our businesses and the payment of dividends by certain of our subsidiaries put in place by certain state regulators.

Certain of our Pharmacy Services and Retail/LTC operations, products and services are subject to:

- the clinical quality, patient safety and other risks inherent in the dispensing, packaging and distribution of drugs and other health care products and services, including claims related to purported dispensing and other operational errors (any failure by our Pharmacy Services and/or Retail/LTC operations to adhere to the laws and regulations applicable to the dispensing of drugs could subject us to civil and criminal penalties);
- federal and state anti-kickback and other laws that govern our relationship with drug manufacturers, customers and consumers;
- compliance requirements under ERISA, including fiduciary obligations in connection with the development and implementation of items such as drug formularies and preferred drug listings; and
- federal and state legislative proposals and/or regulatory activity that could adversely affect pharmacy benefit industry practices.

Our Health Care Benefits products are highly regulated, particularly those that serve Public Exchange, Medicare, Medicaid, dual eligible, dual eligible special needs and small group Commercial customers and members. The laws and regulations governing participation in the Public Exchanges, Medicare Advantage (including dual eligible special needs plans), Medicare Part D, Medicaid, and managed Medicaid plans are complex, are subject to interpretation and can expose us to penalties for non-compliance.

The scope of the practices and activities that are prohibited by federal and state false claims acts is the subject of pending litigation. Claims under federal and state false claims acts can be brought by the government or by private individuals on behalf of the government through a *qui tam* or "whistleblower" suit, and we are a defendant in a number of such proceedings. If we are convicted of fraud or other criminal conduct in the performance of a government program or if there is an adverse decision against us under the False Claims Act, we may be temporarily or permanently suspended from participating in government health care programs, including Public Exchange, Medicare Advantage, Medicare Part D, Medicaid, dual eligible and dual eligible special needs plan programs, and we also may be required to pay significant fines and/or other monetary penalties. Whistleblower suits have resulted in significant settlements between governmental agencies and health care companies. The significant incentives and protections provided to whistleblowers under applicable law increase the risk of whistleblower suits.

If we fail to comply with laws and regulations that apply to government programs, we could be subject to criminal fines, civil penalties, premium refunds, prohibitions on marketing or active or passive enrollment of members, corrective actions, termination of our contracts or other sanctions which could have a material adverse effect on our ability to participate in Public Exchange, Medicare Advantage, Medicare Part D, Medicaid, dual eligible, and dual eligible special needs plans and other programs and on our operating results, cash flows and financial condition.

Our businesses, profitability and growth also may be adversely affected by (i) judicial and regulatory decisions that change and/or expand the interpretations of existing statutes and regulations, expand fiduciary obligations, impose medical or bad faith liability, increase our responsibilities under ERISA or the remedies available under ERISA, or reduce the scope of ERISA and Medicare Part D preemption of state law claims or (ii) other legislation and regulations. For example, in December 2020, the U.S. Supreme Court upheld an Arkansas law that, among other things, mandates a particular pricing methodology, establishes an appeals process for a pharmacy when the reimbursement is below the pharmacy's acquisition cost, permits a pharmacy to reverse and rebill if they cannot procure the drug from its wholesaler at a price equal to or less than the reimbursement rate, prohibits a PBM from reimbursing a pharmacy less than the amount it reimburses an affiliate on a per unit basis, and permits a pharmacy to decline to dispense if the reimbursement is lower than the pharmacy's acquisition cost. Subsequently, in November 2021, the U.S. Court of Appeals for the Eighth Circuit upheld a North Dakota law that regulates employer-sponsored ERISA health plans and certain PBM practices within Medicare and in April 2022 the U.S. District Court for the Western District of Oklahoma affirmed that the Oklahoma Insurance Department could enforce a state law against PBMs that contained provisions that alter and limit some of the options that an ERISA plan can use, because none of the provisions mandate that ERISA plans make any specific choices. Additional litigation has been filed in several states to challenge ERISA and Medicare Part D preemption.

If our compliance or other systems and processes fail or are deemed inadequate, we may suffer brand and reputational harm and become subject to regulatory actions and/or litigation.

In addition to being subject to extensive and complex regulations, many of our contracts with customers include detailed requirements. In order to be eligible to offer certain products or bid on certain contracts, we must demonstrate that we have robust systems and processes in place that are designed to maintain compliance with all applicable legal, regulatory and contractual requirements. These systems and processes frequently are reviewed and audited by our customers and regulators. If our systems and processes designed to maintain compliance with applicable legal and contractual requirements, and to prevent and detect instances of, or the potential for, non-compliance fail or are deemed inadequate, we may suffer brand and reputational harm and be subject to regulatory actions, litigation and other proceedings which may result in damages, fines, suspension or loss of licensure, suspension or exclusion from participation in government programs and/or other penalties, any of which could adversely affect our businesses, operating results, cash flows and/or financial condition.

We routinely are subject to litigation and other adverse legal proceedings, including class actions and qui tam actions. Many of these proceedings seek substantial damages which may not be covered by insurance. These proceedings are costly to defend, may result in changes in our business practices, harm our brand and reputation and adversely affect our businesses and operating results.

PBM, retail pharmacy, mail order pharmacy, specialty pharmacy, LTC pharmacy and health care and related benefits are highly regulated industries whose participants frequently are subject to litigation and other adverse legal proceedings. We are currently subject to various litigation and arbitration matters, investigations, regulatory audits, inspections, government inquiries, and regulatory and other legal proceedings, both inside and outside the U.S. For example, outside the U.S., contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the U.S. Litigation related to our provision of professional services in our medical clinics, pharmacies and LTC operations is increasing as we expand our services along the continuum of health care.

Litigation, and particularly securities, derivative, collective or class action and *qui tam* litigation, is often expensive and disruptive. Many of the legal proceedings against us seek substantial damages (including non-economic or punitive damages and treble damages), and certain of these proceedings also seek changes in our business practices. While we currently have insurance coverage for some potential liabilities, other potential liabilities may not be covered by insurance, insurers may dispute coverage and/or the amount of our insurance may not be enough to cover the damages awarded or costs incurred. In addition, some types of damages, like punitive damages, may not be covered by insurance, and in some jurisdictions the coverage of punitive damages is prohibited. Insurance coverage for all or some forms of liability also may become unavailable or prohibitively expensive in the future.

The outcome of litigation and other adverse legal proceedings is always uncertain, and outcomes that are not justifiable by the evidence or existing law or regulation can and do occur, and the costs incurred frequently are substantial regardless of the outcome. Litigation and other adverse legal proceedings could materially adversely affect our businesses, operating results and/or cash flows because of brand and reputational harm to us caused by such proceedings, the cost of defending such proceedings, the cost of settlement or judgments against us, or the changes in our operations that could result from such proceedings. See Item 3 of this 10-K for additional information.

We frequently are subject to regular and special governmental audits, investigations and reviews that could result in changes to our business practices and also could result in material refunds, fines, penalties, civil liabilities, criminal liabilities and other sanctions.

As one of the largest national retail, mail order, specialty and LTC pharmacy, PBM and health care and related benefits providers, we frequently are subject to regular and special governmental market conduct and other audits, investigations and reviews by, and we receive subpoenas and other requests for information from, various federal and state agencies, regulatory authorities, Attorneys General, committees, subcommittees and members of the U.S. Congress and other state, federal and international governmental authorities. For example, we have received CIDs from, and provided documents and information to, the Civil Division of the DOJ in connection with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. CMS and the OIG also are auditing the risk adjustment-related data of certain of our Medicare Advantage plans, and the number of such audits continues to increase. Several such audits, investigations and reviews by governmental authorities currently are pending, some of which may be resolved in 2023, the results of which may be adverse to us.

Federal and state governments have made investigating and prosecuting health care and other insurance fraud, waste and abuse a priority. Fraud, waste and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical and/or other covered services, improper marketing and violations of patient privacy rights. The regulations and contractual requirements applicable to us and other industry participants are complex and subject to change, making it necessary for us to invest significant resources in complying with our regulatory and contractual requirements. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that our compliance efforts in this area will continue to require significant resources. In addition, our medical costs and the medical expenses of our Health Care Benefits ASC customers may be adversely affected if we do not prevent or detect fraudulent activity by providers and/or members.

Regular and special governmental audits, investigations and reviews by federal, state and international regulators could result in changes to our business practices, and also could result in significant or material premium refunds, fines, penalties, civil liabilities, criminal liabilities or other sanctions, including suspension or exclusion from participation in government programs and suspension or loss of licensure. Any of these audits, investigations or reviews could have a material adverse effect on our businesses, operating results, cash flows and/or financial condition or result in significant liabilities and negative publicity for us.

See “Legal and Regulatory Proceedings” in Note 16 ‘‘Commitments and Contingencies’’ included in Item 8 of this 10-K for additional information.

Our litigation and regulatory risk profile are changing as we offer new products and services and expand in business areas beyond our historical core businesses of Health Care Benefits, Pharmacy Services and Retail/LTC.

Historically, we focused primarily on providing Health Care Benefits, Pharmacy Services and Retail/LTC products and services. As a result of our transformation program and other innovation initiatives, we are expanding our presence in the health care space and plan to offer new products and services which present a different litigation and regulatory risk profile than the products and services that we historically have offered.

The increased volume of business in areas beyond our historical core businesses and new products and services subject us to litigation and regulatory risks that are different from the risks of providing Health Care Benefits, Pharmacy Services and Retail/LTC products and services and increase significantly our exposure to other risks.

We face unique regulatory and other challenges in our Medicare and Medicaid businesses.

We are seeking to substantially grow the Medicare and Medicaid membership in our Health Care Benefits segment in 2023 and over the next several years. We face unique regulatory and other challenges that may inhibit the growth and profitability of those businesses.

- In April 2022, CMS issued its final notice detailing final 2023 Medicare Advantage payment rates. Final 2023 Medicare Advantage rates resulted in an expected average increase in revenue for the Medicare Advantage industry of 5.00%, excluding the CMS estimate of Medicare Advantage risk score trend. On February 1, 2023, CMS issued an advance notice detailing proposed 2024 Medicare Advantage payment rates. The 2024 Medicare Advantage rates, if finalized as proposed, will result in an expected average decrease in revenue for the Medicare Advantage industry of 2.27%, excluding the CMS estimate of Medicare Advantage risk score trend, though the rates may vary widely depending on the provider group and patient demographics. CMS intends to publish the final 2024 rate announcement no later than April 3, 2023. The Company faces a challenge from the impact of the increasing cost of medical care (including prescription medications), changes to methodologies for determining payments and CMS local and national coverage decisions that require the Company to pay for services and supplies that are not factored into the Company's bids. We cannot predict how the rates will be finalized, future Medicare funding levels, the impact of future federal budget actions or ensure that such changes or actions will not have a material adverse effect on our Medicare operating results.
- The organic expansion of our Medicare Advantage and Medicare Part D service area is subject to the ability of CMS to process our requests for service area expansions and our ability to build cost competitive provider networks in the expanded service areas that meet applicable network adequacy requirements. CMS' decisions on our requests for service area expansions also may be affected adversely by compliance issues that arise each year in our Medicare operations.
- CMS regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of the services we provide to our Medicare members, and state regulators are increasingly conducting audits to assess the quality of services we provide to our Medicaid members. As a result of these audits, we may be subject to significant or material retroactive adjustments to and/or withholding of certain premiums and fees, fines, criminal liability, civil monetary penalties, CMS- or state-imposed sanctions (including suspension or exclusion from participation in government programs) or other restrictions on our Medicare, Medicaid and other businesses, including suspension or loss of licensure.
- "Star ratings" from CMS for our Medicare Advantage plans will continue to have a significant effect on our plans' operating results. Only Medicare Advantage plans with a star rating of 4 or higher (out of 5) are eligible for a quality bonus in their basic premium rates. CMS continues to change its rating system to make achieving and maintaining a four or higher star rating more difficult. Our star ratings and past performance scores are adversely affected by any compliance issues that may have arisen each year in our Medicare operations. CMS released the Company's 2023 star ratings in October 2022. The Company's 2023 star ratings will be used to determine which of its Medicare Advantage plans have ratings of 4 stars or higher and qualify for bonus payments in 2024. Based on the 2023 star ratings, the percentage of the Company's Medicare Advantage members in 4 stars or higher plans is expected to drop to 21% (based on enrollment and contract affiliation at December 31, 2022), as compared to 87% based on the 2022 star ratings. The main driver of this decrease was a 1 star decrease in the Company's Aetna National PPO, which dropped from 4.5 to 3.5 stars, while many other of the Company's plans remain rated at 4 stars or higher. The decrease in the star rating for the Aetna National PPO will mean that it will no longer be eligible for CMS' quality bonus payments related to 2024. A lower star rating may also negatively impact new enrollment in the Aetna National PPO as consumers seek out plans that have four star or higher ratings. There can be no assurances that the Company will be successful in maintaining or improving its star ratings in future years. If our star ratings fall or remain below four for a significant portion of our Medicare Advantage membership, or do not match the performance of our competitors, or the star rating quality bonuses are reduced or eliminated, our revenues, operating results and cash flows may be significantly adversely affected.
- Payments we receive from CMS for our Medicare Advantage and Medicare Part D businesses also are subject to risk adjustment based on the health status of the individuals we enroll. Elements of that risk adjustment mechanism continue to be challenged by the DOJ, the OIG and CMS itself. Substantial changes in the risk adjustment mechanism, including those that may result from the RADV Audit Rule or other changes that result from enforcement or audit actions, could materially affect the amount of our Medicare reimbursement, require us to raise prices or reduce the benefits we offer to Medicare beneficiaries, and potentially limit our (and the industry's) participation in the Medicare program.

- The RADV Audit Rule creates uncertainty for Medicare Advantage plans. The lack of detail provided with respect to how CMS will select contracts and claims to audit and how it will extrapolate as part of the RADV Audit Rule may impact future Medicare Advantage bids and result in other implications.
- Changes to the ability of PBMs to have pharmacy performance programs in place for clients and report payments via direct and indirect reporting mechanisms, including requiring all pharmacy payments to be included in point-of-sale pricing, could impact the Pharmacy Services business.
- Medicare Part D has resulted in increased utilization of prescription medications and puts pressure on our pharmacy gross margin rates due to regulatory and competitive pressures. Further, as a result of the ACA and changes to the retiree drug subsidy rules, clients of our PBM business could decide to discontinue providing prescription drug benefits to their Medicare-eligible members. To the extent this phenomenon occurs, the adverse effects of increasing customer migration into Medicare Part D may outweigh the benefits we realize from growth of our Medicare Part D products.
- Our Medicare Part D operating results and our ability to expand our Medicare Part D business could be adversely affected if: the cost and complexity of Medicare Part D exceed management's expectations or prevent effective program implementation or administration; further changes to the regulations regarding how drug costs are reported for Medicare Part D are implemented in a manner that adversely affects the profitability of our Medicare Part D business; changes to the regulations regarding how drug costs are reported for Medicare Part D are implemented in a manner that adversely affects the profitability of our Medicare Part D business; changes to the applicable regulations impact our ability to retain fees from third parties including network pharmacies; the government alters Medicare Part D program requirements or reduces funding because of the higher-than-anticipated cost to taxpayers of Medicare Part D or for other reasons; the government mandated use of point-of-sale manufacturer's rebates continues; the government enacts price controls on certain pharmaceutical products in Medicare Part D; the government makes changes to how pharmacy pay-for-performance is calculated; the government mandates CMS negotiation with manufacturers for certain drugs; or reinsurance thresholds are reduced below their current levels, which is currently scheduled to begin in 2025.
- We have experienced challenges in obtaining complete and accurate encounter data for our Medicaid products due to difficulties with providers and third-party vendors submitting claims in a timely fashion in the proper format, and with state agencies in coordinating such submissions. As states increase their reliance on encounter data, these difficulties could affect the Medicaid premium rates we receive and how Medicaid membership is assigned to us, which could have a material adverse effect on our Medicaid operating results and cash flows and/or our ability to bid for, and continue to participate in, certain Medicaid programs.
- If we fail to report and correct errors discovered through our own auditing procedures or during a CMS audit or otherwise fail to comply with the applicable laws and regulations, we could be subject to fines, civil monetary penalties or other sanctions, including fines and penalties under the False Claims Act, which could have a material adverse effect on our ability to participate in Medicare Advantage, Medicare Part D or other government programs, and on our operating results, cash flows and financial condition.
- The resumption of Medicaid eligibility redeterminations after being suspended during the COVID-19 pandemic could negatively impact the number of members eligible for the Company's Medicaid plans.
- Certain of our Medicaid contracts require the submission of complete and correct encounter data. The accurate and timely reporting of encounter data is increasingly important to the success of our Medicaid programs because more states are using encounter data to determine compliance with performance standards and, in part, to set premium rates. We have expended and may continue to expend additional effort and incur significant additional costs to collect accurate, or to correct inaccurate or incomplete, encounter data and have been and could be exposed to premium withholding, operating sanctions and financial fines and penalties for noncompliance. We have experienced challenges in obtaining complete and accurate encounter data due to difficulties with providers and third-party vendors submitting claims in a timely fashion in the proper format, and with state agencies in coordinating such submissions. As states increase their reliance on encounter data, and some states mandate that certain amounts be included or excluded from encounter data, these difficulties could affect the Medicaid premium rates we receive and how Medicaid membership is assigned to us, which could have a material adverse effect on our Medicaid operating results and cash flows and/or our ability to successfully bid for, and continue to participate in, certain Medicaid programs.

Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues, and we expect that percentage to increase.

Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues, and we expect that percentage to increase. As our government funded businesses grow, our exposure to changes in federal and state government policy with respect to and/or regulation of the various government funded programs in which we participate also increases.

The laws and regulations governing participation in Public Exchange, Medicare Advantage (including dual eligible special needs plans), Medicare Part D, Medicaid, and managed Medicaid plans are complex, are subject to interpretation and can expose us to penalties for non-compliance. Federal, state and local governments have the right to cancel or not to renew their contracts with us on short notice without cause or if funds are not available. Funding for these programs is dependent on many factors outside our control, including general economic conditions, continuing government efforts to contain health care costs and budgetary constraints at the federal or applicable state or local level and general political issues and priorities.

The U.S. federal government and our other government customers also may reduce funding for health care or other programs, cancel or decline to renew contracts with us, or make changes that adversely affect the number of persons eligible for certain programs, the services provided to enrollees in such programs, our premiums and our administrative and health care and other benefit costs, any of which could have a material adverse effect on our businesses, operating results and cash flows. When federal funding is delayed, suspended or curtailed, we continue to receive, and we remain liable for and are required to fund, claims from providers for providing services to beneficiaries of federally funded health benefits programs in which we participate. An extended federal government shutdown or a delay by Congress in raising the federal government's debt ceiling also could lead to a delay, reduction, suspension or cancellation of federal government spending and a significant increase in interest rates that could, in turn, have a material adverse effect on the value of our investment portfolio, our ability to access the capital markets and our businesses, operating results, cash flows and liquidity.

Possible changes in industry pricing benchmarks and drug pricing generally can adversely affect our PBM and Retail/LTC businesses.

It is possible that the pharmaceutical industry, regulators, or federal policymakers may evaluate and/or develop an alternative pricing reference to replace AWP or WAC, which are the pricing references used for many of our PBM and LTC client contracts, drug purchase agreements, retail network contracts, specialty payor agreements and other contracts with third party payors in connection with the reimbursement of drug payments. In addition, many state Medicaid fee-for-service programs have established pharmacy network payments on the basis of Actual Acquisition Cost ("AAC"). The use of an AAC basis in fee for service Medicaid could have an impact on reimbursement practices in Health Care Benefits' Commercial and other Government products. It is also possible that Congress may enact some limited form of price negotiation for Medicare. In addition, CMS also publishes the National Average Drug Acquisition Cost ("NADAC") for certain drugs; NADAC pricing is being adopted in an increasing number of states.

Future changes to the use of AWP, WAC or to other published pricing benchmarks used to establish drug pricing, including changes in the basis for calculating reimbursement by federal and state health care programs and/or other payors, could impact the reimbursement we receive from Medicare and Medicaid programs, the reimbursement we receive from our PBM clients and other payors and/or our ability to negotiate rebates and/or discounts with drug manufacturers, wholesalers, PBMs and retail pharmacies. A failure or inability to fully offset any increased prices or costs or to modify our operations to mitigate the impact of such increases could have a material adverse effect on our operating results. Additionally, any future changes in drug prices could be significantly different than our projections. We cannot predict the effect of these possible changes on our businesses.

We may not be able to obtain adequate premium rate increases in our Insured Health Care Benefits products, which would have an adverse effect on our revenues, MBRs and operating results and could magnify the adverse impact of increases in health care and other benefit costs and of ACA assessments, fees and taxes.

Premium rates for our Insured Health Care Benefits products often must be filed with state insurance regulators and are subject to their approval, which creates risk for us in the current political and regulatory environment. The ACA generally requires a review by HHS in conjunction with state regulators of premium rate increases that exceed a federally specified threshold (or lower state-specific thresholds set by states determined by HHS to have adequate processes). Rate reviews can magnify the adverse impact on our operating margins, MBRs and operating results of increases in health care and other benefit costs, increased utilization of covered services, and ACA assessments, fees and taxes, by restricting our ability to reflect these increases and/or these assessments, fees and taxes in our pricing. Further, our ability to reflect ACA assessments, fees and taxes in our Medicare, Medicaid and CHIP premium rates is limited.

Since 2013, HHS has issued determinations to health plans that their premium rate increases were "unreasonable," and we continue to experience challenges to appropriate premium rate increases in certain states. Regulators or legislatures in several states have implemented or are considering limits on premium rate increases, either by enforcing existing legal requirements more stringently or proposing different regulatory standards. Regulators or legislatures in several states also have conducted hearings on proposed premium rate increases, which can result, and in some instances have resulted, in substantial delays in

implementing proposed rate increases even if they ultimately are approved. Our plans can be excluded from participating in small group Public Exchanges if they are deemed to have a history of "unreasonable" rate increases. Any significant rate increases we may request heighten the risks of adverse publicity, adverse regulatory action and adverse selection and the likelihood that our requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.

We anticipate continued regulatory and legislative action to increase regulation of premium rates in our Insured Health Care Benefits products. We may not be able to obtain rates that are actuarially justified or that are sufficient to make our policies profitable in one or more product lines or geographies. If we are unable to obtain adequate premium rates and/or premium rate increases, it could materially and adversely affect our operating margins and MBRs and our ability to earn adequate returns on Insured Health Care Benefits products in one or more states or cause us to withdraw from certain geographies and/or products.

Minimum MLR rebate requirements limit the level of margin we can earn in our Insured Health Care Benefits products while leaving us exposed to higher than expected medical costs. Challenges to our minimum MLR rebate methodology and/or reports could adversely affect our operating results.

The ACA's minimum MLR rebate requirements limit the level of margin we can earn in Health Care Benefits' Commercial Insured and Medicare Insured businesses. CMS minimum MLR rebate regulations limit the level of margin we can earn in our Medicaid Insured business. Certain portions of our Health Care Benefits Medicaid and FEHB program business also are subject to minimum MLR rebate requirements in addition to but separate from those imposed by the ACA. Minimum MLR rebate requirements leave us exposed to medical costs that are higher than those reflected in our pricing. The process supporting the management and determination of the amount of MLR rebates payable is complex and requires judgment, and the minimum MLR reporting requirements are detailed. CMS has also proposed, but not yet finalized, a definition of "prescription drug price concessions" for commercial MLR calculation purposes, which would make additional PBM information available to plans and the HHS, potentially further complicating the MLR calculation process. Federal and state auditors are challenging our Commercial Health Care Benefits business' compliance with the ACA's minimum MLR requirements as well as our FEHB plans' compliance with OPM's FEHB program-specific minimum MLR requirements. Our Medicare and Medicaid contracts also are subject to minimum MLR audits. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS. Additional challenges to our methodology and/or reports relating to minimum MLR and related rebates by federal and state regulators and private litigants are reasonably possible. The outcome of these audits and additional challenges could adversely affect our operating results.

Our operating results may be adversely affected by changes in laws and policies governing employers and by union organizing activity.

Congress and certain state legislatures continue to consider and pass legislation that increases our costs of doing business, including increased minimum wages and requiring employers to provide paid sick leave or paid family leave. In addition, our employee-related operating costs may be increased by union organizing activity and it is possible that the National Labor Relations Board may adopt regulatory changes through re-making or case law that could facilitate union organizing. If we are unable to reflect these increased expenses in our pricing or otherwise modify our operations to mitigate the effects of such increases, our operating results will be adversely affected.

We face international political, legal and compliance, operational, regulatory, economic and other risks that may be more significant than in our domestic operations.

Our international operations present political, legal, compliance, operational, regulatory, economic and other risks that we do not face or that are more significant than in our domestic operations. These risks vary widely by country and include varying regional and geopolitical business conditions and demands, government intervention and censorship, discriminatory regulation, climate change regulation, nationalization or expropriation of assets and pricing constraints. Our international products need to meet country-specific customer and member preferences as well as country-specific legal requirements, including those related to licensing, data privacy, data storage and data protection.

Our international operations increase our exposure to, and require us to devote significant management resources to implement controls and systems to comply with, the privacy and data protection laws of non-U.S. jurisdictions, such as the EU's GDPR, and the anti-bribery, anti-corruption and anti-money laundering laws of the United States (including the FCPA) and the United Kingdom (including the UK Bribery Act) and similar laws in other jurisdictions. Implementing our compliance policies, internal controls and other systems may also require the investment of considerable management time and financial and other

resources. Violations of these laws and regulations could result in fines, criminal sanctions against us, our officers or employees, restrictions or outright prohibitions on the conduct of our business, and significant brand and reputational harm. We must regularly reassess the size, capability and location of our global infrastructure and make appropriate changes, and must have effective change management processes and internal controls in place to address changes in our businesses and operations. Our success depends, in part, on our ability to anticipate these risks and manage these difficulties, and the failure to do so could have a material adverse effect on our brand, reputation, businesses, operating results and/or financial condition.

Our international operations require us to overcome logistical and other challenges based on differing languages, cultures, legal and regulatory schemes and time zones. Our international operations encounter labor laws, standards and customs that can be difficult and make employee relationships less flexible than in our domestic operations and expensive to modify or terminate. In some countries we are required to, or choose to, operate with local business associates, which requires us to manage our relationships with these third parties and may reduce our operational flexibility and ability to quickly respond to business challenges.

In some countries we may be exposed to currency exchange controls or other restrictions that prevent us from transferring funds internationally or converting local currencies into U.S. dollars or other currencies. Fluctuations in foreign currency exchange rates may adversely affect our revenues, operating results and cash flows from our international operations. Some of our operations are, and are increasingly likely to be, in emerging markets where these risks are heightened. Any measures we may implement to reduce the effect of volatile currencies and other risks on our international operations may not be effective.

Risks Associated with Mergers, Acquisitions, and Divestitures

We may be unable to successfully integrate companies we acquire.

Upon the closing of any acquisition, including the proposed acquisition of Oak Street Health and pending acquisition of Signify Health, we will need to successfully integrate the products, services and related assets, as well as internal controls into our business operations. If an acquisition is consummated, the integration of the acquired business, its products, services and related assets into our company also may be complex, expensive, and time-consuming and, if the integration is not fully successful, we may not achieve the anticipated benefits, operating and cost synergies and/or growth opportunities of an acquisition. Potential difficulties that may be encountered in the integration process, including with respect to Oak Street Health and Signify Health, include the following:

- Integrating personnel, operations and systems (including internal control environments and compliance policies), while maintaining focus on producing and delivering consistent, high quality products and services;
- Coordinating geographically dispersed organizations;
- Disrupting management’s attention from our ongoing business operations;
- Retaining existing customers and attracting new customers;
- Managing inefficiencies associated with integrating our operations; and
- Reconciling post-acquisition costs and liabilities between buyer and seller.

An inability to realize the full extent of the anticipated benefits, operating and cost synergies, innovations and operations efficiencies or growth opportunities of an acquisition, including the proposed acquisition of Oak Street Health and pending acquisition of Signify Health, as well as any delays or additional expenses encountered in the integration process, could have a material adverse effect on our businesses and operating results. Furthermore, acquisitions, including the proposed acquisition of Oak Street Health and pending acquisition of Signify Health, even if successfully integrated, may fail to further our business strategy as anticipated, expose us to increased competition or challenges with respect to our products, services or service areas, and expose us to additional liabilities associated with an acquired business including risks and liabilities associated with litigation involving the acquired business. Any one of these challenges or risks could impair our ability to realize any benefit from our acquisitions after we have expended resources on them.

We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities, as well as strategic divestitures, which may be unsuccessful, cause us to assume unanticipated liabilities, disrupt our existing businesses, be dilutive or lead us to assume significant debt, among other things.

We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities as part of our growth strategy. In addition to the integration risks noted above, some other risks we may face with respect to

acquisitions, including the proposed acquisition of Oak Street Health and pending acquisition of Signify Health, and other inorganic growth strategies include:

- we may not be able to obtain the required regulatory approval for an acquisition in a timely manner, if at all;
- we frequently compete with other firms, some of which may have greater financial and other resources and a greater tolerance for risk, to acquire attractive companies;
- the acquired, alliance and/or joint venture businesses may not perform as projected;
- the goodwill or other intangible assets established as a result of our acquisitions may be incorrectly valued or may become impaired;
- we may assume unanticipated liabilities, including those that were not disclosed to us or which we underestimated;
- the acquired businesses, or the pursuit of other inorganic growth strategies, could disrupt or compete with our existing businesses, distract management, result in the loss of key employees, business partners, suppliers and customers, divert resources, result in tax costs or inefficiencies and make it difficult to maintain our current business standards, controls, information technology systems, policies, procedures and performance;
- we may finance future acquisitions and other inorganic growth strategies by issuing common stock for some or all of the purchase price, which would dilute the ownership interests of our stockholders;
- we may incur significant debt in connection with acquisitions (whether to finance acquisitions or by assuming debt from the businesses we acquire);
- a proposed or pending transaction may have a negative effect on the Company's credit ratings;
- we may not have the expertise to manage and profitably grow the businesses we acquire, and we may need to rely on the retention of key personnel and other suppliers of businesses we acquire, which may be difficult or impossible to accomplish;
- we may enter into merger or purchase agreements but, due to reasons within or outside our control, fail to complete the related transactions, which could result in termination fees or other penalties that could be material, cause material disruptions to our businesses and operations and adversely affect our brand, reputation, or stock price; for example, if the proposed acquisition of Oak Street Health terminates under certain specified circumstances and the receipt of regulatory approval has not been obtained by such time, the Company will be required to pay Oak Street Health a termination fee of approximately $500 million and if the pending acquisition of Signify Health terminates under certain specified circumstances and the receipt of regulatory approval has not been obtained by such time, the Company will be required to pay Signify Health a termination fee in an amount equal to $380 million;
- in order to complete an acquisition, we may be required to divest certain portions of our business, for which we may not be able to obtain favorable pricing;
- we may be involved in litigation related to mergers or acquisitions, including for matters that occurred prior to the applicable closing, which may be costly to defend and may result in adverse rulings against us that could be material;
- announcements related to an acquisition could have an adverse effect on the market price of the Company's common stock and other securities; and
- the integration into our businesses of the businesses and entities we acquire may affect the way in which existing laws and regulations apply to us, including subjecting us to laws and regulations that did not previously apply to us.

Similarly, we may also seek to divest assets that no longer fit into our long-term strategic plan. Such divestitures may take time and, even if such divestitures can be completed, they may have negative short-term financial impacts or may result in regulatory and financial exposure to businesses we have sold. In addition, joint ventures present risks that are different from acquisitions, including selection of appropriate joint venture parties, initial and ongoing governance of the joint venture, joint venture compliance activities (including compliance with applicable CMS requirements), growing the joint venture's business in a manner acceptable to all the parties, including other providers in the networks that include joint ventures, maintaining positive relationships among the joint venture parties and the joint venture's customers, and member and business disruption that may occur upon joint venture termination.

Risks Related to Our Operations

Failure to meet customer expectations may harm our brand and reputation, our ability to retain and grow our customer base and membership and our operating results and cash flows.

Our ability to attract and retain customers and members is dependent upon providing cost effective, quality customer service operations (such as call center operations, PBM functions, retail pharmacy and LTC services, retail, mail order and specialty

pharmacy prescription delivery, claims processing, customer case installation and online access and tools) that meet or exceed our customers' and members' expectations, either directly or through vendors. As we seek to reduce general and administrative expenses, we must balance the potential impact of cost-saving measures on our customers and other services and performances. If we misjudge the effects of such measures, customers and other services may be adversely affected. We depend on third parties for certain of our customer service, PBM and prescription delivery operations. If we or our vendors fail to provide service that meets our customers' and members' expectations, we may have difficulty retaining or profitably growing our customer base and/or membership, which could adversely affect our operating results. For example, noncompliance with any privacy or security laws or regulations or any security breach involving us or one of our third-party vendors could have a material adverse effect on our businesses, operating results, brand and reputation.

We and our vendors have experienced and continue to experience cyber attacks. We can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of such attacks or other information security (including cybersecurity) risks or threats in the future.

We and our vendors have experienced diverse cyber attacks and expect to continue to experience cyber attacks going forward. As examples, the Company and its vendors have experienced attempts to gain access to systems, denial of service attacks, attempted malware infections, account takeovers, scanning activity, and phishing emails. Attacks can originate from external sources (including criminals, terrorists, nation states, or internal actors). The Company is dedicating and will continue to dedicate significant resources and incur significant expenses to maintain and update on an ongoing basis the systems and processes that are designed to mitigate the information security risks it faces and protect the security of its computer systems, software, networks and other technology assets against attempts by unauthorized parties to obtain access to confidential information, disrupt or degrade service, or cause other damage. The impact of known cyber attacks has not been material to the Company's operations or operating results through December 31, 2022. The Board and its Audit Committee and Nominating and Corporate Governance Committee are regularly informed regarding the Company's information security policies, practices and status.

A compromise of our information security controls or of those businesses with whom we interact, which results in confidential information being accessed, obtained, damaged, or used by unauthorized or improper persons, could harm our reputation and expose us to regulatory actions and claims from customers and clients, financial institutions, payment card associations and other persons, any of which could adversely affect our businesses, operating results and financial condition. Because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and may not immediately produce signs of intrusion, we may be unable to anticipate these techniques or to implement adequate preventative measures. Moreover, a data security breach could require that we expend significant resources related to our information systems and infrastructure, and could distract management and other key personnel from performing their primary operational duties. We also could be adversely affected by any significant disruption in the systems of third parties we interact with, including key payors and vendors.

The costs of attempting to protect against the foregoing risks and the costs of responding to an information security incident are significant. Large scale data breaches at other entities increase the challenge we and our vendors face in maintaining the security of our information technology systems and proprietary information and of our customers', employees', members' and other constituents' sensitive information. Following an information security incident, our and/or our vendors' remediation efforts may not be successful, and could result in interruptions, delays or cessation of service, and loss of existing or potential customers and members. In addition, breaches of our and/or our vendors' security measures and the unauthorized access to or dissemination of sensitive personal information or proprietary information or confidential information about us, our customers, our members or other third-parties, could expose our customers', members' and other constituents' private information and our customers, members and other constituents to the risk of financial or medical identity theft, or expose us or other third parties to a risk of loss or misuse of this information, and result in investigations, regulatory enforcement actions, material fines and penalties, loss of customers, litigation or other actions which could have a material adverse effect on our brand, reputation, businesses, operating results and cash flows.

Data governance failures can adversely affect our reputation, businesses and prospects. Our use and disclosure of members', customers' and other constituents' sensitive information is subject to complex regulations at multiple levels. We would be adversely affected if we or our business associates or other vendors fail to adequately protect members', customers' or other constituents' sensitive information.

Our information systems are critical to the operation of our businesses. We collect, process, maintain, retain, evaluate, utilize and distribute large amounts of personally identifiable, personal health, and financial information (including payment card information) and other confidential and sensitive data about our customers, employees, members and other constituents in the

ordinary course of our businesses. Some of our information systems rely upon third party systems, including cloud service providers, to accomplish these tasks. The use and disclosure of such information is regulated at the federal, state and international levels, including, for example, the California Consumer Privacy Act which went into effect January 1, 2020, the EU's GDPR which began to apply across the EU during 2018 and the audit program implemented by HHS under HIPAA. In some cases, such laws, rules and regulations also apply to our vendors and/or may hold us liable for any violations by our vendors. These laws, rules and regulations are subject to change (and many are rapidly evolving) and in recent years have given rise to increased enforcement activity, litigation, and other disputes. International laws, rules and regulations governing the use and disclosure of these types of information are generally more stringent than U.S. laws and regulations, and they vary from jurisdiction to jurisdiction. Noncompliance with applicable privacy or security laws or regulations, or any security breach, information security incident, and any other incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, sensitive or confidential customer, member or other constituent information, whether by us, by one of our business associates or vendors or by another third party, could require us to expend significant resources to remediate any damage, could interrupt our operations and could adversely affect our brand and reputation, membership and operating results and also could expose and/or has exposed us to mandatory disclosure requirements, adverse media attention, litigation (including class action litigation), governmental investigations and enforcement proceedings, material fines, penalties and/or remediation costs, and compensatory, special, punitive and statutory damages, consent orders, adverse actions against our licenses to do business and/or injunctive relief, any of which could adversely affect our businesses, operating results, cash flows or financial condition.

Our businesses depend on our customers', members' and other constituents' willingness to entrust us with their health related and other sensitive personal information. Events that adversely affect that trust, including inadequate disclosure to our members or customers of our uses of their information, failing to keep our information technology systems and our customers', members' and other constituents' sensitive information secure from significant attack, theft, damage, loss or unauthorized disclosure or access, whether as a result of our action or inaction (including human error) or that of our business associates, vendors or other third parties, could adversely affect our brand and reputation, membership and operating results and also could expose and/or has exposed us to mandatory disclosure to the media, litigation (including class action litigation), governmental investigations and enforcement proceedings, material fines, penalties and/or remediation costs, and compensatory, special, punitive and statutory damages, consent orders, adverse actions against our licenses to do business and/or injunctive relief, any of which could adversely affect our businesses, operating results, cash flows or financial condition. There can be no assurance that awe have or will be able to adequately prevent, detect, and/or remediate such data security incidents.

Product liability, product recall or personal injury issues could damage our reputation and have a significant adverse effect on our businesses, operating results, cash flows and/or financial condition.

The products that we sell could become subject to contamination, product tampering, mislabeling, recall or other damage. In addition, errors in the dispensing, packaging or administration of drugs or other products and consuming drugs in a manner that is not prescribed could lead to serious injury or death. Product liability or personal injury claims may be asserted against us with respect to any of the drugs or other products we sell or services we provide. For example, we are a defendant in hundreds of litigation proceedings relating to opioids and the sale of products containing talc. Our businesses involve the provision of professional services, including by pharmacists, physician assistants, nurses and nurse practitioners, which exposes us to professional liability claims. Should a product or other liability issue arise, the coverage available under our insurance programs and the indemnification amounts available to us from third parties may not be adequate to protect us against the financial impact of the related claims. We also may not be able to maintain our existing levels of insurance on acceptable terms in the future. A product liability or personal injury issue or judgment against us or a product recall, tampering, or mislabeling could damage our reputation and have a significant adverse effect on our businesses, operating results and/or financial condition.

We face significant competition in attracting and retaining talented employees. Further, managing succession for, and retention of, key executives is critical to our success, and our failure to do so could adversely affect our businesses, operating results and/or future performance.

Our ability to attract and retain qualified and experienced employees is essential to meet our current and future goals and objectives. There is no guarantee we will be able to attract and retain such employees or that competition among potential employers will not result in increased compensation and/or benefits costs. If we are unable to retain existing employees or attract additional employees, or we experience an unexpected loss of leadership, we could experience a material adverse effect on our businesses, operating results and/or future performance.

In addition, our failure to adequately plan for succession of senior management and other key management roles or the failure of key employees to successfully transition into new roles could have a material adverse effect on our businesses, operating

results and/or future performance. The succession plans we have in place and our employment arrangements with certain key executives do not guarantee the services of these executives will continue to be available to us.

Sales of our products and services are dependent on our ability to attract and motivate internal sales personnel and independent third-party brokers, consultants and agents. New distribution channels create new disintermediation risk. We may be subject to penalties or other regulatory actions as a result of the marketing practices of brokers and agents selling our products.

Our products are sold primarily through our sales personnel, who frequently work with independent brokers, consultants and agents who assist in the production and servicing of business. The independent brokers, consultants and agents generally are not dedicated to us exclusively and may frequently recommend and/or market health care benefits products of our competitors. Accordingly, we must compete intensely for their services and allegiance. Our sales could be adversely affected if we are unable to attract, retain or motivate sales personnel and third-party brokers, consultants and agents, or if we do not adequately provide support, training and education to this sales network regarding our complex product portfolio, or if our sales strategy is not appropriately aligned across distribution channels. This risk is heightened as we develop, operate and expand our consumer-oriented products and services and we expand in the health care space and our business model evolves to include a greater focus on consumers and direct-to-consumer sales, such as competing for sales on Insurance Exchanges.

New distribution channels for our products and services continue to emerge, including Private Exchanges operated by health care consultants and technology companies. These channels may make it more difficult for us to directly engage consumers and other customers in the selection and management of their health care benefits, in health care utilization and in the effective navigation of the health care system. We also may be challenged by new technologies and marketplace entrants that could interfere with our existing relationships with customers and health plan members in these areas.

In addition, there have been several investigations regarding the marketing practices of brokers and agents selling health care and other insurance products and the payments they receive. These investigations have resulted in enforcement actions against companies in our industry and brokers and agents marketing and selling those companies' products. For example, CMS and state departments of insurance have increased their scrutiny of the marketing practices of brokers and agents who market Medicare products. These investigations and enforcement actions could result in penalties and the imposition of corrective action plans and/or changes to industry practices, which could adversely affect our ability to market our products.

Failure of our businesses to effectively collaborate could prevent us from maximizing our operating results.

To maximize our overall enterprise value, our various businesses need to collaborate effectively. Our businesses need to be aligned in order to prioritize goals and coordinate the design of new products intended to utilize the offerings of multiple businesses, including our transformation and enterprise modernization programs. In addition, misaligned incentives, information siloes, ineffective product development and failure of our corporate governance policies or procedures, for example significant financial decisions being made at an inappropriate level in our organization, also could prevent us from maximizing our operating results and/or achieving our financial and other projections.

The failure or disruption of our information technology systems or the failure of our information technology infrastructure to support our businesses could adversely affect our reputation, businesses, operating results and cash flows.

Our information systems are subject to damage or interruption from power outages, facility damage, computer and telecommunications failures, computer viruses, security breaches (including credit card or personally identifiable information breaches), cyber attacks, vandalism, catastrophic events and human error. If our information systems are damaged, fail to work properly or otherwise become unavailable, we may incur substantial costs to repair or replace them, and may experience reputational damage, loss of critical information, customer disruption and interruptions or delays in our ability to perform essential functions and implement new and innovative services. We use third-party vendors to set-up, service, and/or maintain portions of our information technology systems, and our vendors may suffer the same types of issues, which could adversely affect our ability to access and use such systems and the data contained therein, which could result in similar harm. In addition, our efforts to comply with changes in U.S. and foreign laws and regulations, including privacy and information security laws and standards, may cause us to incur significant expense due to increased investment in technology and the development of new operational processes.

Our business success and operating results depend in part on effective information technology systems and on continuing to develop and implement improvements in technology. Pursuing multiple initiatives simultaneously could make this continued development and implementation significantly more challenging.

Many aspects of our operations are dependent on our information systems and the information collected, processed, stored, and handled by these systems. We rely heavily on our computer systems to manage our ordering, pricing, point-of-sale, pharmacy fulfillment, inventory replenishment, claims processing, customer loyalty and subscription programs, finance, human resources, and other processes. Throughout our operations, we collect, process, maintain, retain, evaluate, utilize and distribute large amounts of confidential and sensitive data and information, including personally identifiable information and protected health information, that our customers, employees, members and other constituents provide to purchase products or services, enroll in programs or services, register on our websites, interact with our personnel, or otherwise communicate with us. For these operations, we depend in part on the secure transmission of confidential information over public networks.

We have many different information and other technology systems supporting our businesses (including as a result of our acquisitions). Our businesses depend in large part on these systems to adequately price our products and services; accurately establish reserves, process claims and report operating results; and interact with providers, employer plan sponsors, customers, members, consumers and vendors in an efficient and uninterrupted fashion. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Certain of our technology systems (including software) are older, legacy systems that are less flexible, less efficient and require a significant ongoing commitment of capital and human resources to maintain, protect and enhance them and to integrate them with our other systems. We must re-engineer and reduce the number of these systems to meet changing consumer and vendor preferences and needs, improve our productivity and reduce our operating expenses. We also need to develop or acquire new technology systems, contract with new vendors or modify certain of our existing systems to support the consumer-oriented and transformation products and services we are developing, operating and expanding and/or to meet current and developing industry and regulatory standards, including to keep pace with continuing changes in information processing technology, emerging cybersecurity risks and threats, and changes to applicable privacy and security laws, rules and regulations. If we fail to achieve these objectives, our ability to profitably grow our business and/or our operating results may be adversely affected.

In addition, information technology and other technology and process improvement projects, including our transformation and enterprise modernization programs, frequently are long-term in nature and may take longer to complete and cost more than we expect and may not deliver the benefits we project once they are complete. If we do not effectively and efficiently secure, manage, integrate and enhance our technology portfolio (including vendor sourced systems), we could, among other things, have problems determining health care and other benefit cost estimates and/or establishing appropriate pricing, meeting the needs of customers, consumers, providers, members and vendors, developing and expanding our consumer-oriented products and services or keeping pace with industry and regulatory standards, and our operating results may be adversely affected.

We are subject to payment-related risks that could increase our operating costs, expose us to fraud or theft, subject us to potential liability and disrupt our business operations.

We accept payments using a variety of methods, including cash, checks, credit cards, debit cards, gift cards, mobile payments and potentially other technologies in the future. Acceptance of these payment methods subjects us to rules, regulations, contractual obligations and compliance requirements, including payment network rules and operating guidelines, data security standards and certification requirements, and rules governing electronic funds transfers. These requirements may change in the future, which could make compliance more difficult or costly. For certain payment options, including credit and debit cards, we pay interchange and other fees, which could increase periodically thereby raising our operating costs. We rely on third parties to provide payment processing services, including the processing of credit cards, debit cards, and various other forms of electronic payment. If these vendors are unable to provide these services to us, or if their systems are compromised, our operations could be disrupted. The payment methods that we offer also expose us to potential fraud and theft by persons seeking to obtain unauthorized access to, or exploit any weaknesses in, the payment systems we use. If we fail to abide by applicable rules or requirements, or if data relating to our payment systems is compromised due to a breach or misuse, we may be responsible for any costs incurred by payment card issuing banks and other third parties or subject to fines and higher transaction fees. In addition, our reputation and ability to accept certain types of payments could each be harmed resulting in reduced sales and adverse effects on our operating results.

Both our and our vendors' operations are subject to a variety of business continuity hazards and risks, any of which could interrupt our operations or otherwise adversely affect our performance and operating results.

We and our vendors are subject to business continuity hazards and other risks, including natural disasters, utility and other mechanical failures, acts of war or terrorism, acts of civil unrest, crime, disruption of communications, data security and preservation, disruption of supply or distribution, safety regulation and labor difficulties. The occurrence of any of these or

other events to us or our vendors might disrupt or shut down our operations or otherwise adversely affect our operations. We also may be subject to certain liability claims in the event of an injury or loss of life, or damage to property, resulting from such events. Although we have developed procedures for crisis management and disaster recovery and business continuity plans and maintain insurance policies that we believe are customary and adequate for our size and industry, our insurance policies include limits and exclusions and, as a result, our coverage may be insufficient to protect against all potential hazards and risks incident to our businesses. In addition, our crisis management and disaster recovery procedures and business continuity plans may not be effective. Should any such hazards or risks occur, or should our insurance coverage be inadequate or unavailable, our businesses, operating results, cash flows and financial condition could be adversely affected.

Financial Risks

We would be adversely affected if we do not effectively deploy our capital. Downgrades or potential downgrades in our credit ratings, should they occur, could adversely affect our brand and reputation, businesses, operating results, cash flows and financial condition.

Our operations generate significant capital, and we may from time to time raise additional capital, subject to market conditions. The manner in which we deploy our capital, including investments in our businesses, our operations (such as information technology and other strategic and capital projects), dividends, acquisitions, share and/or debt repurchases, repayment of debt, reinsurance or other capital uses, impacts our financial strength, claims paying ability and credit ratings issued by nationally-recognized statistical rating organizations. Credit ratings issued by nationally-recognized statistical rating organizations are broadly distributed and generally used throughout our industries. Our ratings reflect each rating organization's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to our insureds. We believe our credit ratings and the financial strength and claims paying ability of our principal insurance and HMO subsidiaries are important factors in marketing our Health Care Benefits products to certain of our customers.

Each of the ratings organizations reviews our ratings periodically, and there can be no assurance that our current ratings will be maintained in the future. Downgrades in our ratings could adversely affect our businesses, operating results, cash flows and financial condition.

Goodwill and other intangible assets could, in the future, become impaired.

As of December 31, 2022 and December 31, 2021, we had $102.9 billion and $108.1 billion, respectively, of goodwill and other intangible assets. Goodwill and indefinite-lived intangible assets are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that the carrying value may not be recoverable. When evaluating goodwill for potential impairment, we compare the fair value of our reporting units to their respective carrying amounts. We estimate the fair value of our reporting units using a combination of a discounted cash flow method and a market multiple method. If the carrying amount of a reporting unit exceeds its estimated fair value, a goodwill impairment loss is recognized in an amount equal to the excess to the extent of the goodwill balance. Indefinite-lived intangible assets are tested for impairment by comparing the estimated fair value of the asset to its carrying value. The Company estimates the fair value of its indefinite-lived trademarks using the relief from royalty method under the income approach. If the carrying value of the asset exceeds its estimated fair value, an impairment loss is recognized, and the asset is written down to its estimated fair value. Definite-lived intangible assets are tested for impairment whenever events or changes in circumstances indicate that the carrying value of such an asset may not be recoverable. If indicators of impairment are present, the Company first compares the carrying amount of the asset group to the estimated future cash flows associated with the asset group (undiscounted). If the estimated future cash flows used in this analysis are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to the asset group's estimated future cash flows (discounted).

Estimated fair values could change if, for example, there are changes in the business climate, industry-wide changes, changes in the competitive environment, adverse legal or regulatory actions or developments, changes in capital structure, cost of debt, interest rates, capital expenditure levels, operating cash flows or market capitalization. Because of the significance of our goodwill and intangible assets, any future impairment of these assets could require material noncash charges to our operating results, which also could have a material adverse effect on our financial condition.

Adverse conditions in the U.S. and global capital markets can significantly and adversely affect the value of our investments in debt and equity securities, mortgage loans, alternative investments and other investments, and our operating results and/or our financial condition.

The global capital markets, including credit markets, continue to experience volatility and uncertainty. As an insurer, we have a substantial investment portfolio that supports our policy liabilities and surplus and is comprised largely of debt securities of issuers located in the U.S. As a result, the income we earn from our investment portfolio is largely driven by the level of interest rates in the U.S., and to a lesser extent the international financial markets; and volatility, uncertainty and/or disruptions in the global capital markets, particularly the U.S. credit markets, and governments' monetary policy, particularly U.S. monetary policy, can significantly and adversely affect the value of our investment portfolio, our operating results and/or our financial condition by:

- significantly reducing the value and/or liquidity of the debt securities we hold in our investment portfolio and creating realized capital losses that reduce our operating results and/or unrealized capital losses that reduce our shareholders' equity;
- lowering interest rates on high-quality short-term or medium-term debt securities and thereby materially reducing our net investment income and operating results as the proceeds from securities in our investment portfolio that mature or are otherwise disposed of continue to be reinvested in lower yielding securities;
- reducing the fair values of our investments if interest rates rise;
- causing non-performance of or defaults on their obligations to us by third parties, including customers, issuers of securities in our investment portfolio, mortgage borrowers and/or reinsurance and/or derivatives counterparties;
- making it more difficult to value certain of our investment securities, for example if trading becomes less frequent, which could lead to significant period-to-period changes in our estimates of the fair values of those securities and cause period-to-period volatility in our net income and shareholders' equity;
- reducing our ability to issue short-term debt securities at attractive interest rates, thereby increasing our interest expense and decreasing our operating results; and
- reducing our ability to issue other securities.

Although we seek, within guidelines we deem appropriate, to match the duration of our assets and liabilities and to manage our credit and counterparty exposures, a failure adequately to do so could adversely affect our net income and our financial condition and, in extreme circumstances, our cash flows.

Risks Related to Our Relationships with Manufacturers, Providers, Suppliers and Vendors

We face risks relating to the market availability, pricing, suppliers and safety profiles of prescription drugs and other products that we purchase and sell.

Our Retail/LTC segment and our mail order and specialty pharmacy operations generate revenues in significant part by dispensing prescription drugs. Our PBM business generates revenues primarily by contracting with clients to provide prescription drugs and related health care services to plan members. As a result, we are dependent on our relationships with prescription drug manufacturers and suppliers. We acquire a substantial amount of our mail order and specialty pharmacies' prescription drug supply from a limited number of suppliers. Certain of our agreements with such suppliers are short-term and cancelable by either party without cause. In addition, these agreements may allow the supplier to distribute through channels other than us. Certain of these agreements also allow pricing and other terms to be adjusted periodically for changing market conditions or required service levels. A termination or modification to any of these relationships could adversely affect our prescription drug supply and have a material adverse effect on our businesses, operating results and financial condition. Moreover, many products distributed by our pharmacies are manufactured with ingredients that are susceptible to supply shortages. In some cases, we depend upon a single source of supply. Any such supply shortages or loss of any such single source of supply could adversely affect our operating results and cash flows.

Much of the branded and generic drug product that we sell in our pharmacies, and much of the other merchandise we sell, is manufactured in whole or in substantial part outside of the United States. In most cases, the products or merchandise are imported by others and sold to us. As a result, significant changes in tax or trade policies, tariffs or trade relations between the United States and other countries, such as the imposition of unilateral tariffs on imported products, could result in significant increases in our costs, restrict our access to suppliers, depress economic activity, and have a material adverse effect on our businesses, operating results and cash flows. In addition, other countries may change their business and trade policies and such changes, as well as any negative sentiments towards the United States in response to increased import tariffs and other changes in U.S. trade regulations, could adversely affect our businesses.

Our suppliers are independent entities subject to their own operational and financial risks that are outside our control. If our current suppliers were to stop selling prescription drugs to us or delay delivery, including as a result of supply shortages,

supplier production disruptions, supplier quality issues, closing or bankruptcies of our suppliers, or for other reasons, we may be unable to procure alternatives from other suppliers in a timely and efficient manner and on acceptable terms, or at all.

Our operating results may be adversely affected if we are unable to contract with providers on competitive terms and develop and maintain attractive networks with high quality providers.

We are seeking to enhance our health care provider networks by entering into joint ventures and other collaborative risk-sharing arrangements with providers. Providers' willingness to enter these arrangements with us depends upon, among other things, our ability to provide them with up to date quality of care data to support these value-based contracts. These arrangements are designed to give providers incentives to engage in population health management and optimize delivery of health care to our members. These arrangements also may allow us to expand into new geographies, target new customer groups, increase membership and reduce medical costs and, if we provide technology or other services to the relevant health system or provider organization, may contribute to our revenue and earnings from alternative sources. If such arrangements do not result in the lower medical costs that we project or if we fail to attract providers to such arrangements, or are less successful at implementing such arrangements than our competitors, our medical costs may not be competitive and may be higher than we project, our attractiveness to customers may be reduced, we may lose or be unable to grow medical membership, and our ability to profitably grow our business and/or our operating results may be adversely affected.

While we believe joint ventures, accountable care organizations ("ACOs") and other non-traditional health care provider organizational structures present opportunities for us, the implementation of our joint ventures and other non-traditional structure strategies may not achieve the intended results, which could adversely affect our operating results and cash flows. Among other things, joint ventures require us to maintain collaborative relationships with our counterparties, continue to gain access to provider rates that make the joint ventures economically sustainable and devote significant management time to the operation and management of the joint ventures. We may not be able to achieve these objectives in one or more of our joint ventures, which could adversely affect our operating results and cash flows.

If our suppliers or service providers fail to meet their contractual obligations to us or to comply with applicable laws or regulations, we may be exposed to brand and reputational harm, litigation and/or regulatory action. This risk is particularly high in our Medicare, Medicaid, dual eligible and dual eligible special needs plan programs.

In addition to our suppliers, we contract with various third parties to perform certain functions and services and provide us with certain information technology systems. Our arrangements with suppliers and these third parties may expose us to public scrutiny, adversely affect our brand and reputation, expose us to litigation or regulatory action, and otherwise make our operations vulnerable if we fail to adequately oversee, monitor and regulate their performance or if they fail to meet their contractual obligations to us or to comply with applicable laws or regulations, including those related to human capital and climate change. For example, certain of our vendors have been responsible for releases of sensitive information of our members and employees, which has caused us to incur additional expenses and given rise to regulatory actions and litigation against us.

These risks are particularly high in our in Medicare Advantage (including dual eligible special needs plans), Medicare Part D, Medicaid, and managed Medicaid plans, where third parties may perform medical management and other member related services for us. Any failure of our or these third parties' prevention, detection or control systems related to regulatory compliance, compliance with our internal policies, data security and/or cybersecurity or any incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, members', customers' or other constituents' sensitive information could require us to expend significant resources to remediate any damage, interrupt our operations and adversely affect our brand and reputation and also expose us to whistleblower, class action and other litigation, other proceedings, prohibitions on marketing or active or passive enrollment of members, corrective actions, fines, sanctions and/or penalties, any of which could adversely affect our businesses, operating results, cash flows and/or financial condition.

We may experience increased medical and other benefit costs, litigation risk and customer and member dissatisfaction when providers that do not have contracts with us render services to our Health Care Benefits members.

Some providers that render services to our Health Care Benefits members do not have contracts with us. In those cases, we do not have a pre-established understanding with these providers as to the amount of compensation that is due to them for services rendered to our members. In some states, the amount of compensation due to these nonparticipating providers is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover the difference between what we have paid them and the amount they charged us from our members, which may result in customer and member dissatisfaction. For example, in October 2018, an arbitrator

awarded certain claimant hospitals approximately $150 million in a proceeding relating to Aetna's out-of-network benefit payment and administration practices, and in March 2019 that award was reduced to approximately $86 million. Such disputes may cause us to pay higher medical or other benefit costs than we projected.

Continuing consolidation and integration among providers and other suppliers may increase our medical and other covered benefits costs, make it difficult for us to compete in certain geographies and create new competitors.

Hospitals and other providers and health systems continue to consolidate across the health care industry. While this consolidation could increase efficiency and has the potential to improve the delivery of health care services, it also reduces competition and the number of potential contracting parties in certain geographies. These health systems also are increasingly forming and considering forming health plans to directly offer health insurance in competition with us, a process that has been accelerated by the ACA. In addition, ACOs (including Commercial and Medicaid-only ACOs developed as a result of state Medicaid laws), practice management companies, consolidation among and by integrated health systems and other changes in the organizational structures that physicians, hospitals and other providers adopt continues to change the way these providers interact with us and the competitive landscape in which we operate. These changes may increase our medical and other covered benefits costs, may affect the way we price our products and services and estimate our medical and other covered benefits costs and may require us to change our operations, including by withdrawing from certain geographies where we do not have a significant presence across our businesses or are unable to collaborate or contract with providers on acceptable terms. Each of these changes may adversely affect our businesses and operating results.

Item 1B. Unresolved Staff Comments.

There are no unresolved SEC Staff Comments.

Item 2. Properties.

The Company's principal office is an owned building complex located in Woonsocket, Rhode Island, which totals approximately one million square feet. The Company also leases office space in other locations in the United States.

Health Care Benefits Segment

The Health Care Benefits segment's principal office is an owned building complex located in Hartford, Connecticut, which totals approximately 1.7 million square feet. The Health Care Benefits segment also owns or leases office space in other locations in the United States and several other countries.

Pharmacy Services Segment

The Pharmacy Services segment includes owned or leased mail service dispensing pharmacies, call centers, on-site pharmacy stores, retail specialty pharmacy stores, specialty mail service pharmacies and branches for infusion and enteral services throughout the United States.

Retail/LTC Segment

As of December 31, 2022, the Retail/LTC segment operated the following properties:

- Approximately 7,795 retail stores, of which approximately 5% were owned. Net selling space for retail stores was approximately 77.4 million square feet as of December 31, 2022.
- Approximately 1,880 retail pharmacies within retail chains, as well as approximately 60 clinics in Target Corporation ("Target") stores;
- Owned distribution centers and leased distribution facilities throughout the United States totaling approximately 10.7 million square feet; and
- Owned and leased LTC pharmacies throughout the United States and an owned LTC repackaging facility.

In connection with certain business dispositions completed between 1995 and 1997, the Company continues to guarantee lease obligations for 67 former stores. The Company is indemnified for these guarantee obligations by the respective initial purchasers. These guarantees generally remain in effect for the initial lease term and any extension thereof pursuant to a

renewal option provided for in the lease prior to the time of the disposition. For additional information on these guarantees, see "Lease Guarantees" in Note 16 ''Commitments and Contingencies'' included in Item 8 of this 10-K.

Management believes that the Company's owned and leased facilities are suitable and adequate to meet the Company's anticipated needs. At the end of the existing lease terms, management believes the leases can be renewed or replaced by alternative space. For additional information on the right-of-use assets and lease liabilities associated with the Company's leases, see Note 6 ''Leases'' included in Item 8 of this 10-K.

Item 3. Legal Proceedings.

The information contained in Note 16 ''Commitments and Contingencies'' included in Item 8 of this 10-K is incorporated herein by reference.

Item 4. Mine Safety Disclosures.

Not applicable.

Information about our Executive Officers

The following sets forth the name, age and biographical information for each of the Registrant's executive officers as of February 8, 2023. In each case the officer's term of office extends to the date of the meeting of the Board following the next annual meeting of stockholders of CVS Health Corporation. Previous positions and responsibilities held by each of the executive officers over the past five years or more are indicated below:

Sreekanth K. Chaguturu, M.D., age 44, Executive Vice President and Chief Medical Officer of CVS Health Corporation since May 2022; Chief Medical Officer of CVS Caremark from September 2019 through May 2022; Chief Population Health Officer at Mass General Brigham, a non-profit hospital formerly known as Partners HealthCare, from August 2017 through August 2019; Vice President, Population Health Management at Mass General Brigham from June 2014 through August 2017. Dr. Chaguturu is also an Attending Physician at Massachusetts General Hospital and an Instructor in Internal Medicine at Harvard Medical School from July 2007 to the present.

James D. Clark, age 58, Senior Vice President - Controller and Chief Accounting Officer of CVS Health Corporation since November 2018; Vice President - Finance and Accounting of CVS Pharmacy, Inc. from September 2009 through October 2018.

Daniel P. Finke, age 52, Executive Vice President of CVS Health Corporation and President of Health Care Benefits since February 2021; Executive Vice President, Commercial Business and Markets of Aetna Inc. from February 2020 through January 2021; Executive Vice President, Consumer Health and Service of Aetna Inc. from June 2018 through January 2020; Senior Vice President, Network and Clinical Services of Aetna Inc. from January 2016 through May 2018.

Shawn M. Guertin, age 59, Executive Vice President and Chief Financial Officer of CVS Health Corporation since May 2021; Executive Vice President, Chief Financial Officer and Chief Enterprise Risk Officer of Aetna Inc. from February 2013 through May 2019; Senior Vice President, Finance of Aetna Inc. from April 2011 through January 2013.

Laurie P. Havanec, age 62, Executive Vice President and Chief People Officer of CVS Health Corporation since February 2021; Executive Vice President and Chief People Officer, Otis Worldwide Corporation, an elevator, escalator and moving walkway manufacturer, from October 2019 through January 2021; Corporate Vice President, Talent of United Technologies Corporation, a multinational manufacturing conglomerate, from April 2017 through October 2019; Vice President - Human Resources, Institution Businesses of Aetna Inc. from 2013 through March 2017. Ms. Havanec is also a member of the board of directors of American Water Works Company, Inc., a publicly traded water and wastewater utility company.

J. David Joyner, age 58, Executive Vice President of CVS Health Corporation and President of Pharmacy Services since January 2023; Strategic Business Advisor to gWell, Inc., a wellness technology company, since July 2021; Advisor to Podimetrics Inc., a health care company focused on the identification and treatment of diabetic foot ulcers since September 2020; Advisory Council to the Rawls College of Business of Texas Tech University since July 2020; Executive Vice President – Sales and Account Services, CVS Caremark for CVS Health Corporation from March 2011 through December 2019.

Karen S. Lynch, age 60, President and Chief Executive Officer of CVS Health Corporation since February 2021; Executive Vice President of CVS Health Corporation from November 2018 through January 2021; President of Aetna Inc. from January 2015 through January 2021; and a director of CVS Health Corporation since February 2021.

Tilak Mandadi, age 59, Executive Vice President and Chief Data, Digital and Technology Officer of CVS Health Corporation since July 2022; Chief Strategy Officer, MGM Resorts International from July 2021 through July 2022; Executive Vice President, Digital & Global Chief Technology Officer, Disney Parks, Experiences and Products from March 2013 through July 2021.

Thomas M. Moriarty, age 59, Executive Vice President and General Counsel of CVS Health Corporation since October 2012; Chief Policy and External Affairs Officer since March 2017; Chief Strategy Officer from March 2014 through February 2017.

Michelle A. Peluso, age 50, Executive Vice President and Chief Customer Officer of CVS Health Corporation since January 2021 and Co-President of Retail since January 2022; Senior Vice President, Digital Sales and Chief Marketing Officer, IBM, a multinational technology corporation, from February 2016 through January 2021; Chief Executive Officer, Gilt Groupe, Inc., an online shopping destination, from 2013 through February 2016. Ms. Peluso is also a member of the board of directors of Nike, Inc., an athletic footwear and clothing manufacturer.

Prem Shah, age 43, Executive Vice President and Chief Pharmacy Officer of CVS Health Corporation since November 2021 and Co-President of Retail since January 2022; Executive Vice President, Specialty and Product Innovation, CVS Caremark from August 2018 through November 2021; Vice President - Specialty Pharmacy, CVS Caremark from February 2013 through July 2018.

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.

Market Information

CVS Health Corporation's common stock is listed on the New York Stock Exchange under the symbol "CVS."

Dividends

During 2022, 2021 and 2020, the quarterly cash dividend was $0.55, $0.50 and $0.50 per share, respectively. In December 2022, the Board authorized a 10% increase in the quarterly cash dividend to $0.605 per share effective in 2023. CVS Health Corporation has paid cash dividends every quarter since becoming a public company. Future dividends will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

See Note 12 ''Shareholders' Equity'' included in Item 8 of this 10-K for information regarding CVS Health Corporation's dividends.

Holders of Common Stock

As of February 1, 2023, there were 24,142 registered holders of the registrant's common stock according to the records maintained by the registrant's transfer agent.

Issuer Purchases of Equity Securities

The following share repurchase programs have been authorized by the Board:

In billions **Authorization Date**	**Authorized**	**Remaining as of December 31, 2022**
November 17, 2022 ("2022 Repurchase Program")	$ 10.0	$ 10.0
December 9, 2021 ("2021 Repurchase Program")	10.0	6.5

Each of the share Repurchase Programs was effective immediately and permit the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase ("ASR") transactions, and/or other derivative transactions. Both the 2022 and 2021 Repurchase Programs can be modified or terminated by the Board at any time.

During the year ended December 31, 2022, the Company repurchased an aggregate of 34.1 million shares of common stock for approximately $3.5 billion pursuant to the 2021 Repurchase Program, including share repurchases under the $1.5 billion fixed dollar ASR transaction described below. During the years ended December 31, 2021 and 2020, the Company did not repurchase any shares of common stock.

Pursuant to the authorization under the 2021 Repurchase Program, the Company entered into a $2.0 billion fixed dollar ASR with Citibank, N.A. ("Citibank"). Upon payment of the $2.0 billion purchase price on January 4, 2023, the Company received a number of shares of CVS Health Corporation's common stock equal to 80% of the $2.0 billion notional amount of the ASR or approximately 17.4 million shares at a price of $92.19 per share, which were placed into treasury stock in January 2023. At the conclusion of the ASR, the Company may receive additional shares representing the remaining 20% of the $2.0 billion notional amount. The ultimate number of shares the Company may receive will depend on the daily volume-weighted average price of the Company's stock over an averaging period, less a discount. It is also possible, depending on such weighted average price, that the Company will have an obligation to Citibank which, at the Company's option, could be settled in additional cash or by issuing shares. Under the terms of the ASR, the maximum number of shares that could be delivered to the Company is 43.4 million.

Pursuant to the authorization under the 2021 Repurchase Program, the Company entered into a $1.5 billion fixed dollar ASR with Barclays Bank PLC. Upon payment of the $1.5 billion purchase price on January 4, 2022, the Company received a number of shares of CVS Health Corporation's common stock equal to 80% of the $1.5 billion notional amount of the ASR or approximately 11.6 million shares at a price of $103.34 per share, which were placed into treasury stock in January 2022. The

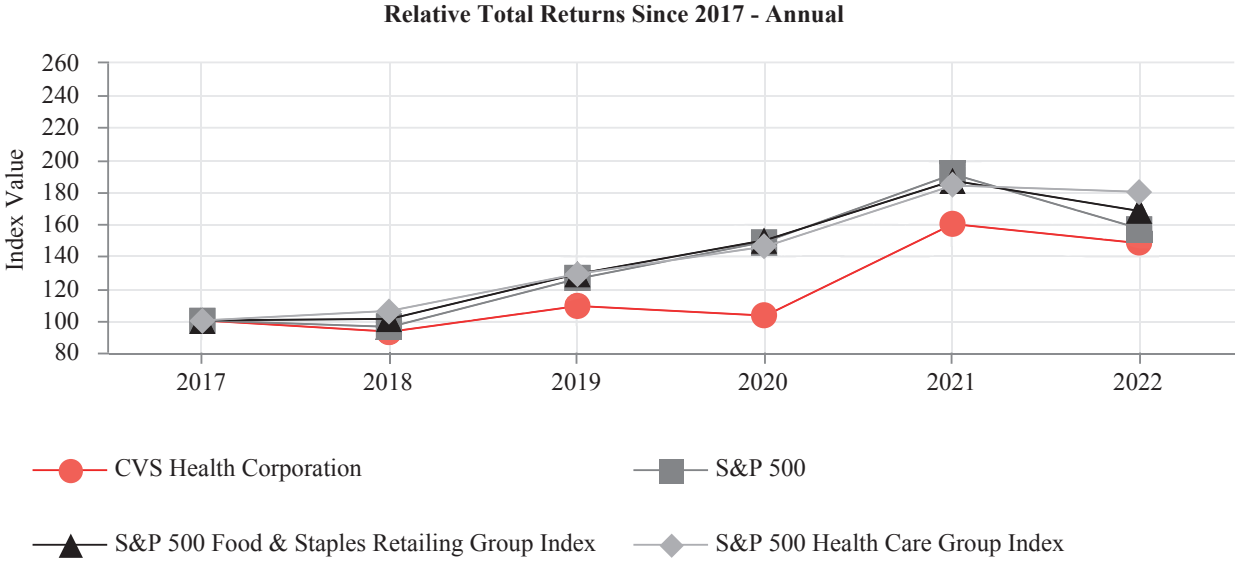
ASR was accounted for as an initial treasury stock transaction for $1.2 billion and a forward contract for $0.3 billion. The forward contract was classified as an equity instrument and was recorded within capital surplus. In February 2022, the Company received approximately 2.7 million shares of CVS Health Corporation's common stock, representing the remaining 20% of the $1.5 billion notional amount of the ASR, thereby concluding the ASR. These shares were placed into treasury stock and the forward contract was reclassified from capital surplus to treasury stock in February 2022.

At the time they were received, the initial and final receipt of shares resulted in an immediate reduction of the outstanding shares used to calculate the weighted average common shares outstanding for basic and diluted earnings per share.

See Note 12 ''Shareholders' Equity'' included in Item 8 of this 10-K for additional information regarding the Company's share repurchases.

Stock Performance Graph

The following graph compares the cumulative total shareholder return on CVS Health Corporation's common stock (assuming reinvestment of dividends) with the cumulative total return on the S&P 500 Index, the S&P 500 Food and Staples Retailing Industry Group Index and the S&P 500 Healthcare Sector Group Index from December 31, 2017 through December 31, 2022. The graph assumes a $100 investment in shares of CVS Health Corporation's common stock on December 31, 2017.



	December 31,					
	2017	2018	2019	2020	2021	2022
CVS Health Corporation	$ 100	$ 93	$ 109	$ 103	$ 160	$ 148
S&P 500 [1]	100	96	126	149	191	157
S&P 500 Food & Staples Retailing Group Index [2]	100	101	129	150	187	168
S&P 500 Health Care Group Index [1] [3]	100	106	129	146	184	180

(1) Includes CVS Health Corporation.
(2) Includes five companies (COST, KR, SYY, WBA, WMT).
(3) Includes 63 companies.

The year-ended values of each investment shown in the preceding graph are based on share price appreciation plus dividends, with the dividends reinvested as of the last business day of the month during which such dividends were ex-dividend. The calculations exclude trading commissions and taxes. Total shareholder returns from each investment can be calculated from the year-end investment values shown beneath the graph.

Item 6. Reserved

Not applicable.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations. ("MD&A")

The following discussion and analysis should be read in conjunction with the audited consolidated financial statements and related notes included in Item 8 of this Annual Report on Form 10-K (this "10-K"), "Risk Factors" included in Item 1A of this 10-K and the "Cautionary Statement Concerning Forward-Looking Statements" in this 10-K.

Overview of Business

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health," the "Company," "we," "our" or "us"), is a leading diversified health solutions company reshaping health care to help make healthier happen for more Americans. In an increasingly connected and digital world, CVS Health is meeting people wherever they are and changing health care to meet their needs. The Company has more than 9,000 retail locations, more than 1,100 walk-in medical clinics, a leading pharmacy benefits manager with over 110 million plan members with expanding specialty pharmacy solutions and a dedicated senior pharmacy care business serving more than one million patients per year. The Company also serves an estimated 35 million people through traditional, voluntary and consumer-directed health insurance products and related services, including expanding Medicare Advantage offerings and a leading standalone Medicare Part D prescription drug plan ("PDP"). The Company believes its integrated health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

The Company has four reportable segments: Health Care Benefits, Pharmacy Services, Retail/LTC and Corporate/Other, which are described below.

Overview of the Health Care Benefits Segment

The Health Care Benefits segment operates as one of the nation's leading diversified health care benefits providers. The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make more informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental and behavioral health plans, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services, and health information technology products and services. The Health Care Benefits segment also provided workers' compensation administrative services through its Coventry Health Care Workers' Compensation business ("Workers' Compensation business") prior to the sale of this business on July 31, 2020. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates. The Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk for medical and dental care costs) as "ASC." In addition, effective January 2022, the Company entered the individual public health insurance exchanges ("Public Exchanges") in eight states through which it sells Insured plans directly to individual consumers. The Company entered Public Exchanges in four additional states effective January 2023.

Overview of the Pharmacy Services Segment

The Pharmacy Services segment provides a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services and mail order pharmacy. In addition, through the Pharmacy Services segment, the Company provides specialty pharmacy and infusion services, clinical services, disease management services, medical spend management and pharmacy and/or other administrative services for providers and federal 340B drug pricing program covered entities ("Covered Entities").The Company operates a group purchasing organization that negotiates pricing for the purchase of pharmaceuticals and rebates with pharmaceutical manufacturers on behalf of its participants. The Company also provides various administrative, management and reporting services to pharmaceutical manufacturers. The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, PDPs, Medicaid managed care plans, plans offered on Public Exchanges and private health insurance exchanges, other sponsors of health benefit plans throughout the United States and Covered Entities. The Pharmacy Services segment operates retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services.

Overview of the Retail/LTC Segment

The Retail/LTC segment sells prescription drugs and a wide assortment of health and wellness products and general merchandise, provides health care services through its MinuteClinic® walk-in medical clinics, provides medical diagnostic testing, administers vaccinations for illnesses such as influenza, coronavirus disease 2019 ("COVID-19") and shingles and conducts long-term care pharmacy ("LTC") operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to long-term care facilities and other care settings. As of December 31, 2022, the Retail/LTC segment operated more than 9,000 retail locations, more than 1,100 MinuteClinic locations as well as online retail pharmacy websites, LTC pharmacies and on-site pharmacies. For the year ended December 31, 2022, the Company dispensed 26.8% of the total retail pharmacy prescriptions in the United States.

Overview of the Corporate/Other Segment

The Company presents the remainder of its financial results in the Corporate/Other segment, which primarily consists of:

- Management and administrative expenses to support the Company's overall operations, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments, expenses associated with the Company's investments in its transformation and enterprise modernization programs and acquisition-related integration costs; and
- Products for which the Company no longer solicits or accepts new customers such as its large case pensions and long-term care insurance products.

COVID-19

The COVID-19 pandemic and its emerging new variants continue to impact the economies of the U.S. and other countries around the world. Our strong local presence and scale in communities across the country has enabled us to continue to play an indispensable role in the national response to COVID-19, as well as provide seamless support for our customers wherever they need us: in our CVS locations, in their homes, and virtually. The COVID-19 pandemic had a significant impact on the Company's operating results for the years ended December 31, 2022, 2021 and 2020, primarily in the Company's Health Care Benefits and Retail/LTC segments.

Health Care Benefits Segment

Beginning in mid-March 2020, the health care system experienced a significant reduction in utilization of medical services ("utilization") that is discretionary and the cancellation of elective medical procedures. Utilization remained below historical levels through April 2020, began to recover in May and June 2020 and reached more normal levels in the third and fourth quarters of 2020, with select geographies impacted by COVID-19 waves. In response to COVID-19, the Company provided expanded benefit coverage to its members, including cost-sharing waivers for COVID-19 related treatments, as well as assistance to members through premium credits, telehealth cost-sharing waivers and other investments. During 2020, COVID-19 also resulted in a shift in the Company's medical membership. The Company experienced declines in Commercial membership due to reductions in workforce at our existing customers, substantially offset by increases in Medicaid membership primarily as a result of the suspension of eligibility redeterminations and increased unemployment.

During the year ended December 31, 2021, overall medical costs in the first quarter were generally consistent with historical baseline levels in the aggregate, however the segment experienced increased COVID-19 testing and treatment costs and lower Medicare risk-adjusted revenue. During the second quarter, COVID-19 testing and treatment costs persisted, however at levels significantly lower than those observed during the first quarter. Beginning in the third quarter of 2021, medical costs once again increased primarily driven by the spread of emerging new variants of COVID-19, which resulted in increased testing and treatment costs throughout the remainder of the year.

During the year ended December 31, 2022, the impact of COVID-19 within the Health Care Benefits segment has generally stabilized as a result of the Company's ability to capture COVID-19 related medical costs in pricing.

Retail/LTC Segment

During March 2020, the Company experienced increased prescription volume due to the greater use of 90-day prescriptions and early refills of maintenance medications, as well as increased front store volume as consumers prepared for the COVID-19 pandemic. Beginning in the second quarter and continuing throughout the remainder of the year, the Company experienced reduced customer traffic in its retail pharmacies and MinuteClinic locations due to shelter-in-place orders as well as reduced new therapy prescriptions and decreased long-term care prescription volume as a result of the COVID-19 pandemic. In addition, the Company incurred incremental operating expenses associated with the Company's COVID-19 pandemic response efforts and waived fees associated with prescription home delivery and associated front store products. During 2020, the Company also played a key role in supporting the local communities in which it operates through the administration of diagnostic testing at its CVS pharmacy locations, as well as in long-term care facilities, at community-based testing sites in underserved areas and through its Return Ready^{SM} solution. The Company also began administering COVID-19 vaccinations in long-term care facilities during December 2020.

During the first quarter of 2021, the Company experienced reduced customer traffic in its retail pharmacies, which reflected the impact of a weaker cough, cold and flu season, while it administered the highest quarterly volume of COVID-19 diagnostic tests. The Company began administering COVID-19 vaccines in its retail pharmacies during February 2021. During the second quarter, the segment generated earnings from COVID-19 vaccines and saw improved customer traffic as vaccinated customers began more actively shopping in CVS locations. During the third and fourth quarters, emerging new variants drove the continued administration of COVID-19 vaccinations (including boosters) and diagnostic testing, while the segment also generated earnings from the sale of over-the-counter ("OTC") test kits in the front store. During the year ended December 31, 2021, the Company administered more than 32 million COVID-19 tests and more than 59 million COVID-19 vaccines and sold more than 22 million OTC test kits.

During the year ended December 31, 2022, the customary quarterly operating income progression in the Retail/LTC segment continued to be impacted by COVID-19. During the first quarter, the Company saw high volumes of administration of COVID-19 vaccinations, as well as demand for OTC test kits in the front store, particularly in the beginning of the year when

the Omicron variant incidence was high. In addition, the Company administered the highest quarterly volume of COVID-19 diagnostic tests of 2022 during the first quarter, however a decline compared to the prior year. During the second and third quarters, the Company continued to generate earnings from the sale of OTC test kits, as customers performed more in-home testing versus diagnostic testing, in addition to earnings from the continued administration of COVID-19 diagnostic testing and vaccinations, albeit at lower levels than those experienced in the first quarter. During the fourth quarter, the Company saw an increase in COVID-19 vaccine administration from the prior quarter related to the bivalent COVID-19 booster. During the year ended December 31, 2022, the Company administered more than 15 million COVID-19 tests and nearly 28 million COVID-19 vaccines and sold more than 63 million OTC test kits.

The COVID-19 pandemic continues to evolve. The Company believes COVID-19's impact on its businesses, operating results, cash flows and/or financial condition primarily will be driven by the geographies impacted and the severity and duration of the pandemic; the pandemic's impact on the U.S. and global economies and consumer behavior and health care utilization patterns; and the timing, scope and impact of legislation as well as other federal, state and local governmental responses to the pandemic. Those primary drivers are beyond the Company's knowledge and control. As a result, the impact COVID-19 will have on the Company's businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be adverse and material. COVID-19 also may result in legal and regulatory proceedings, investigations and claims against the Company.

Results of Operations

The following information summarizes the Company's results of operations for 2022 compared to 2021. For discussion of the Company's results of operations for 2021 compared to 2020, see "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2021 filed with the U.S. Securities and Exchange Commission (the "SEC") on February 9, 2022.

Summary of Consolidated Financial Results

	Year Ended December 31,			Change			
				2022 vs. 2021		2021 vs. 2020	
In millions	**2022**	**2021**	**2020**	**$**	**%**	**$**	**%**
Revenues:							
Products	$226,616	$203,738	$190,688	$ 22,878	11.2 %	$13,050	6.8 %
Premiums	85,330	76,132	69,364	9,198	12.1 %	6,768	9.8 %
Services	9,683	11,042	7,856	(1,359)	(12.3)%	3,186	40.6 %
Net investment income	838	1,199	798	(361)	(30.1)%	401	50.3 %
Total revenues	322,467	292,111	268,706	30,356	10.4 %	23,405	8.7 %
Operating costs:							
Cost of products sold	196,892	175,803	163,981	21,089	12.0 %	11,822	7.2 %
Benefit costs	71,281	64,260	55,679	7,021	10.9 %	8,581	15.4 %
Opioid litigation charges	5,803	—	—	5,803	100.0 %	—	— %
Loss on assets held for sale	2,533	—	—	2,533	100.0 %	—	— %
Store impairments	—	1,358	—	(1,358)	(100.0)%	1,358	100.0 %
Goodwill impairment	—	431	—	(431)	(100.0)%	431	100.0 %
Operating expenses	38,212	37,066	35,135	1,146	3.1 %	1,931	5.5 %
Total operating costs	314,721	278,918	254,795	35,803	12.8 %	24,123	9.5 %
Operating income	7,746	13,193	13,911	(5,447)	(41.3)%	(718)	(5.2)%
Interest expense	2,287	2,503	2,907	(216)	(8.6)%	(404)	(13.9)%
Loss on early extinguishment of debt	—	452	1,440	(452)	(100.0)%	(988)	(68.6)%
Other income	(169)	(182)	(206)	13	7.1 %	24	11.7 %
Income before income tax provision	5,628	10,420	9,770	(4,792)	(46.0)%	650	6.7 %
Income tax provision	1,463	2,522	2,569	(1,059)	(42.0)%	(47)	(1.8)%
Income from continuing operations	4,165	7,898	7,201	(3,733)	(47.3)%	697	9.7 %
Loss from discontinued operations, net of tax	—	—	(9)	—	— %	9	100.0 %
Net income	4,165	7,898	7,192	(3,733)	(47.3)%	706	9.8 %
Net (income) loss attributable to noncontrolling interests	(16)	12	(13)	(28)	(233.3)%	25	192.3 %
Net income attributable to CVS Health	$ 4,149	$ 7,910	$ 7,179	$ (3,761)	(47.5)%	$ 731	10.2 %

Commentary - 2022 compared to 2021

Revenues

- Total revenues increased $30.4 billion, or 10.4%, in 2022 compared to 2021. The increase in total revenues was primarily driven by growth across all segments.
- Please see "Segment Analysis" later in this MD&A for additional information about the revenues of the Company's segments.

Operating expenses

- Operating expenses increased $1.1 billion, or 3.1%, in 2022 compared to 2021. The increase in operating expenses was primarily due to increased operating expenses to support growth in the business, incremental investments in business operations and decreased gains from legal settlements in 2022 compared to 2021. These increases were partially offset by a decrease in amortization of intangible assets compared to the prior year, as well as pre-tax gains of $250 million on the sale

of the Company's wholly-owned subsidiary bswift LLC ("bswift") and $225 million on the sale of PayFlex Holdings, Inc. ("PayFlex"), both of which were sold during 2022.

- Operating expenses as a percentage of total revenues decreased to 11.8% in 2022 compared to 12.7% in 2021. The decrease in operating expenses as a percentage of total revenues was primarily due to the increases in total revenues described above.
- Please see "Segment Analysis" later in this MD&A for additional information about the operating expenses of the Company's segments.

Operating income

- Operating income decreased $5.4 billion, or 41.3%, in 2022 compared to 2021. The decrease in operating income was primarily driven by the $5.8 billion of opioid litigation charges and declines in the Retail/LTC segment, which included a $2.5 billion loss on assets held for sale related to the write-down of the Company's Omnicare® long-term care business ("LTC business") during 2022, partially offset by the absence of a store impairment charge of approximately $1.4 billion and a $431 million goodwill impairment charge on the remaining goodwill of the LTC reporting unit, both of which were recorded in the prior year. These decreases were partially offset by increases in the Health Care Benefits segment, which included the pre-tax gains of $250 million on the sale of bswift and $225 million on the sale of PayFlex and a decrease in amortization of intangible assets, as well as improved purchasing economics and growth in specialty pharmacy in the Pharmacy Services segment.
- Please see "Segment Analysis" later in this MD&A for additional information about the operating results of the Company's segments.

Interest expense

- Interest expense decreased $216 million, or 8.6%, in 2022 compared to 2021, due to lower debt in the year ended December 31, 2022. See "Liquidity and Capital Resources" later in this report for additional information.

Loss on early extinguishment of debt

- During 2021, the loss on early extinguishment of debt relates to the Company's repayment of approximately $2.3 billion of its outstanding senior notes in December 2021 pursuant to its early redemption make-whole provision for such senior notes, which resulted in a loss on early extinguishment of debt of $89 million, and the repayment of approximately $2.0 billion of its outstanding senior notes pursuant to its tender offer for such notes in August 2021, which resulted in a loss on early extinguishment of debt of $363 million. See Note 8 ‘‘Borrowings and Credit Agreements’’ included in Item 8 of this 10-K for additional information.

Income tax provision

- The Company's effective income tax rate increased to 26.0% in 2022 compared to 24.2% in the prior year. The increase was primarily due to certain nondeductible legal charges and basis differences on the sale of certain subsidiaries in 2022. These increases were partially offset by the impact of certain discrete tax items concluded in the first quarter of 2022.

Outlook for 2023

With respect to 2023, the Company believes you should consider the following important information:

- The Health Care Benefits segment is expected to continue to benefit from Medicare and Commercial membership growth, partially offset by declines in Medicaid due to the impact of redeterminations in 2023.
- The Pharmacy Services segment is expected to continue to benefit from the Company's ability to drive further improvements in purchasing economics and strong pharmacy network volume. These increases are expected to be partially offset by continued client price improvements and regulation of pharmacy pricing.
- The Retail/LTC segment is expected to continue to benefit from increased prescription volume and improved generic drug purchasing, partially offset by continued pharmacy reimbursement pressure and lower contributions from COVID-19 vaccinations, diagnostic testing and OTC test kits as COVID-19 transitions to the endemic stage.
- The Company is expected to benefit from enterprise-wide cost savings initiatives, which aim to reduce the Company's operating cost structure in a way that improves the consumer experience and is sustainable. Key drivers include:
    - Investments in digital, technology and analytics capabilities that will streamline processes and improve outcomes,
    - Implementing workforce and workplace strategies, and
    - Deploying vendor and procurement strategies.
- The Company expects changes to its business environment to continue as elected and other government officials at the national and state levels continue to propose and enact significant modifications to public policy and existing laws and regulations that govern or impact the Company's businesses.
- The COVID-19 pandemic continues to impact the economies of the U.S. and other countries around the world. The Company believes COVID-19's impact on its businesses, operating results, cash flows and/or financial condition primarily will be driven by the geographies impacted and the severity and duration of the pandemic, as well as the pandemic's impact on the U.S. and global economies, global supply chain, consumer behavior, and health care utilization patterns. In addition, as described in the "Government Regulation" section of this Form 10-K, federal, state and local governmental policies and initiatives designed to reduce the transmission of COVID-19 and emerging new variants may not effectively combat the severity and/or duration of the COVID-19 pandemic, and have resulted in a myriad of impacts on the Company's businesses. Those primary drivers are beyond the Company's knowledge and control. As a result, the impact COVID-19 will have on the Company's businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be adverse and material.

The Company's current expectations described above are forward-looking statements. Please see "Risk Factors" included in Item 1A of this 10-K and the "Cautionary Statement Concerning Forward-Looking Statements" in this 10-K for information regarding important factors that may cause the Company's actual results to differ from those currently projected and/or otherwise materially affect the Company.

Segment Analysis

The following discussion of segment operating results is presented based on the Company's reportable segments in accordance with the accounting guidance for segment reporting and is consistent with the segment disclosure in Note 17 ''Segment Reporting'' included in Item 8 of this 10-K.

The Company has three operating segments, Health Care Benefits, Pharmacy Services and Retail/LTC, as well as a Corporate/ Other segment. The Company's segments maintain separate financial information, and the Company's chief operating decision maker (the "CODM") evaluates the segments' operating results on a regular basis in deciding how to allocate resources among the segments and in assessing segment performance. The CODM evaluates the performance of the Company's segments based on adjusted operating income, which is defined as operating income (GAAP measure) excluding the impact of amortization of intangible assets and other items, if any, that neither relate to the ordinary course of the Company's business nor reflect the Company's underlying business performance. See the reconciliations of operating income (GAAP measure) to adjusted operating income below for further context regarding the items excluded from operating income in determining adjusted operating income. The Company uses adjusted operating income as its principal measure of segment performance as it enhances the Company's ability to compare past financial performance with current performance and analyze underlying business performance and trends. Non-GAAP financial measures the Company discloses, such as consolidated adjusted operating income, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

The following is a reconciliation of financial measures of the Company's segments to the consolidated totals:

In millions	Health Care Benefits	Pharmacy Services [1]	Retail/ LTC	Corporate/ Other	Intersegment Eliminations [2]	Consolidated Totals
2022						
Total revenues	$ 91,409	$ 169,236	$ 106,594	$ 530	$ (45,302)	$ 322,467
Adjusted operating income (loss)	5,984	7,356	6,705	(1,785)	(728)	17,532
2021						
Total revenues	82,186	153,022	100,105	721	(43,923)	292,111
Adjusted operating income (loss)	5,012	6,859	7,623	(1,471)	(711)	17,312
2020						
Total revenues	75,467	141,938	91,198	426	(40,323)	268,706
Adjusted operating income (loss)	6,188	5,688	6,146	(1,306)	(708)	16,008

(1) Total revenues of the Pharmacy Services segment include approximately $12.6 billion, $11.6 billion and $10.9 billion of retail co-payments for 2022, 2021 and 2020, respectively. See Note 1 ''Significant Accounting Policies'' included in Item 8 of this 10-K for additional information about retail co-payments.

(2) Intersegment revenue eliminations relate to intersegment revenue generating activities that occur between the Health Care Benefits segment, the Pharmacy Services segment, and/or the Retail/LTC segment. Intersegment adjusted operating income eliminations occur when members of Pharmacy Services segment clients enrolled in Maintenance Choice® elect to pick up maintenance prescriptions at one of the Company's retail pharmacies instead of receiving them through the mail. When this occurs, both the Pharmacy Services and Retail/LTC segments record the adjusted operating income on a stand-alone basis.

The following are reconciliations of consolidated operating income (GAAP measure) to consolidated adjusted operating income, as well as reconciliations of segment GAAP operating income to segment adjusted operating income:

	Year Ended December 31, 2022					
In millions	**Health Care Benefits**	**Pharmacy Services**	**Retail/ LTC**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
Operating income (loss) (GAAP measure)	$ 5,118	$ 7,187	$ 3,778	$ (7,609)	$ (728)	$ 7,746
Amortization of intangible assets [1]	1,203	167	435	3	—	1,808
Office real estate optimization charges [2]	97	2	—	18	—	117
Gain on divestiture of subsidiaries [3]	(475)	—	—	—	—	(475)
Opioid litigation charges [4]	—	—	—	5,803	—	5,803
Loss on assets held for sale [5]	41	—	2,492	—	—	2,533
Adjusted operating income (loss)	$ 5,984	$ 7,356	$ 6,705	$ (1,785)	$ (728)	$ 17,532

	Year Ended December 31, 2021					
In millions	**Health Care Benefits**	**Pharmacy Services**	**Retail/ LTC**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
Operating income (loss) (GAAP measure)	$ 3,521	$ 6,667	$ 5,322	$ (1,606)	$ (711)	$ 13,193
Amortization of intangible assets [1]	1,552	192	512	3	—	2,259
Acquisition-related integration costs [6]	—	—	—	132	—	132
Store impairments [7]	—	—	1,358	—	—	1,358
Goodwill impairment [8]	—	—	431	—	—	431
Acquisition purchase price adjustment outside of measurement period [9]	(61)	—	—	—	—	(61)
Adjusted operating income (loss)	$ 5,012	$ 6,859	$ 7,623	$ (1,471)	$ (711)	$ 17,312

	Year Ended December 31, 2020					
In millions	**Health Care Benefits**	**Pharmacy Services**	**Retail/ LTC**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
Operating income (loss) (GAAP measure)	$ 5,166	$ 5,454	$ 5,640	$ (1,641)	$ (708)	$ 13,911
Amortization of intangible assets [1]	1,598	234	506	3	—	2,341
Acquisition-related integration costs [6]	—	—	—	332	—	332
Gain on divestiture of subsidiary [3]	(269)	—	—	—	—	(269)
Receipt of fully reserved ACA risk corridor receivable [10]	(307)	—	—	—	—	(307)
Adjusted operating income (loss)	$ 6,188	$ 5,688	$ 6,146	$ (1,306)	$ (708)	$ 16,008

(1) The Company's acquisition activities have resulted in the recognition of intangible assets as required under the acquisition method of accounting which consist primarily of trademarks, customer contracts/relationships, covenants not to compete, technology, provider networks and value of business acquired. Definite-lived intangible assets are amortized over their estimated useful lives and are tested for impairment when events indicate that the carrying value may not be recoverable. The amortization of intangible assets is reflected in the Company's GAAP consolidated statements of operations in operating expenses within each segment. Although intangible assets contribute to the Company's revenue generation, the amortization of intangible assets does not directly relate to the underwriting of the Company's insurance products, the services performed for the Company's customers or the sale of the Company's products or services. Additionally, intangible asset amortization expense typically fluctuates based on the size and timing of the Company's acquisition activity. Accordingly, the Company believes excluding the amortization of intangible assets enhances the Company's and investors' ability to compare the Company's past financial performance with its current performance and to analyze underlying business performance and trends. Intangible asset amortization excluded from the related non-GAAP financial measure represents the entire amount recorded within the Company's GAAP financial statements, and the revenue generated by the associated intangible assets has not been excluded from the related non-GAAP financial measure. Intangible asset amortization is excluded from the related non-GAAP financial measure because the amortization, unlike the related revenue, is not affected by operations of any particular period unless an intangible asset becomes impaired or the estimated useful life of an intangible asset is revised.

(2) In 2022, the office real estate optimization charges primarily relate to the abandonment of leased real estate and the related right-of-use assets and property and equipment in connection with the planned reduction of corporate office real estate space in response to the Company's new flexible work arrangement. The office real estate optimization charges are reflected in the Company's GAAP consolidated statement of operations in operating expenses within the Health Care Benefits, Corporate/Other and Pharmacy Services segments.

(3) In 2022, the gain on divestiture of subsidiaries represents the pre-tax gain on the sale of bswift, which the Company sold in November 2022, and the pre-tax gain on the sale of PayFlex, which the Company sold in June 2022. In 2020, the gain on divestiture of subsidiary represents the pre-tax gain on the

sale of the Workers' Compensation business, which the Company sold in July 2020. The gains on divestitures are reflected as a reduction of operating expenses in the Company's GAAP consolidated statements of operations within the Health Care Benefits segment.

(4) In 2022, the opioid litigation charges relate to agreements to resolve substantially all opioid claims against the Company by certain states and governmental entities. The opioid litigation charges are reflected within the Corporate/Other segment.

(5) In 2022, the loss on assets held for sale relates to the LTC reporting unit within the Retail/LTC segment. The Company continually evaluates its portfolio for non-strategic assets. The Company determined that its LTC business was no longer a strategic asset and during the third quarter of 2022 committed to a plan to sell the LTC business. As of September 30, 2022, the LTC business met the criteria for held-for-sale accounting and the net assets were accounted for as assets held for sale. The carrying value of the LTC business was determined to be greater than its estimated fair value less costs to sell and a loss on assets held for sale was recorded during the third quarter of 2022. As of December 31, 2022, the net assets of the LTC business continued to meet the criteria for held-for-sale accounting and during the fourth quarter of 2022, an incremental loss on assets held for sale was recorded to write down the carrying value of the LTC business to its estimated fair value less costs to sell. During 2022, the loss on assets held for sale also relates to the Commercial Business reporting unit within the Health Care Benefits segment. In March 2022, the Company reached an agreement to sell its international health care business domiciled in Thailand ("Thailand business"), which was included in the Commercial Business reporting unit. At that time, a portion of the Commercial Business goodwill was specifically allocated to the Thailand business. The net assets of the Thailand business were accounted for as assets held for sale at March 31, 2022. The carrying value of the Thailand business was determined to be greater than its estimated fair value less costs to sell and a loss on assets held for sale was recorded during the first quarter of 2022. The sale of the Thailand business closed in the second quarter of 2022, and the ultimate loss on the sale was not material.

(6) In 2021 and 2020, acquisition-related integration costs relate to the Company's acquisition (the "Aetna Acquisition") of Aetna Inc. ("Aetna"). The acquisition-related integration costs are reflected in the Company's GAAP consolidated statements of operations in operating expenses within the Corporate/Other segment.

(7) In 2021, the store impairment charge relates to the write down of operating lease right-of-use assets and property and equipment in connection with the planned closure of approximately 900 retail stores between 2022 and 2024. The store impairment charge is reflected within the Retail/LTC segment.

(8) In 2021, the goodwill impairment charge relates to an impairment of the remaining goodwill of the LTC reporting unit within the Retail/LTC segment.

(9) In 2021, the Company received $61 million related to a purchase price working capital adjustment for an acquisition completed during the first quarter of 2020. The resolution of this matter occurred subsequent to the acquisition accounting measurement period and is reflected in the Company's GAAP consolidated statement of operations as a reduction of operating expenses within the Health Care Benefits segment.

(10) In 2020, the Company received $313 million owed to it under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (as amended, collectively, the "ACA")'s risk corridor program that was previously fully reserved for as payment was uncertain. After considering offsetting items such as the ACA's minimum medical loss ratio ("MLR") rebate requirements and premium taxes, the Company recognized pre-tax income of $307 million in the Company's GAAP consolidated statement of operations within the Health Care Benefits segment.

Health Care Benefits Segment

The following table summarizes the Health Care Benefits segment's performance for the respective periods:

	Year Ended December 31,			Change			
				2022 vs. 2021		2021 vs. 2020	
In millions, except percentages and basis points ("bps")	**2022**	**2021**	**2020**	**$**	**%**	**$**	**%**
Revenues:							
Premiums	$ 85,274	$ 76,064	$ 69,301	$ 9,210	12.1 %	$ 6,763	9.8 %
Services	5,659	5,536	5,683	123	2.2 %	(147)	(2.6)%
Net investment income	476	586	483	(110)	(18.8)%	103	21.3 %
Total revenues	91,409	82,186	75,467	9,223	11.2 %	6,719	8.9 %
Benefit costs	71,611	64,662	56,083	6,949	10.7 %	8,579	15.3 %
MBR (Benefit costs as a % of premium revenues)	84.0 %	85.0 %	80.9%	(100) bps		410 bps	
Loss on assets held for sale	$ 41	$ —	$ —	$ 41	100.0 %	$ —	— %
Operating expenses	14,639	14,003	14,218	636	4.5 %	(215)	(1.5)%
Operating expenses as a % of total revenues	16.0 %	17.0 %	18.8 %				
Operating income	$ 5,118	$ 3,521	$ 5,166	$ 1,597	45.4 %	$ (1,645)	(31.8)%
Operating income as a % of total revenues	5.6 %	4.3 %	6.8 %				
Adjusted operating income [(1)]	$ 5,984	$ 5,012	$ 6,188	$ 972	19.4 %	$ (1,176)	(19.0)%
Adjusted operating income as a % of total revenues	6.5 %	6.1 %	8.2 %				
Premium revenues (by business):							
Government	$ 63,141	$ 55,739	$ 48,928	$ 7,402	13.3 %	$ 6,811	13.9 %
Commercial	22,133	20,325	20,373	1,808	8.9 %	(48)	(0.2)%

(1) See "Segment Analysis" above in this MD&A for a reconciliation of operating income (GAAP measure) to adjusted operating income for the Health Care Benefits segment, which represents the Company's principal measure of segment performance.

Commentary - 2022 compared to 2021

Revenues

- Total revenues increased $9.2 billion, or 11.2%, to $91.4 billion in 2022 compared to 2021 driven by growth across all product lines.

Medical Benefit Ratio

- Medical benefit ratio is calculated as benefit costs divided by premium revenues and represents the percentage of premium revenues spent on medical benefits for the Company's Insured members. Management uses MBR to assess the underlying business performance and underwriting of its insurance products, understand variances between actual results and expected results and identify trends in period-over-period results. MBR provides management and investors with information useful in assessing the operating results of the Company's Insured Health Care Benefits products.
- The MBR decreased from 85.0% to 84.0% in 2022 compared to the prior year primarily driven by the net favorable impact of COVID-19 compared to the prior year, partially offset by the unfavorable impact of the flu compared to the prior year.

Loss on assets held for sale

- During 2022, the Company recorded a $41 million loss on assets held for sale on its Thailand business, which is included in the Commercial Business reporting unit within the Health Care Benefits segment. See Note 2 ''Acquisitions, Divestitures and Asset Sales'' included in Item 8 of this 10-K for additional information.

Operating expenses

- Operating expenses in the Health Care Benefits segment include selling, general and administrative expenses and depreciation and amortization expenses.

- Operating expenses increased $636 million, or 4.5%, in 2022 compared to 2021. The increase in operating expenses was primarily driven by increased operating expenses to support the growth across all product lines described above, incremental investments in the business, as well as office real estate optimization charges recorded in 2022 in connection with the planned reduction of corporate office real estate space. These increases were partially offset by the pre-tax gains of $250 million on the sale of bswift and $225 million on the sale of PayFlex.
- Operating expenses as a percentage of total revenues decreased to 16.0% in 2022 compared to 17.0% in 2021. The decrease in operating expenses as a percentage of total revenues was primarily driven by the increases in total revenues described above and the pre-tax gains on the sales of bswift and PayFlex.

Adjusted operating income

- Adjusted operating income increased $972 million, or 19.4%, in 2022 compared to 2021. The increase in adjusted operating income was primarily driven by the net favorable impact of COVID-19 compared to the prior year, strong underlying performance and membership growth. These increases were partially offset by incremental investments to support growth in the business, the unfavorable impact of the flu compared to the prior year and net realized capital losses.

The following table summarizes the Health Care Benefits segment's medical membership as of December 31, 2022 and 2021:

	2022			2021		
In thousands	**Insured**	**ASC**	**Total**	**Insured**	**ASC**	**Total**
Medical membership:						
Commercial	3,136	13,896	17,032	3,258	13,530	16,788
Medicare Advantage	3,270	—	3,270	2,971	—	2,971
Medicare Supplement	1,363	—	1,363	1,285	—	1,285
Medicaid	2,234	497	2,731	2,333	471	2,804
Total medical membership	10,003	14,393	24,396	9,847	14,001	23,848
Supplemental membership information:						
Medicare Prescription Drug Plan (standalone)			6,128			5,777

Medical Membership

- Medical membership represents the number of members covered by the Company's Insured and ASC medical products and related services at a specified point in time. Management uses this metric to understand variances between actual medical membership and expected amounts as well as trends in period-over-period results. This metric provides management and investors with information useful in understanding the impact of medical membership on segment total revenues and operating results.
- Medical membership as of December 31, 2022 of 24.4 million increased 548,000 compared with December 31, 2021, reflecting increases in Medicare and Commercial membership, as underlying Commercial growth more than offset the impact of international divestitures. These increases were partially offset by a decline in Medicaid membership reflecting the previously disclosed loss of a large customer in the third quarter of 2022.

Medicare Update

On April 4, 2022, the U.S. Centers for Medicare & Medicaid Services ("CMS") issued its final notice detailing final 2023 Medicare Advantage payment rates. Final 2023 Medicare Advantage rates resulted in an expected average increase in revenue for the Medicare Advantage industry of 5.00%, excluding the CMS estimate of Medicare Advantage risk score trend. On February 1, 2023, CMS issued an advance notice detailing proposed 2024 Medicare Advantage payment rates. The 2024 Medicare Advantage rates, if finalized as proposed, will result in an expected average decrease in revenue for the Medicare Advantage industry of 2.27%, excluding the CMS estimate of Medicare Advantage risk score trend. CMS intends to publish the final 2024 rate announcement no later than April 3, 2023.

The ACA ties a portion of each Medicare Advantage plan's reimbursement to the plan's "star ratings." Plans must have a star rating of four or higher (out of five) to qualify for bonus payments. CMS released the Company's 2023 star ratings in October 2022. The Company's 2023 star ratings will be used to determine which of the Company's Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2024. Based on the Company's membership at December 31, 2022, 21% of the Company's Medicare Advantage members were in plans with 2023 star ratings of at least 4.0 stars, compared to 87% of the Company's Medicare Advantage members being in plans with 2022 star ratings of at least 4.0 stars based on the Company's membership at December 31, 2021.

Pharmacy Services Segment

The following table summarizes the Pharmacy Services segment's performance for the respective periods:

	Year Ended December 31,			Change			
				2022 vs. 2021		2021 vs. 2020	
In millions, except percentages	**2022**	**2021**	**2020**	**$**	**%**	**$**	**%**
Revenues:							
Products	$ 168,004	$ 151,851	$ 140,950	$ 16,153	10.6 %	$ 10,901	7.7 %
Services	1,232	1,171	988	61	5.2 %	183	18.5 %
Total revenues	169,236	153,022	141,938	16,214	10.6 %	11,084	7.8 %
Cost of products sold	160,421	144,894	135,045	15,527	10.7 %	9,849	7.3 %
Operating expenses	1,628	1,461	1,439	167	11.4 %	22	1.5 %
Operating expenses as a % of total revenues	1.0 %	1.0 %	1.0 %				
Operating income	$ 7,187	$ 6,667	$ 5,454	$ 520	7.8 %	$ 1,213	22.2 %
Operating income as a % of total revenues	4.2 %	4.4 %	3.8 %				
Adjusted operating income [1]	$ 7,356	$ 6,859	$ 5,688	$ 497	7.2 %	$ 1,171	20.6 %
Adjusted operating income as a % of total revenues	4.3 %	4.5 %	4.0 %				
Revenues (by distribution channel):							
Pharmacy network [2]	$ 97,668	$ 91,715	$ 85,045	$ 5,953	6.5 %	$ 6,670	7.8 %
Mail choice [3]	70,466	60,547	56,071	9,919	16.4 %	4,476	8.0 %
Other	1,102	760	822	342	45.0 %	(62)	(7.5)%
Pharmacy claims processed: [4]							
Total	2,336.6	2,244.7	2,112.9	91.9	4.1 %	131.8	6.2 %
Pharmacy network [2]	2,003.6	1,914.0	1,790.1	89.6	4.7 %	123.9	6.9 %
Mail choice [3]	333.0	330.7	322.8	2.3	0.7 %	7.9	2.4 %
Generic dispensing rate: [4]							
Total	87.4 %	86.8 %	88.2 %				
Pharmacy network [2]	87.7 %	87.0 %	88.7 %				
Mail choice [3]	85.6 %	85.6 %	85.3 %				

(1) See "Segment Analysis" above in this MD&A for a reconciliation of operating income (GAAP measure) to adjusted operating income for the Pharmacy Services segment, which represents the Company's principal measure of segment performance.

(2) Pharmacy network is defined as claims filled at retail and specialty retail pharmacies, including the Company's retail pharmacies and LTC pharmacies, but excluding Maintenance Choice® activity, which is included within the mail choice category. Maintenance Choice permits eligible client plan members to fill their maintenance prescriptions through mail order delivery or at a CVS pharmacy retail store for the same price as mail order.

(3) Mail choice is defined as claims filled at a Pharmacy Services mail order facility, which includes specialty mail claims inclusive of Specialty Connect® claims picked up at a retail pharmacy, as well as prescriptions filled at the Company's retail pharmacies under the Maintenance Choice program.

(4) Includes an adjustment to convert 90-day prescriptions to the equivalent of three 30-day prescriptions. This adjustment reflects the fact that these prescriptions include approximately three times the amount of product days supplied compared to a normal prescription.

Commentary - 2022 compared to 2021

Revenues

- Total revenues increased $16.2 billion, or 10.6%, to $169.2 billion in 2022 compared to 2021. The increase was primarily driven by increased pharmacy claims volume, growth in specialty pharmacy and brand inflation, partially offset by continued client price improvements.

Operating expenses

- Operating expenses in the Pharmacy Services segment include selling, general and administrative expenses; depreciation and amortization expense; and expenses related to specialty retail pharmacies, which include administrative payroll, employee benefits and occupancy costs.
- Operating expenses increased $167 million, or 11.4%, in 2022 compared to 2021. The increase was primarily driven by restructuring and business integration costs recorded in 2022.
- Operating expenses as a percentage of total revenues remained consistent at 1.0% in both 2022 and 2021.

Adjusted operating income

- Adjusted operating income increased $497 million, or 7.2%, in 2022 compared to 2021. The increase in adjusted operating income was primarily driven by improved purchasing economics, including increased contributions from the products and services of the Company's group purchasing organization, partially offset by continued client price improvements.
- As you review the Pharmacy Services segment's performance in this area, you should consider the following important information about the business:
    - The Company's efforts to (i) retain existing clients, (ii) obtain new business and (iii) maintain or improve the rebates, fees and/or discounts the Company receives from manufacturers, wholesalers and retail pharmacies continue to have an impact on adjusted operating income. In particular, competitive pressures in the PBM industry have caused the Company and other PBMs to continue to share with clients a larger portion of rebates, fees and/or discounts received from pharmaceutical manufacturers. In addition, marketplace dynamics and regulatory changes have limited the Company's ability to offer plan sponsors pricing that includes retail network "differential" or "spread," and the Company expects these trends to continue. The "differential" or "spread" is any difference between the drug price charged to plan sponsors, including Medicare Part D plan sponsors, by a PBM and the price paid for the drug by the PBM to the dispensing provider.

Pharmacy claims processed

- Total pharmacy claims processed represents the number of prescription claims processed through our pharmacy benefits manager and dispensed by either our retail network pharmacies or our own mail and specialty pharmacies. Management uses this metric to understand variances between actual claims processed and expected amounts as well as trends in period-over-period results. This metric provides management and investors with information useful in understanding the impact of pharmacy claim volume on segment total revenues and operating results.
- The Company's pharmacy network claims processed increased 4.7% on a 30-day equivalent basis in 2022 compared to 2021 primarily driven by net new business, increased utilization and the impact of an elevated cough, cold and flu season compared to the prior year. These increases were partially offset by a decrease in COVID-19 vaccinations.
- The Company's mail choice claims processed increased 0.7% on a 30-day equivalent basis in 2022 compared to 2021 primarily driven by net new business and the increased utilization of Maintenance Choice prescriptions.
- Excluding the impact of COVID-19 vaccinations, total pharmacy claims processed increased 5.1% on a 30-day equivalent basis in 2022 compared to the prior year.

Generic dispensing rate

- Generic dispensing rate is calculated by dividing the Pharmacy Services segment's generic drug prescriptions processed or filled by its total prescriptions processed or filled. Management uses this metric to evaluate the effectiveness of the business at encouraging the use of generic drugs when they are available and clinically appropriate, which aids in decreasing costs for client members and retail customers. This metric provides management and investors with information useful in understanding trends in segment total revenues and operating results.
- The Pharmacy Services segment's total generic dispensing rate increased to 87.4% in 2022 compared to 86.8% in the prior year. The increase in the segment's generic dispensing rate was primarily driven by a decrease in brand prescriptions, largely attributable to decreased COVID-19 vaccinations in 2022 compared to the prior year. Excluding the impact of COVID-19 vaccinations, the segment's total generic dispensing rate was 88.3% and 88.5% in 2022 and 2021, respectively.

Retail/LTC Segment

The following table summarizes the Retail/LTC segment's performance for the respective periods:

	Year Ended December 31,			Change			
				2022 vs. 2021		2021 vs. 2020	
In millions, except percentages	**2022**	**2021**	**2020**	**$**	**%**	**$**	**%**
Revenues:							
Products	$ 103,762	$ 95,652	$ 89,944	$ 8,110	8.5 %	$ 5,708	6.3 %
Services	2,876	4,436	1,254	(1,560)	(35.2)%	3,182	253.7 %
Net investment income (loss)	(44)	17	—	(61)	(358.8)%	17	100.0 %
Total revenues	106,594	100,105	91,198	6,489	6.5 %	8,907	9.8 %
Cost of products sold	79,684	72,832	67,284	6,852	9.4 %	5,548	8.2 %
Loss on assets held for sale	2,492	—	—	2,492	100.0 %	—	— %
Store impairments	—	1,358	—	(1,358)	(100.0)%	1,358	100.0 %
Goodwill impairment	—	431	—	(431)	(100.0)%	431	100.0 %
Operating expenses	20,640	20,162	18,274	478	2.4 %	1,888	10.3 %
Operating expenses as a % of total revenues	19.4 %	20.1 %	20.0 %				
Operating income	$ 3,778	$ 5,322	$ 5,640	$ (1,544)	(29.0)%	$ (318)	(5.6)%
Operating income as a % of total revenues	3.5 %	5.3 %	6.2 %				
Adjusted operating income [1]	$ 6,705	$ 7,623	$ 6,146	$ (918)	(12.0)%	$ 1,477	24.0 %
Adjusted operating income as a % of total revenues	6.3 %	7.6 %	6.7 %				
Revenues (by major goods/service lines):							
Pharmacy	$ 82,010	$ 76,121	$ 70,176	$ 5,889	7.7 %	$ 5,945	8.5 %
Front Store	22,780	21,315	19,655	1,465	6.9 %	1,660	8.4 %
Other	1,848	2,652	1,367	(804)	(30.3)%	1,285	94.0 %
Net investment income (loss)	(44)	17	—	(61)	(358.8)%	17	100.0 %
Prescriptions filled [2]	1,623.8	1,587.6	1,465.2	36.2	2.3 %	122.4	8.4 %
Same store sales increase: [3]							
Total	9.0 %	8.9 %	5.6 %				
Pharmacy	9.5 %	9.3 %	7.0 %				
Front Store	7.4 %	7.6 %	0.9 %				
Prescription volume [2]	4.0 %	9.3 %	4.7 %				
Generic dispensing rate [2]	87.4 %	85.7 %	88.3 %				

(1) See "Segment Analysis" above in this MD&A for a reconciliation of operating income (GAAP measure) to adjusted operating income for the Retail/LTC segment, which represents the Company's principal measure of segment performance.

(2) Includes an adjustment to convert 90-day prescriptions to the equivalent of three 30-day prescriptions. This adjustment reflects the fact that these prescriptions include approximately three times the amount of product days supplied compared to a normal prescription.

(3) Same store sales and prescription volume represent the change in revenues and prescriptions filled in the Company's retail pharmacy stores that have been operating for greater than one year, expressed as a percentage that indicates the increase or decrease relative to the comparable prior period. Same store metrics exclude revenues from MinuteClinic and revenues and prescriptions from LTC operations. Management uses these metrics to evaluate the performance of existing stores on a comparable basis and to inform future decisions regarding existing stores and new locations. Same-store metrics provide management and investors with information useful in understanding the portion of current revenues and prescriptions resulting from organic growth in existing locations versus the portion resulting from opening new stores.

Commentary - 2022 compared to 2021

Revenues

- Total revenues increased $6.5 billion, or 6.5%, to $106.6 billion in 2022 compared to 2021. The increase was primarily driven by increased prescription and front store volume, including the impact of an elevated cough, cold and flu season compared to the prior year and increased sales of COVID-19 OTC test kits in 2022 compared to 2021, as well as pharmacy

drug mix and brand inflation. These increases were partially offset by decreased COVID-19 vaccinations and diagnostic testing, the impact of recent generic introductions and continued pharmacy reimbursement pressure.

- Pharmacy same store sales increased 9.5% in 2022 compared to 2021. The increase was primarily driven by the 4.0% increase in pharmacy same store prescription volume on a 30-day equivalent basis, including the impact of an elevated cough, cold and flu season compared to the prior year, pharmacy drug mix and brand inflation. These increases were partially offset by the impact of recent generic introductions and continued pharmacy reimbursement pressure.
- Front store same store sales increased 7.4% in 2022 compared to 2021. The increase was primarily due to strength in consumer health, including the impact of an elevated cough, cold and flu season compared to the prior year and increased sales of COVID-19 OTC test kits in 2022 compared to 2021.
- Other revenues decreased 30.3% in 2022 compared to 2021. The decrease was primarily due to decreased COVID-19 diagnostic testing in 2022 compared to the prior year.

Loss on assets held for sale

- During 2022, the Company recorded a loss on assets held for sale of approximately $2.5 billion related to the write-down of its LTC business. See Note 2 ‘‘Acquisitions, Divestitures and Asset Sales’’ included in Item 8 of this 10-K for additional information.

Store impairments

- During 2021, the Company recorded a store impairment charge of approximately $1.4 billion related to the write-down of operating lease right-of-use assets and property and equipment in connection with the planned closure of approximately 900 retail stores between 2022 and 2024. See Note 6 ‘‘Leases’’ included in Item 8 of this 10-K for additional information.

Goodwill impairment

- During 2021, the Company recorded a $431 million goodwill impairment charge related to the LTC reporting unit within the Retail/LTC segment. See Note 5 ‘‘Goodwill and Other Intangibles’’ included in Item 8 of this 10-K for additional information.

Operating expenses

- Operating expenses in the Retail/LTC segment include store payroll, store employee benefits, store occupancy costs, selling expenses, advertising expenses, depreciation and amortization expense and certain administrative expenses.
- Operating expenses increased $478 million, or 2.4%, in 2022 compared to 2021. The increase was primarily due to incremental costs associated with increased volume, increased investments in the segment’s operations and capabilities, as well as decreased gains from legal settlements in 2022 compared to 2021. These increases were partially offset by lower expenses associated with COVID-19 vaccination administration compared to the prior year and the favorable impact of business initiatives in 2022.
- Operating expenses as a percentage of total revenues decreased to 19.4% in 2022 compared to 20.1% in 2021. The decrease in operating expenses as a percentage of total revenues was primarily driven by the increases in total revenues described above.

Adjusted operating income

- Adjusted operating income decreased $918 million, or 12.0%, in 2022 compared to 2021. The decrease in adjusted operating income was primarily driven by decreased COVID-19 vaccinations and diagnostic testing, continued pharmacy reimbursement pressure, increased investments in the segment’s operations and capabilities and decreased gains from legal settlements in 2022 compared to 2021. These decreases were partially offset by the increased prescription and front store volume described above, improved generic drug purchasing and the favorable impact of business initiatives in 2022.
- As you review the Retail/LTC segment’s performance in this area, you should consider the following important information about the business:
    - The segment’s adjusted operating income has been adversely affected by the efforts of managed care organizations, PBMs and governmental and other third-party payors to reduce their prescription drug costs, including the use of restrictive networks, as well as changes in the mix of business within the pharmacy portion of the Retail/LTC segment. If the pharmacy reimbursement pressure accelerates, the segment may not be able to grow revenues, and its adjusted operating income could be adversely affected.
    - The increased use of generic drugs has positively impacted the segment’s adjusted operating income but has resulted in third-party payors augmenting their efforts to reduce reimbursement payments to retail pharmacies for prescriptions. This trend, which the Company expects to continue, reduces the benefit the segment realizes from brand-to-generic drug conversions.

Prescriptions filled

- Prescriptions filled represents the number of prescriptions dispensed through the Retail/LTC segment's pharmacies. Management uses this metric to understand variances between actual prescriptions dispensed and expected amounts as well as trends in period-over-period results. This metric provides management and investors with information useful in understanding the impact of prescription volume on segment total revenues and operating results.
- Prescriptions filled increased 2.3% on a 30-day equivalent basis in 2022 compared to 2021 primarily driven by increased utilization and the impact of an elevated cough, cold and flu season compared to the prior year, partially offset by a decrease in COVID-19 vaccinations. Excluding the impact of COVID-19 vaccinations, prescriptions filled increased 4.4%, on a 30-day equivalent basis in 2022 compared to the prior year.

Generic dispensing rate

- Generic dispensing rate is calculated by dividing the Retail/LTC segment's generic drug prescriptions filled by its total prescriptions filled. Management uses this metric to evaluate the effectiveness of the business at encouraging the use of generic drugs when they are available and clinically appropriate, which aids in decreasing costs for client members and retail customers. This metric provides management and investors with information useful in understanding trends in segment total revenues and operating results.
- The Retail/LTC segment's generic dispensing rate increased to 87.4% in 2022 compared to 85.7% in the prior year. The increase in the segment's generic dispensing rate was primarily driven by a decrease in brand prescriptions, largely attributable to decreased COVID-19 vaccinations in 2022 compared to the prior year. Excluding the impact of COVID-19 vaccinations, the segment's total generic dispensing rate was 89.0% in both 2022 and 2021.

Corporate/Other Segment

The following table summarizes the Corporate/Other segment's performance for the respective periods:

				Change			
	Year Ended December 31,			2022 vs. 2021		2021 vs. 2020	
In millions, except percentages	**2022**	**2021**	**2020**	**$**	**%**	**$**	**%**
Revenues:							
Premiums	$ 56	$ 68	$ 63	$ (12)	(17.6)%	$ 5	7.9 %
Services	68	57	48	11	19.3 %	9	18.8 %
Net investment income	406	596	315	(190)	(31.9)%	281	89.2 %
Total revenues	530	721	426	(191)	(26.5)%	295	69.2 %
Cost of products sold	42	37	—	5	13.5 %	37	100.0 %
Benefit costs	319	212	221	107	50.5 %	(9)	(4.1)%
Opioid litigation charges	5,803	—	—	5,803	100.0 %	—	— %
Operating expenses	1,975	2,078	1,846	(103)	(5.0)%	232	12.6 %
Operating loss	(7,609)	(1,606)	(1,641)	(6,003)	(373.8)%	35	2.1 %
Adjusted operating loss [(1)]	(1,785)	(1,471)	(1,306)	(314)	(21.3)%	(165)	(12.6)%

(1) See "Segment Analysis" above in this MD&A for a reconciliation of Corporate/Other segment operating loss (GAAP measure) to adjusted operating loss, which represents the Company's principal measure of segment performance.

Commentary - 2022 compared to 2021

Revenues

- Revenues primarily relate to products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products.
- Total revenues decreased $191 million, or 26.5%, in 2022 compared to 2021. The decrease was primarily driven by net realized capital losses in 2022 compared to net realized capital gains in 2021 and lower net investment income from private equity investments, partially offset by higher average invested assets and favorable average investment yields in 2022 compared to 2021.

Opioid litigation charges

- During 2022, the Company recorded $5.8 billion of opioid litigation charges. See Note 16 ''Commitments and Contingencies'' included in Item 8 of this 10-K for additional information.

Adjusted operating loss

- Adjusted operating loss increased $314 million, or 21.3%, in 2022 compared to 2021. The increase was primarily driven by the decreases in net investment income described above and the strengthening of reserves in the Company's long-term care insurance business, which occurred during the second quarter of 2022.

Liquidity and Capital Resources

Cash Flows

The Company maintains a level of liquidity sufficient to allow it to meet its cash needs in the short-term. Over the long term, the Company manages its cash and capital structure to maximize shareholder return, maintain its financial condition and maintain flexibility for future strategic initiatives. The Company continuously assesses its regulatory capital requirements, working capital needs, debt and leverage levels, debt maturity schedule, capital expenditure requirements, dividend payouts, potential share repurchases and future investments or acquisitions. The Company believes its operating cash flows, commercial paper program, credit facilities, as well as any potential future borrowings, will be sufficient to fund these future payments and long-term initiatives. As of December 31, 2022, the Company had approximately $12.9 billion in cash and cash equivalents, approximately $5.4 billion of which was held by the parent company or nonrestricted subsidiaries.

The net change in cash, cash equivalents and restricted cash for the years ended December 31, 2022, 2021 and 2020 was as follows:

				Change			
	Year Ended December 31,			2022 vs. 2021		2021 vs. 2020	
In millions	**2022**	**2021**	**2020**	**$**	**%**	**$**	**%**
Net cash provided by operating activities	$ 16,177	$ 18,265	$ 15,865	$ (2,088)	(11.4)%	$ 2,400	15.1 %
Net cash used in investing activities	(5,047)	(5,261)	(5,534)	214	4.1 %	273	4.9 %
Net cash used in financing activities	(10,516)	(11,356)	(7,696)	840	7.4 %	(3,660)	(47.6)%
Net increase in cash, cash equivalents and restricted cash	$ 614	$ 1,648	$ 2,635	$ (1,034)	(62.7)%	$ (987)	(37.5)%

Commentary - 2022 compared to 2021

- *Net cash provided by operating activities* decreased by $2.1 billion in 2022 compared to 2021 primarily due to the timing of payments and higher inventory purchases.
- *Net cash used in investing activities* decreased by $214 million in 2022 compared to 2021 primarily due to lower net purchases of investments and the gross proceeds from the divestitures of PayFlex and bswift, largely offset by a reduction in restricted cash as a result of the sale of health savings account funds held on behalf of customers in conjunction with the sale of PayFlex. In addition, cash used in investing activities reflected the following activity:
    - Gross capital expenditures remained relatively consistent at approximately $2.7 billion and $2.5 billion in 2022 and 2021, respectively. During 2022, approximately 73% of the Company's total capital expenditures were for technology, digital and other strategic initiatives and 27% were for store, fulfillment and support facilities expansion and improvements.
- *Net cash used in financing activities* decreased to $10.5 billion in 2022 compared to $11.4 billion in 2021. The decrease in cash used in financing activities primarily related to lower net repayments of long-term debt during 2022 compared to the prior year, partially offset by share repurchases in 2022.

Included in net cash used in investing activities for the years ended December 31, 2022, 2021 and 2020 was the following store development activity: [(1)]

	2022	**2021**	**2020**
Total stores (beginning of year)	9,939	9,962	9,896
New and acquired stores [(2)]	41	58	156
Closed stores [(2)]	(306)	(81)	(90)
Total stores (end of year)	9,674	9,939	9,962
Relocated stores [(2)]	4	17	18

(1) Includes retail drugstores and pharmacies within retail chains, primarily in Target Corporation ("Target") stores.
(2) Relocated stores are not included in new and acquired stores or closed stores totals.

Short-term Borrowings

Commercial Paper and Back-up Credit Facilities
The Company did not have any commercial paper outstanding as of December 31, 2022 or 2021. In connection with its commercial paper program, the Company maintains a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 16, 2025, a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 11, 2026, and a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 16, 2027. The credit facilities allow for borrowings at various rates that are dependent, in part, on the Company's public debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately 0.03%, regardless of usage. As of December 31, 2022 and 2021, there were no borrowings outstanding under any of the Company's back-up credit facilities.

Federal Home Loan Bank of Boston ("FHLBB")
A subsidiary of the Company is a member of the FHLBB. As a member, the subsidiary has the ability to obtain cash advances, subject to certain minimum collateral requirements. The maximum borrowing capacity available from the FHLBB as of December 31, 2022 was approximately $915 million. At both December 31, 2022 and 2021, there were no outstanding advances from the FHLBB.

Long-term Borrowings

Exercise of Par Call Redemptions
In May 2022, the Company exercised the par call redemption on its outstanding 3.5% senior notes due July 2022 to redeem for cash on hand the entire $1.5 billion aggregate principal amount.

In August 2022, the Company exercised the par call redemption on its outstanding 2.75% senior notes due November 2022 (issued by Aetna) to redeem for cash on hand the entire $1.0 billion aggregate principal amount.

In September 2022, the Company exercised the par call redemptions on its outstanding 2.75% senior notes due December 2022 and 4.75% senior notes due December 2022 (including notes issued by Omnicare, Inc.) to redeem for cash on hand the entire aggregate principal amount of $1.25 billion and $399 million, respectively.

2021 Notes
On August 18, 2021, the Company issued $1.0 billion aggregate principal amount of 2.125% unsecured senior notes due September 15, 2031 for total proceeds of $987 million, net of discounts, underwriting fees and offering expenses. The net proceeds of this offering were used for the purchase of senior notes in connection with the Company's cash tender offer in August 2021 as described below.

Cash Flow Hedges
During March 2020, the Company entered into several interest rate swap transactions to manage interest rate risk. These agreements were designated as cash flow hedges and were used to hedge the exposure to variability in future cash flows resulting from changes in interest rates related to the anticipated issuance of $750 million aggregate principal amount of 3.625% unsecured senior notes due April 1, 2027, $1.5 billion aggregate principal amount of 3.75% unsecured senior notes due April 1, 2030, $1.0 billion aggregate principal amount of 4.125% unsecured senior notes due April 1, 2040 and $750 million aggregate principal amount of 4.25% unsecured senior notes due April 1, 2050 (collectively, the "March 2020 Notes"). In connection with the issuance of the March 2020 Notes on March 31, 2020, the Company terminated all outstanding cash flow hedges. The Company paid a net amount of $7 million to the hedge counterparties upon termination, which was recorded as a loss, net of tax, of $5 million in accumulated other comprehensive income and will be reclassified as interest expense over the life of the March 2020 Notes. See Note 13 ''Other Comprehensive Income (Loss)'' included in Item 8 of this 10-K for additional information.

Early Extinguishments of Debt
In December 2021, the Company redeemed for cash the remaining $2.3 billion of its outstanding 3.7% senior notes due 2023. In connection with the early redemption of such senior notes, the Company paid a make-whole premium of $80 million in excess of the aggregate principal amount of the senior notes that were redeemed, wrote-off $8 million of unamortized deferred financing costs and incurred $1 million in fees, for a total loss on early extinguishment of debt of $89 million.

In August 2021, the Company purchased approximately $2.0 billion of its outstanding 4.3% senior notes due 2028 through a cash tender offer. In connection with the purchase of such senior notes, the Company paid a premium of $332 million in excess

of the aggregate principal amount of the senior notes that were purchased, wrote-off $26 million of unamortized deferred financing costs and incurred $5 million in fees, for a total loss on early extinguishment of debt of $363 million.

In December 2020, the Company purchased $4.5 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $113 million of its 4.0% senior notes due 2023, $1.4 billion of its 3.7% senior notes due 2023, $1.0 billion of its 4.1% senior notes due 2025 and $2.0 billion of its 4.3% senior notes due 2028. In connection with the purchase of such senior notes, the Company paid a premium of $619 million in excess of the aggregate principal amount of the senior notes that were purchased, wrote-off $45 million of unamortized deferred financing costs and incurred $10 million in fees, for a total loss on early extinguishment of debt of $674 million.

In August 2020, the Company purchased $6.0 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $723 million of its 4.0% senior notes due 2023, $2.3 billion of its 3.7% senior notes due 2023 and $3.0 billion of its 4.1% senior notes due 2025. In connection with the purchase of such senior notes, the Company paid a premium of $706 million in excess of the aggregate principal amount of the senior notes that were purchased, wrote-off $47 million of unamortized deferred financing costs and incurred $13 million in fees, for a total loss on early extinguishment of debt of $766 million.

See Note 8 ‘‘Borrowings and Credit Agreements’’ included in Item 8 of this 10-K for additional information about debt issuances and debt repayments.

Derivative Financial Instruments

The Company uses derivative financial instruments in order to manage interest rate and foreign exchange risk and credit exposure. The Company’s use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps.

Debt Covenants

The Company’s back-up revolving credit facilities and unsecured senior notes (see Note 8 ‘‘Borrowings and Credit Agreements’’ included in Item 8 of this 10-K) contain customary restrictive financial and operating covenants. These covenants do not include an acceleration of the Company’s debt maturities in the event of a downgrade in the Company’s credit ratings. The Company does not believe the restrictions contained in these covenants materially affect its financial or operating flexibility. As of December 31, 2022, the Company was in compliance with all of its debt covenants.

Debt Ratings

As of December 31, 2022, the Company’s long-term debt was rated “Baa2” by Moody’s Investors Service, Inc. (“Moody’s”) and “BBB” by Standard & Poor’s Financial Services LLC (“S&P”), and its commercial paper program was rated “P-2” by Moody’s and “A-2” by S&P. The outlook on the Company’s long-term debt is “Stable” by Moody’s. In December 2022, S&P changed the outlook on the Company’s long-term debt from “Positive” to “Stable.” In assessing the Company’s credit strength, the Company believes that both Moody’s and S&P considered, among other things, the Company’s capital structure and financial policies as well as its consolidated balance sheet, its historical acquisition activity and other financial information. Although the Company currently believes its long-term debt ratings will remain investment grade, it cannot guarantee the future actions of Moody’s and/or S&P. The Company’s debt ratings have a direct impact on its future borrowing costs, access to capital markets and new store operating lease costs.

Share Repurchase Programs

The following share repurchase programs have been authorized by CVS Health Corporation’s Board of Directors (the “Board”):

The following share repurchase programs have been authorized by the Board:

In billions **Authorization Date**	**Authorized**	**Remaining as of December 31, 2022**
November 17, 2022 (“2022 Repurchase Program”)	$ 10.0	$ 10.0
December 9, 2021 (“2021 Repurchase Program”)	10.0	6.5

Each of the share Repurchase Programs was effective immediately and permit the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase ("ASR") transactions, and/or other derivative transactions. Both the 2022 and 2021 Repurchase Programs can be modified or terminated by the Board at any time.

During the year ended December 31, 2022, the Company repurchased an aggregate of 34.1 million shares of common stock for approximately $3.5 billion pursuant to the 2021 Repurchase Program, including share repurchases under the $1.5 billion fixed dollar ASR transaction described below. During the years ended December 31, 2021 and 2020, the Company did not repurchase any shares of common stock.

Pursuant to the authorization under the 2021 Repurchase Program, the Company entered into a $2.0 billion fixed dollar ASR with Citibank, N.A. ("Citibank"). Upon payment of the $2.0 billion purchase price on January 4, 2023, the Company received a number of shares of CVS Health Corporation's common stock equal to 80% of the $2.0 billion notional amount of the ASR or approximately 17.4 million shares at a price of $92.19 per share, which were placed into treasury stock in January 2023. At the conclusion of the ASR, the Company may receive additional shares representing the remaining 20% of the $2.0 billion notional amount. The ultimate number of shares the Company may receive will depend on the daily volume-weighted average price of the Company's stock over an averaging period, less a discount. It is also possible, depending on such weighted average price, that the Company will have an obligation to Citibank which, at the Company's option, could be settled in additional cash or by issuing shares. Under the terms of the ASR, the maximum number of shares that could be delivered to the Company is 43.4 million.

Pursuant to the authorization under the 2021 Repurchase Program, the Company entered into a $1.5 billion fixed dollar ASR with Barclays Bank PLC. Upon payment of the $1.5 billion purchase price on January 4, 2022, the Company received a number of shares of CVS Health Corporation's common stock equal to 80% of the $1.5 billion notional amount of the ASR or approximately 11.6 million shares at a price of $103.34 per share, which were placed into treasury stock in January 2022. The ASR was accounted for as an initial treasury stock transaction for $1.2 billion and a forward contract for $0.3 billion. The forward contract was classified as an equity instrument and was recorded within capital surplus. In February 2022, the Company received approximately 2.7 million shares of CVS Health Corporation's common stock, representing the remaining 20% of the $1.5 billion notional amount of the ASR, thereby concluding the ASR. These shares were placed into treasury stock and the forward contract was reclassified from capital surplus to treasury stock in February 2022.

At the time they were received, the initial and final receipt of shares resulted in an immediate reduction of the outstanding shares used to calculate the weighted average common shares outstanding for basic and diluted earnings per share.

Dividends

During 2022, 2021 and 2020 the quarterly cash dividend was $0.55, $0.50 and $0.50 per share, respectively. In December 2022, the Board authorized a 10% increase in the quarterly cash dividend to $0.605 per share effective in 2023. CVS Health Corporation has paid cash dividends every quarter since becoming a public company. Future dividend payments will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

Future Cash Requirements

The following table summarizes certain estimated future cash requirements under the Company's various contractual obligations at December 31, 2022, in total and disaggregated into current and long-term obligations. The table below does not include future payments of claims to health care providers or pharmacies because certain terms of these payments are not determinable at December 31, 2022 (for example, the timing and volume of future services provided under fee-for-service arrangements and future membership levels for capitated arrangements).

In millions	Total	Current	Long-Term
Operating lease liabilities [1]	$ 24,039	$ 2,685	$ 21,354
Finance lease liabilities [1]	2,288	139	2,149
Contractual lease obligations with Target [2]	2,487	—	2,487
Long-term debt [3]	51,288	1,719	49,569
Interest payments on long-term debt [3]	29,472	2,042	27,430
Opioid litigation settlement agreements [4]	5,712	539	5,173
Other long-term liabilities on the consolidated balance sheets [5]			
Future policy benefits [6]	5,407	385	5,022
Unpaid claims [6]	1,329	243	1,086
Policyholders' funds [6] [7]	1,861	1,394	467
Total	$ 123,883	$ 9,146	$ 114,737

(1) Refer to Note 6 ''Leases'' included in Item 8 of this 10-K for additional information regarding the maturity of lease liabilities under operating and finance leases.

(2) The Company leases pharmacy and clinic space from Target. See Note 6 ''Leases'' included in Item 8 of this 10-K for additional information regarding the lease arrangements with Target. Amounts related to such operating and finance leases are reflected within the operating lease liabilities and finance lease liabilities in the table above. Pharmacy lease amounts due in excess of the remaining estimated economic life of the buildings are reflected in the table above assuming equivalent stores continue to operate through the term of the arrangements.

(3) Refer to Note 8 ''Borrowings and Credit Agreements'' included in Item 8 of this 10-K for additional information regarding the maturities of debt principal. Interest payments on long-term debt are calculated using outstanding balances and interest rates in effect on December 31, 2022.

(4) Refer to Note 16 ''Commitments and Contingencies'' included in Item 8 of this 10-K for additional information regarding the opioid litigation settlement agreements.

(5) Payments of other long-term liabilities exclude Separate Accounts liabilities of approximately $3.2 billion because these liabilities are supported by assets that are legally segregated and are not subject to claims that arise out of the Company's business.

(6) Total payments of future policy benefits, unpaid claims and policyholders' funds include $705 million, $1.3 billion and $170 million, respectively, of reserves for contracts subject to reinsurance. The Company expects the assuming reinsurance carrier to fund these obligations and has reflected these amounts as reinsurance recoverable assets on the consolidated balance sheets.

(7) Customer funds associated with group life and health contracts of approximately $107 million have been excluded from the table above because such funds may be used primarily at the customer's discretion to offset future premiums and/or for refunds, and the timing of the related cash flows cannot be determined. Additionally, net unrealized capital losses on debt securities supporting experience-rated products of $56 million, before tax, have been excluded from the table above.

Restrictions on Certain Payments

In addition to general state law restrictions on payments of dividends and other distributions to stockholders applicable to all corporations, health maintenance organizations ("HMOs") and insurance companies are subject to further regulations that, among other things, may require those companies to maintain certain levels of equity (referred to as surplus) and restrict the amount of dividends and other distributions that may be paid to their equity holders. These regulations are not directly applicable to CVS Health Corporation as a holding company, since CVS Health Corporation is not an HMO or an insurance company. In addition, in connection with the Aetna Acquisition, the Company made certain undertakings that require prior regulatory approval of dividends by certain of its HMOs and insurance companies. The additional regulations and undertakings applicable to the Company's HMO and insurance company subsidiaries are not expected to affect the Company's ability to service the Company's debt, meet other financing obligations or pay dividends, or the ability of any of the Company's subsidiaries to service their debt or other financing obligations. Under applicable regulatory requirements and undertakings, at December 31, 2022, the maximum amount of dividends that may be paid by the Company's insurance and HMO subsidiaries without prior approval by regulatory authorities was $2.7 billion in the aggregate.

The Company maintains capital levels in its operating subsidiaries at or above targeted and/or required capital levels and dividends amounts in excess of these levels to meet liquidity requirements, including the payment of interest on debt and stockholder dividends. In addition, at the Company's discretion, it uses these funds for other purposes such as funding share and debt repurchase programs, investments in new businesses and other purposes considered advisable.

At December 31, 2022 and 2021, the Company held investments of $331 million and $450 million, respectively, that are not accounted for as Separate Accounts assets but are legally segregated and are not subject to claims that arise out of the Company's business. See Note 3 ''Investments'' included in Item 8 of this 10-K for additional information on investments related to the 2012 conversion of an existing group annuity contract from a participating to a non-participating contract.

Solvency Regulation

The National Association of Insurance Commissioners (the "NAIC") utilizes risk-based capital ("RBC") standards for insurance companies that are designed to identify weakly-capitalized companies by comparing each company's adjusted surplus to its required surplus (the "RBC Ratio"). The RBC Ratio is designed to reflect the risk profile of insurance companies. Within certain ratio ranges, regulators have increasing authority to take action as the RBC Ratio decreases. There are four levels of regulatory action, ranging from requiring an insurer to submit a comprehensive financial plan for increasing its RBC to the state insurance commissioner to requiring the state insurance commissioner to place the insurer under regulatory control. At December 31, 2022, the RBC Ratio of each of the Company's primary insurance subsidiaries was above the level that would require regulatory action. The RBC framework described above for insurers has been extended by the NAIC to health organizations, including HMOs. Although not all states had adopted these rules at December 31, 2022, at that date, each of the Company's active HMOs had a surplus that exceeded either the applicable state net worth requirements or, where adopted, the levels that would require regulatory action under the NAIC's RBC rules. External rating agencies use their own capital models and/or RBC standards when they determine a company's rating.

Critical Accounting Policies

The Company prepares the consolidated financial statements in conformity with generally accepted accounting principles, which require management to make certain estimates and apply judgment. Estimates and judgments are based on historical experience, current trends and other factors that management believes to be important at the time the consolidated financial statements are prepared. On a regular basis, the Company reviews its accounting policies and how they are applied and disclosed in the consolidated financial statements. While the Company believes the historical experience, current trends and other factors considered by management support the preparation of the consolidated financial statements in conformity with generally accepted accounting principles, actual results could differ from estimates, and such differences could be material.

Significant accounting policies are discussed in Note 1 ‘‘Significant Accounting Policies’’ included in Item 8 of this 10-K. Management believes the following accounting policies include a higher degree of judgment and/or complexity and, thus, are considered to be critical accounting policies. The Company has discussed the development and selection of these critical accounting policies with the Audit Committee of the Board (the “Audit Committee”), and the Audit Committee has reviewed the disclosures relating to them.

Revenue Recognition

Health Care Benefits Segment
Health Care Benefits revenue is principally derived from insurance premiums and fees billed to customers. Revenue is recognized based on customer billings, which, in the Company’s Commercial business, reflect contracted rates per member and the number of covered members recorded in the Company’s records at the time the billings are prepared. Billings are generally sent monthly for coverage during the following month. Revenue related to the Company’s Government business is collected monthly from the U.S. federal government and various government agencies based on fixed payment rates and member eligibility.

The Company’s billings may be subsequently adjusted to reflect enrollment changes due to member terminations or other factors. These adjustments are known as retroactivity adjustments. In each period, the Company estimates the amount of future retroactivity and adjusts the recorded revenue accordingly. As information regarding actual retroactivity amounts becomes known, the Company refines its estimates and records any required adjustments to revenues in the period in which they arise. A significant difference in the actual level of retroactivity compared to estimated levels would have a significant effect on the Company’s operating results.

Premium Revenue
Premiums are recognized as revenue in the month in which the enrollee is entitled to receive health care services. Premiums are reported net of an allowance for estimated terminations and uncollectible amounts. Additionally, premium revenue subject to the MLR rebate requirements of the ACA is recorded net of the estimated minimum MLR rebates for the current calendar year. Premiums related to unexpired contractual coverage periods (unearned premiums) are reported as other insurance liabilities on the consolidated balance sheets and recognized as revenue when earned.

Some of the Company’s contracts allow for premiums to be adjusted to reflect actual experience or the relative health status of Insured members. Such adjustments are reasonably estimable at the outset of the contract, and adjustments to those estimates are made based on actual experience of the customer emerging under the contract and the terms of the underlying contract.

Services Revenue
Services revenue relates to contracts that can include various combinations of services or series of services which generally are capable of being distinct and accounted for as separate performance obligations. The Health Care Benefits segment’s services revenue primarily consists of ASC fees received in exchange for performing certain claim processing and member services for ASC members. ASC fee revenue is recognized over the period the service is provided. Some of the Company’s administrative services contracts include guarantees with respect to certain functions, such as customer service response time, claim processing accuracy and claim processing turnaround time, as well as certain guarantees that a plan sponsor’s benefit claim experience will fall within a certain range. With any of these guarantees, the Company is financially at risk if the conditions of the arrangements are not met, although the maximum amount at risk typically is limited to a percentage of the fees otherwise payable to the Company by the customer involved. Each period the Company estimates its obligations under the terms of these guarantees and records its estimate as an offset to services revenues.

Accounting for Medicare Part D

Revenues include insurance premiums earned by the Company's PDPs, which are determined based on the PDP's annual bid and related contractual arrangements with CMS. The insurance premiums include a beneficiary premium, which is the responsibility of the PDP member, and can be subsidized by CMS in the case of low-income members, and a direct premium paid by CMS. Premiums collected in advance are initially recorded within other insurance liabilities and are then recognized ratably as revenue over the period in which members are entitled to receive benefits.

Revenues also include a risk-sharing feature of the Medicare Part D program design referred to as the risk corridor. The Company estimates variable consideration in the form of amounts payable to, or receivable from, CMS under the risk corridor, and adjusts revenue based on calculations of additional subsidies to be received from or owed to CMS at the end of the reporting year.

In addition to Medicare Part D premiums, the Company receives additional payments each month from CMS related to catastrophic reinsurance, low-income cost-sharing subsidies and coverage gap benefits. If the subsidies received differ from the amounts earned from actual prescriptions transferred, the difference is recorded in either accounts receivable, net or accrued expenses.

Pharmacy Services Segment

The Pharmacy Services segment sells prescription drugs directly through its mail service dispensing pharmacies and indirectly through the Company's retail pharmacy network. The Company's pharmacy benefit arrangements are accounted for in a manner consistent with a master supply arrangement as there are no contractual minimum volumes and each prescription is considered a separate purchasing decision and distinct performance obligation transferred at a point in time. PBM services performed in connection with each prescription claim are considered part of a single performance obligation which culminates in the dispensing of prescription drugs.

The Company recognizes revenue using the gross method at the contract price negotiated with its clients when the Company has concluded it controls the prescription drug before it is transferred to the client plan members. The Company controls prescriptions dispensed indirectly through its retail pharmacy network because it has separate contractual arrangements with those pharmacies, has discretion in setting the price for the transaction and assumes primary responsibility for fulfilling the promise to provide prescription drugs to its client plan members while also performing the related PBM services.

Revenues include (i) the portion of the price the client pays directly to the Company, net of any discounts earned on brand name drugs or other discounts and refunds paid back to the client (see "Drug Discounts" and "Guarantees" below), (ii) the price paid to the Company by client plan members for mail order prescriptions and the price paid to retail network pharmacies by client plan members for retail prescriptions ("retail co-payments"), and (iii) claims based administrative fees for retail pharmacy network contracts. Sales taxes are not included in revenues.

The Company recognizes revenue when control of the prescription drugs is transferred to customers, in an amount that reflects the consideration the Company expects to be entitled to receive in exchange for those prescription drugs. The Company has established the following revenue recognition policies for the Pharmacy Services segment:

- Revenues generated from prescription drugs sold by mail service dispensing pharmacies are recognized when the prescription drug is delivered to the client plan member. At the time of delivery, the Company has performed substantially all of its performance obligations under its client contracts and does not experience a significant level of returns or reshipments.
- Revenues generated from prescription drugs sold by third party pharmacies in the Company's retail pharmacy network and associated administrative fees are recognized at the Company's point-of-sale, which is when the claim is adjudicated by the Company's online claims processing system and the Company has transferred control of the prescription drug and completed all of its performance obligations.

For contracts under which the Company acts as an agent or does not control the prescription drugs prior to transfer to the client plan member, revenue is recognized using the net method.

Drug Discounts

The Company records revenue net of manufacturers' rebates earned by its clients based on their plan members' utilization of brand-name formulary drugs. The Company estimates these rebates at period-end based on actual and estimated claims data and its estimates of the manufacturers' rebates earned by its clients. The estimates are based on the best available data at period-end and recent history for the various factors that can affect the amount of rebates due to the client. The Company adjusts its rebates

payable to clients to the actual amounts paid when these rebates are paid or as significant events occur. Any cumulative effect of these adjustments is recorded against revenues at the time it is identified. Adjustments generally result from contract changes with clients or manufacturers that have retroactive rebate adjustments, differences between the estimated and actual product mix subject to rebates, or whether the brand name drug was included in the applicable formulary. The effect of adjustments between estimated and actual manufacturers' rebate amounts has not been material to the Company's operating results or financial condition.

Guarantees

The Company also adjusts revenues for refunds owed to clients resulting from pricing guarantees and performance against defined service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's operating results or financial condition.

Retail/LTC Segment

Retail Pharmacy

The Company's retail drugstores recognize revenue at the time the customer takes possession of the merchandise. For pharmacy sales, each prescription claim is its own arrangement with the customer and is a performance obligation, separate and distinct from other prescription claims under other retail network arrangements. Revenues are adjusted for refunds owed to third party payers resulting from pricing guarantees and performance against defined value-based service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's operating results or financial condition.

Revenue from Company gift cards purchased by customers is deferred as a contract liability until goods or services are transferred. Any amounts not expected to be redeemed by customers (i.e., breakage) are recognized based on historical redemption patterns.

Customer returns are not material to the Company's operating results or financial condition. Sales taxes are not included in revenues.

Loyalty and Other Programs

The Company's customer loyalty program, ExtraCare®, consists of two components, ExtraSavings™ and ExtraBucks® Rewards. ExtraSavings are coupons that are recorded as a reduction of revenue when redeemed as the Company concluded that they do not represent a promise to the customer to deliver additional goods or services at the time of issuance because they are not tied to a specific transaction or spending level.

ExtraBucks Rewards are accumulated by customers based on their historical spending levels. Thus, the Company has determined that there is an additional performance obligation to those customers at the time of the initial transaction. The Company allocates the transaction price to the initial transaction and the ExtraBucks Rewards transaction based upon the relative standalone selling price, which considers historical redemption patterns for the rewards. Revenue allocated to ExtraBucks Rewards is recognized as those rewards are redeemed. At the end of each period, unredeemed ExtraBucks Rewards are reflected as a contract liability.

The Company also offers a subscription-based membership program, CarePass®, under which members are entitled to a suite of benefits delivered over the course of the subscription period, as well as a promotional reward that can be redeemed for future goods and services. Subscriptions are paid for on a monthly or annual basis at the time of or in advance of the Company delivering the goods and services. Revenue from these arrangements is recognized as the performance obligations are satisfied.

Long-term Care

Revenue is recognized when control of the promised goods or services is transferred to customers in an amount that reflects the consideration the Company expects to be entitled to receive in exchange for those goods or services. Each prescription claim represents a separate performance obligation of the Company, separate and distinct from other prescription claims under customer arrangements. A significant portion of long-term care revenue from sales of pharmaceutical and medical products is reimbursed by the federal Medicare Part D program and, to a lesser extent, state Medicaid programs. The Company monitors its revenues and receivables from these reimbursement sources, as well as long-term care facilities and other third party insurance payors, and reduces revenue at the revenue recognition date to properly account for the variable consideration due to anticipated differences between billed and reimbursed amounts. Accordingly, the total revenues and receivables reported in the Company's consolidated financial statements are recorded at the amount expected to be ultimately received from these payors.

Patient co-payments associated with Medicare Part D, certain state Medicaid programs, Medicare Part B and certain third party payors typically are not collected at the time products are delivered or services are rendered, but are billed to the individuals as part of normal billing procedures and subject to normal accounts receivable collections procedures.

Walk-In Medical Clinics
For services provided by the Company's walk-in medical clinics, revenue recognition occurs for completed services provided to patients, with adjustments taken for third party payor contractual obligations and patient direct bill historical collection rates.

Impairments of Debt Securities

The Company regularly reviews its debt securities to determine whether a decline in fair value below the cost basis or carrying value has occurred. If a debt security is in an unrealized loss position and the Company has the intent to sell the security, or it is more likely than not that the Company will have to sell the security before recovery of its amortized cost basis, the amortized cost basis of the security is written down to its fair value and the difference is recognized in net income. If a debt security is in an unrealized loss position and the Company does not have the intent to sell and it is more likely than not that the Company will not have to sell such security before recovery of its amortized cost basis, the Company bifurcates the impairment into credit-related and non-credit related (yield-related) components. The amount of the credit-related component is recorded as an allowance for credit losses and recognized in net income, and the amount of the non-credit related component is included in other comprehensive income (loss). The Company analyzes all facts and circumstances believed to be relevant for each investment when performing this analysis, in accordance with applicable accounting guidance.

In evaluating whether a credit related loss exists, the Company considers a variety of factors including: the extent to which the fair value is less than the amortized cost basis; adverse conditions specifically related to the issuer of a security, an industry or geographic area; the payment structure of the security; the failure of the issuer of the security to make scheduled interest or principle payments; and any changes to the rating of the security by a rating agency.

Among the factors considered in evaluating whether a decline in fair value below the cost basis or carrying value has occurred are whether the decline results from a change in the quality of the debt security itself, whether the decline results from a downward movement in the market as a whole, and the prospects for realizing the carrying value of the debt security based on the investment's current and short-term prospects for recovery. For unrealized losses determined to be the result of market conditions (for example, increasing interest rates and volatility due to conditions in the overall market) or industry-related events, the Company determines whether it intends to sell the debt security or if it is more likely than not that the Company will be required to sell the debt security prior to the anticipated recovery of the debt security's amortized cost basis. If either case is true, the Company recognizes a non-credit related impairment, and the cost basis or carrying amount of the debt security is written down to fair value.

During the years ended December 31, 2022, 2021 and 2020, the Company recorded yield-related impairment losses on debt securities of $143 million, $42 million and $49 million, respectively. During the year ended December 31, 2022, the Company recorded credit-related losses on debt securities of $13 million. During the years ended December 31, 2021 and 2020, the Company did not record any credit-related impairment losses on debt securities.

The risks inherent in assessing the impairment of a debt security include the risk that market factors may differ from projections and the risk that facts and circumstances factored into the Company's assessment may change with the passage of time. Unexpected changes to market factors and circumstances that were not present in past reporting periods are among the factors that may result in a current period decision to sell debt securities that were not impaired in prior reporting periods.

Vendor Allowances and Purchase Discounts

Vendor and manufacturer receivables were $12.4 billion and $10.6 billion as of December 31, 2022 and 2021, respectively, the majority of which relate to purchase discounts and vendor allowances as described below.

Pharmacy Services Segment
The Pharmacy Services segment receives purchase discounts on products purchased. Contractual arrangements with vendors, including manufacturers, wholesalers and retail pharmacies, normally provide for the Pharmacy Services segment to receive purchase discounts from established list prices in one, or a combination, of the following forms: (i) a direct discount at the time of purchase, (ii) a discount for the prompt payment of invoices or (iii) when products are purchased indirectly from a manufacturer (e.g., through a wholesaler or retail pharmacy), a discount (or rebate) paid subsequent to dispensing. These

rebates are recognized when prescriptions are dispensed and are generally calculated and billed to manufacturers within 30 days of the end of each completed quarter. Historically, the effect of adjustments resulting from the reconciliation of rebates recognized to the amounts billed and collected has not been material to the Company's operating results or financial condition. The Company accounts for the effect of any such differences as a change in accounting estimate in the period the reconciliation is completed. The Pharmacy Services segment also receives additional discounts under its wholesaler contracts if it exceeds contractually defined purchase volumes. In addition, the Pharmacy Services segment receives fees from pharmaceutical manufacturers for administrative services. Purchase discounts and administrative service fees are recorded as a reduction of cost of products sold.

Retail/LTC Segment
Vendor allowances received by the Retail/LTC segment reduce the carrying cost of inventory and are recognized in cost of products sold when the related inventory is sold, unless they are specifically identified as a reimbursement of incremental costs for promotional programs and/or other services provided. Amounts that are directly linked to advertising commitments are recognized as a reduction of advertising expense (included in operating expenses) when the related advertising commitment is satisfied. Any such allowances received in excess of the actual cost incurred also reduce the carrying cost of inventory. The total value of any upfront payments received from vendors that are linked to purchase commitments is initially deferred. The deferred amounts are then amortized to reduce cost of products sold over the life of the contract based upon sales volume. The total value of any upfront payments received from vendors that are not linked to purchase commitments is also initially deferred. The deferred amounts are then amortized to reduce cost of products sold on a straight-line basis over the life of the related contract.

The Company establishes a receivable for vendor income that is earned but not yet received based on historical trends and data. The majority of vendor receivables are collected within the following fiscal quarter. Historically, adjustments to the Company's vendor receivables resulting from the reconciliation of receivables recognized to the amounts collected have not been material to the Company's operating results or financial condition.

There have not been any material changes in the way the Company accounts for vendor allowances or purchase discounts during the past three years.

Inventory

Inventories are valued at the lower of cost or net realizable value using the weighted average cost method.

The value of ending inventory is reduced for estimated inventory losses that have occurred during the interim period between physical inventory counts. Physical inventory counts are taken on a regular basis in each retail store and LTC pharmacy, and a continuous cycle count process is the primary procedure used to validate the inventory balances on hand in each distribution center and mail facility to ensure that the amounts reflected in the consolidated financial statements are properly stated. The Company's accounting for inventory contains uncertainty since management must use judgment to estimate the inventory losses that have occurred during the interim period between physical inventory counts. When estimating these losses, a number of factors are considered which include historical physical inventory results on a location-by-location basis and current physical inventory loss trends.

The total reserve for estimated inventory losses covered by this critical accounting policy was $559 million and $522 million as of December 31, 2022 and 2021, respectively. Although management believes there is sufficient current and historical information available to record reasonable estimates for estimated inventory losses, it is possible that actual results could differ. In order to help investors assess the aggregate risk, if any, associated with the inventory-related uncertainties discussed above, a ten percent (10%) pre-tax change in estimated inventory losses, which is a reasonably likely change, would increase or decrease the total reserve for estimated inventory losses by approximately $56 million as of December 31, 2022.

Although management believes that the estimates discussed above are reasonable and the related calculations conform to generally accepted accounting principles, actual results could differ from such estimates, and such differences could be material.

Right-of-Use Assets and Lease Liabilities

The Company determines if an arrangement contains a lease at the inception of a contract. Right-of-use assets represent the Company's right to use an underlying asset for the lease term and lease liabilities represent the Company's obligation to make lease payments arising from the lease. Right-of-use assets and lease liabilities are recognized at the commencement date of the

lease, renewal date of the lease or significant remodeling of the lease space based on the present value of the remaining future minimum lease payments. As the interest rate implicit in the Company's leases is not readily determinable, the Company utilizes its incremental borrowing rate, determined by class of underlying asset, to discount the lease payments. The operating lease right-of-use assets also include lease payments made before commencement and are reduced by lease incentives. The Company evaluates the recoverability of its right-of-use assets as described in "Recoverability of Long-Lived Assets" below.

The Company's real estate leases typically contain options that permit renewals for additional periods of up to five years each. For real estate leases, the options to extend are not considered reasonably certain at lease commencement because the Company reevaluates each lease on a regular basis to consider the economic and strategic incentives of exercising the renewal options and regularly opens or closes stores to align with its operating strategy. Generally, the renewal option periods are not included within the lease term and the associated payments are not included in the measurement of the right-of-use asset and lease liability. Similarly, renewal options are not included in the lease term for non-real estate leases because they are not considered reasonably certain of being exercised at lease commencement. Leases with an initial term of 12 months or less are not recorded on the balance sheets, and lease expense is recognized on a straight-line basis over the term of the short-term lease.

For real estate leases, the Company accounts for lease components and nonlease components as a single lease component. Certain real estate leases require additional payments based on sales volume, as well as reimbursement for real estate taxes, common area maintenance and insurance, which are expensed as incurred as variable lease costs. Other real estate leases contain one fixed lease payment that includes real estate taxes, common area maintenance and insurance. These fixed payments are considered part of the lease payment and included in the right-of-use assets and lease liabilities.

Recoverability of Long-Lived Assets

Recoverability of Definite-Lived Assets
The Company evaluates the recoverability of long-lived assets, excluding goodwill and indefinite-lived intangible assets, which are tested for impairment using separate tests described below, whenever events or changes in circumstances indicate that the carrying value of such an asset may not be recoverable. The Company groups and evaluates these long-lived assets for impairment at the lowest level at which individual cash flows can be identified. If indicators of impairment are present, the Company first compares the carrying amount of the asset group to the estimated future cash flows associated with the asset group (undiscounted). If the estimated future cash flows used in this analysis are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to the asset group's estimated future cash flows (discounted). If required, an impairment loss is recorded for the portion of the asset group's carrying value that exceeds the asset group's estimated future cash flows (discounted).

The long-lived asset impairment loss calculation contains uncertainty since management must use judgment to estimate each asset group's future sales, profitability and cash flows. When preparing these estimates, the Company considers historical results and current operating trends and consolidated sales, profitability and cash flow results and forecasts. These estimates can be affected by a number of factors including general economic and regulatory conditions, efforts of third party organizations to reduce their prescription drug costs and/or increased member co-payments, the continued efforts of competitors to gain market share and consumer spending patterns.

During the fourth quarter of 2022, the Company undertook an initiative to evaluate its corporate office real estate space in response to its new flexible work arrangement. As part of this initiative, the Company evaluated its current real estate space and changes in employee work arrangement requirements to ensure it had the appropriate space to support the business. As a result of this assessment, the Company determined that it would vacate and abandon certain leased corporate office spaces. Accordingly, in the three months ended December 31, 2022, the Company recorded office real estate optimization charges of $117 million, primarily consisting of $71 million related to operating lease right-of-use assets and $44 million related to property and equipment, within the Health Care Benefits, Corporate/Other and Pharmacy Services segments.

During the fourth quarter of 2021, the Company completed a strategic review of its retail business and announced the creation of new formats for its stores to continue to drive higher engagement with customers. As part of this review, the Company evaluated changes in population, consumer buying patterns and future health needs to ensure it has the right kinds of stores in the right locations for consumers and for the business. In connection with this initiative, on November 17, 2021, the Board authorized the closing of approximately 900 retail stores, approximately 300 stores each year, between 2022 and 2024. As a result, management determined that there were indicators of impairment with respect to the impacted stores' asset groups, including the associated operating lease right-of-use assets and property and equipment. A long-lived asset impairment test was performed during the fourth quarter of 2021 and the results of the impairment test indicated that the fair value of certain retail store asset groups was lower than their respective carrying values. Accordingly, in the three months ended December 31, 2021, the Company recorded a store impairment charge of approximately $1.4 billion, consisting of a write down of approximately

$1.1 billion related to operating lease right-of-use assets and $261 million related to property and equipment, within the Retail/ LTC segment.

There were no material impairment charges recognized on long-lived assets during the year ended December 31, 2020.

Recoverability of Goodwill
Goodwill represents the excess of amounts paid for acquisitions over the fair value of the net identifiable assets acquired. Goodwill is subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that the carrying value may not be recoverable. Goodwill is tested for impairment on a reporting unit basis. The impairment test is performed by comparing the reporting unit's fair value with its net book value (or carrying amount), including goodwill. The fair value of the reporting units is estimated using a combination of a discounted cash flow method and a market multiple method. If the net book value (carrying amount) of the reporting unit exceeds its fair value, the reporting unit's goodwill is considered to be impaired, and an impairment is recognized in an amount equal to the excess.

The determination of the fair value of the reporting units requires the Company to make significant assumptions and estimates. These assumptions and estimates primarily include the selection of appropriate peer group companies; control premiums and valuation multiples appropriate for acquisitions in the industries in which the Company competes; discount rates; terminal growth rates; and forecasts of revenue, operating income, depreciation and amortization, income taxes, capital expenditures and future working capital requirements. When determining these assumptions and preparing these estimates, the Company considers each reporting unit's historical results and current operating trends; consolidated revenues, profitability and cash flow results and forecasts; and industry trends. The Company's estimates can be affected by a number of factors, including general economic and regulatory conditions; the risk-free interest rate environment; the Company's market capitalization; efforts of customers and payers to reduce costs, including their prescription drug costs, and/or increase member co-payments; the continued efforts of competitors to gain market share, consumer spending patterns and the Company's ability to achieve its revenue growth projections and execute on its cost reduction initiatives.

2022 Goodwill Impairment Test
During the third quarter of 2022, the Company performed its required annual impairment test of goodwill. The results of the impairment tests indicated that there was no impairment of goodwill as of the testing date. The fair values of the reporting units with goodwill exceeded their carrying values by significant margins.

Subsequent to the closing date of the Aetna Acquisition in November 2018, the Company had experienced declines in its Commercial Insured medical membership. In 2022, the Company has grown its Commercial Insured medical membership, excluding the impact of the divestiture of the Thailand business described in Note 2 ''Acquisitions, Divestitures and Asset Sales'' included in Item 8 of this 10-K. Adverse economic conditions may impact medical membership in the Commercial business due to reductions in workforce at existing customers. The Company's fair value estimate is sensitive to significant assumptions including changes in medical membership, revenue growth rate, operating income and the discount rate. The Company believes the financial projections used to determine the fair value of the Commercial Business reporting unit in the third quarter of 2022 were reasonable and achievable. As of December 31, 2022, the goodwill balance in the Commercial Business reporting unit was $25.5 billion.

2021 Goodwill Impairment Test
During the third quarter of 2021, the Company performed its required annual impairment tests of goodwill. The results of the impairment tests indicated an impairment of the goodwill associated with the LTC reporting unit, as the reporting unit's carrying value exceeded its fair value as of the testing date. The results of the impairment tests of the remaining reporting units indicated that there was no impairment of goodwill as of the testing date. The fair values of the reporting units with goodwill exceeded their carrying values by significant margins, with the exception of the Commercial Business reporting unit, which exceeded its carrying value by approximately 3%.

As discussed in Note 5 ''Goodwill and Other Intangibles'' included in Item 8 of this 10-K, during 2021, the LTC reporting unit has continued to face challenges that have impacted the Company's ability to grow the LTC reporting unit's business at the rate estimated when its 2020 goodwill impairment test was performed. These challenges include lower net facility admissions, net long-term care facility customer losses and the prolonged adverse impact of the COVID-19 pandemic and the emerging new variants, which resulted in more significant declines in occupancy rates experienced by the Company's long-term care facility customers than previously anticipated. During the third quarter of 2021, LTC management updated their 2021 annual forecast and submitted their long-term plan which showed deterioration in the financial results for the remainder of 2021 and beyond. The Company utilized these updated projections in performing its annual impairment test, which indicated that the fair value of the LTC reporting unit was lower than its carrying value, resulting in a $431 million goodwill impairment charge in the third

quarter of 2021. The fair value of the LTC reporting unit was determined using a combination of a discounted cash flow method and a market multiple method. Subsequent to the impairment charge recorded in the third quarter of 2021, there is no remaining goodwill balance in the LTC reporting unit.

2020 Goodwill Impairment Test

During the third quarter of 2020, the Company performed its required annual impairment test of goodwill. The results of this impairment test indicated that there was no impairment of goodwill as of the testing date. The goodwill impairment test resulted in the fair values of all of the Company's reporting units exceeding their carrying values by significant margins, with the exception of the Commercial Business and LTC reporting units, which exceeded their carrying values by approximately 6% and 12%, respectively.

Recoverability of Indefinite-Lived Intangible Assets

Indefinite-lived intangible assets are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that their carrying value may not be recoverable. Indefinite-lived intangible assets are tested by comparing the estimated fair value of the asset to its carrying value. If the carrying value of the asset exceeds its estimated fair value, an impairment loss is recognized, and the asset is written down to its estimated fair value.

The indefinite-lived intangible asset impairment loss calculation contains uncertainty since management must use judgment to estimate fair value based on the assumption that, in lieu of ownership of an intangible asset, the Company would be willing to pay a royalty in order to utilize the benefits of the asset. Fair value is estimated by discounting the hypothetical royalty payments to their present value over the estimated economic life of the asset. These estimates can be affected by a number of factors including general economic conditions, availability of market information and the profitability of the Company. There were no impairment losses recognized on indefinite-lived intangible assets in any of the years ended December 31, 2022, 2021 or 2020.

Health Care Costs Payable

At both December 31, 2022 and 2021, 75% of health care costs payable are estimates of the ultimate cost of (i) services rendered to the Company's Insured members but not yet reported to the Company and (ii) claims which have been reported to the Company but not yet paid (collectively, "IBNR"). Health care costs payable also include an estimate of the cost of services that will continue to be rendered after the financial statement date if the Company is obligated to pay for such services in accordance with contractual or regulatory requirements. The remainder of health care costs payable is primarily comprised of pharmacy and capitation payables, other amounts due to providers pursuant to risk sharing agreements and accruals for state assessments. The Company develops its estimate of IBNR using actuarial principles and assumptions that consider numerous factors. See Note 1 ''Significant Accounting Policies'' included in Item 8 of this 10-K for additional information on the Company's reserving methodology.

During 2022 and 2021, the Company observed an increase in completion factors relative to those assumed at the prior year end. After considering the claims paid in 2022 and 2021 with dates of service prior to the fourth quarter of the previous year, the Company observed assumed incurred claim weighted average completion factors that were 3 and 21 basis points higher, respectively, than previously estimated, resulting in a decrease of $32 million and $207 million in 2022 and 2021, respectively, in health care costs payable that related to the prior year. The Company has considered the pattern of changes in its completion factors when determining the completion factors used in its estimates of IBNR as of December 31, 2022. However, based on historical claim experience, it is reasonably possible that the Company's estimated weighted average completion factors may vary by plus or minus 12 basis points from the Company's assumed rates, which could impact health care costs payable by approximately plus or minus $207 million pretax.

Also, during 2022 and 2021, the Company observed that health care costs for claims with claim incurred dates of three months or less before the financial statement date were lower than previously estimated. Specifically, after considering the claims paid in 2022 and 2021 with claim incurred dates for the fourth quarter of the previous year, the Company observed health care costs that were 4.8% and 5.0% lower, respectively, for each fourth quarter than previously estimated, resulting in a reduction of $622 million and $581 million in 2022 and 2021, respectively, in health care costs payable that related to prior year.

Management considers historical health care cost trend rates together with its knowledge of recent events that may impact current trends when developing estimates of current health care cost trend rates. When establishing reserves as of December 31, 2022, the Company increased its assumed health care cost trend rates for the most recent three months by 4.9% from health care cost trend rates recently observed. Health care cost trend rates during the past three years have been impacted by utilization changes driven by the COVID-19 pandemic. The impact has not been uniform, with products and select geographies

experiencing utilization impacts due to COVID-19 waves. Based on historical claim experience, it is reasonably possible that the Company's estimated health care cost trend rates may vary by plus or minus 3.5% from the assumed rates, which could impact health care costs payable by plus or minus $487 million pretax.

Income Taxes

The Company accounts for income taxes using the asset and liability method. Deferred tax assets and liabilities are established for any temporary differences between financial and tax reporting bases and are adjusted as needed to reflect changes in the enacted tax rates expected to be in effect when the temporary differences reverse. Such adjustments are recorded in the period in which changes in tax laws are enacted, regardless of when they are effective. Deferred tax assets are reduced, if necessary, by a valuation allowance to the extent future realization of those losses, deductions or other tax benefits is sufficiently uncertain. Significant judgment is required in determining the provision for income taxes and the related taxes payable and deferred tax assets and liabilities since, in the ordinary course of business, there are transactions and calculations where the ultimate tax outcome is uncertain. Additionally, the Company's tax returns are subject to audit by various domestic and foreign tax authorities that could result in material adjustments based on differing interpretations of the tax laws. Although management believes that its estimates are reasonable and are based on the best available information at the time the provision is prepared, actual results could differ from these estimates resulting in a final tax outcome that may be materially different from that which is reflected in the consolidated financial statements.

The tax benefit from an uncertain tax position is recognized only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position. The tax benefits recognized in the consolidated financial statements from such positions are then measured based on the largest benefit that has a greater than 50% likelihood of being realized upon settlement with the related tax authority. Interest and/or penalties related to uncertain tax positions are recognized in the income tax provision. Significant judgment is required in determining uncertain tax positions. The Company has established accruals for uncertain tax positions using its judgment and adjusts these accruals, as warranted, due to changing facts and circumstances.

New Accounting Pronouncements

See Note 1 ''Significant Accounting Policies'' included in Item 8 of this 10-K for a description of new accounting pronouncements applicable to the Company.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk.

The Company's earnings and financial condition are exposed to interest rate risk, credit quality risk, market valuation risk, foreign currency risk, commodity risk and operational risk.

Evaluation of Interest Rate and Credit Quality Risk

The Company manages interest rate risk by seeking to maintain a tight match between the durations of assets and liabilities when appropriate. The Company manages credit quality risk by seeking to maintain high average credit quality ratings and diversified sector exposure within its debt securities portfolio. In connection with its investment and risk management objectives, the Company also uses derivative financial instruments whose market value is at least partially determined by, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets or credit ratings/spreads. The Company's use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps. These instruments, viewed separately, subject the Company to varying degrees of interest rate, equity price and credit risk. However, when used for hedging, the Company expects these instruments to reduce overall risk.

Investments
The Company's investment portfolio supported the following products at December 31, 2022 and 2021:

In millions	**2022**	**2021**
Experience-rated products	$ 744	$ 957
Remaining products	23,147	25,185
Total investments [(1)]	$ 23,891	$ 26,142

(1) Includes long-term investments of $17 million which have been accounted for as assets held for sale and are included in assets held for sale on the consolidated balance sheet at December 31, 2022. See Note 2 ''Acquisitions, Divestitures and Asset Sales'' included in Item 8 of this 10-K for additional information.

Investment risks associated with experience-rated products generally do not impact the Company's operating results. The risks associated with investments supporting experience-rated pension and annuity products in the large case pensions business in the Company's Corporate/Other segment are assumed by the contract holders and not by the Company (subject to, among other things, certain minimum guarantees). Assets supporting experience-rated products may be subject to contract holder or participant withdrawals.

The debt securities in the Company's investment portfolio had an average credit quality rating of A at both December 31, 2022 and 2021, with a fair value of approximately $6.0 billion and $6.7 billion rated AAA at December 31, 2022 and 2021, respectively. The fair value of debt securities that were rated below investment grade (that is, having a credit quality rating below BBB-/Baa3) was $1.9 billion and $2.3 billion at December 31, 2022 and 2021, respectively (of which 1.6% and 2.0% at December 31, 2022 and 2021, respectively, supported experience-rated products).

At December 31, 2022 and 2021, the Company held $202 million and $305 million, respectively, of municipal debt securities that were guaranteed by third parties, representing 1% of total investments at both December 31, 2022 and 2021. These securities had an average credit quality rating of AA+ and AA at December 31, 2022 and 2021, respectively, with the guarantee. These securities had an average credit quality rating of A at both December 31, 2022 and 2021, respectively, without the guarantee. The Company does not have any significant concentration of investments with third party guarantors (either direct or indirect).

The Company generally classifies debt securities as available for sale, and carries them at fair value on the consolidated balance sheets. At both December 31, 2022 and 2021, less than 1% of debt securities were valued using inputs that reflect the Company's assumptions (categorized as Level 3 inputs in accordance with accounting principles generally accepted in the United States of America). See Note 4 ''Fair Value'' included in Item 8 of this 10-K for additional information on the methodologies and key assumptions used to determine the fair value of investments. For additional information related to investments, see Note 3 ''Investments'' included in Item 8 of this 10-K.

The Company regularly reviews debt securities in its portfolio to determine whether a decline in fair value below the cost basis or carrying value has occurred. If a debt security is in an unrealized loss position and the Company has the intent to sell the security, or it is more likely than not that the Company will have to sell the security before recovery of its amortized cost basis,

the amortized cost basis of the security is written down to its fair value and the difference is recognized in net income. If a debt security is in an unrealized loss position and the Company does not have the intent to sell and it is more likely than not that the Company will not have to sell such security before recovery of its amortized cost basis, the Company bifurcates the impairment into credit-related and non-credit related components. The amount of the credit-related component is recorded as an allowance for credit losses and recognized in net income, and the amount of the non-credit related component is included in other comprehensive income (loss). The impairment of debt securities is considered a critical accounting policy. See ‘‘Critical Accounting Policies - Impairments of Debt Securities” in the MD&A included in Item 7 of this 10-K for additional information.

Evaluation of Market Valuation Risks

The Company regularly evaluates its risk from market-sensitive instruments by examining, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets and/or credit ratings/spreads. The Company also regularly evaluates the appropriateness of investments relative to management-approved investment guidelines (and operates within those guidelines) and the business objectives of its portfolios.

On a quarterly basis, the Company reviews the impact of hypothetical net losses in its investment portfolio on the Company’s consolidated near-term financial condition, operating results and cash flows assuming the occurrence of certain reasonably possible changes in near-term market rates and prices. Interest rate changes (whether resulting from changes in treasury yields or credit spreads or other factors) represent the most material risk exposure category for the Company. The Company has estimated the impact on the fair value of market sensitive instruments based on the net present value of cash flows using a representative set of likely future interest rate scenarios. The assumptions used were as follows: an immediate increase of 100 basis points in interest rates (which the Company believes represents a moderately adverse scenario) for long-term debt issued by the Company, as well as its interest rate sensitive investments and an immediate decrease of 15% in prices for publicly traded domestic equity securities in the Company’s investment portfolio.

Assuming an immediate increase of 100 basis points in interest rates, the theoretical decline in the fair values of market sensitive instruments at December 31, 2022 is as follows:

- The fair value of long-term debt issued by the Company would decline by approximately $2.9 billion ($3.6 billion pretax). Changes in the fair value of long-term debt do not impact the Company’s operating results or financial condition.
- The theoretical reduction in the fair value of interest rate sensitive investments partially offset by the theoretical reduction in the fair value of interest rate sensitive liabilities would result in a net decline in fair value of approximately $595 million ($750 million pretax) related to continuing non-experience-rated products. Reductions in the fair value of investment securities would be reflected as an unrealized loss in equity, as the Company classifies these debt securities as available for sale. The Company does not record liabilities at fair value.

If the value of the Company’s publicly traded domestic equity securities held within its investment portfolio were to decline by 15%, this would result in a net decline in fair value of $20 million ($26 million pretax).

Based on overall exposure to interest rate risk and equity price risk, the Company believes that these changes in market rates and prices would not materially affect consolidated near-term financial condition, operating results or cash flows as of December 31, 2022.

Evaluation of Foreign Currency and Commodity Risk

At December 31, 2022 and 2021, the Company did not have any material foreign currency exchange rate or commodity derivative instruments in place and believes its exposure to foreign currency exchange rate risk is not material.

Evaluation of Operational Risks

The Company also faces certain operational risks. Those risks include risks related to the COVID-19 pandemic and risks related to information security, including cybersecurity.

The spread of COVID-19, or actions taken to mitigate its spread, could have material and adverse effects on our ability to operate our businesses effectively, including as a result of the complete or partial closure of facilities or labor shortages. Disruptions in our supply chains, our distribution chains and/or public and private infrastructure, including communications, financial services and supply chains, could materially and adversely impact our business operations. We have transitioned a significant subset of our colleagues to a remote work environment in an effort to mitigate the spread of COVID-19, as have a

significant number of our third-party service providers, which may amplify certain risks to our businesses, including an increased demand for information technology resources, increased risk of phishing and other cyber attacks, increased risk of unauthorized dissemination of sensitive personal information or proprietary or confidential information about us or our medical members or other third-parties and increased risk of business interruptions.

The Company and its vendors have experienced diverse cyber attacks and expect to continue to experience cyber attacks going forward. As examples, the Company and its vendors have experienced attempts to gain access to systems, denial of service attacks, attempted malware infections, account takeovers, scanning activity and phishing emails. Attacks can originate from external criminals, terrorists, nation states or internal actors. The Company is dedicating and will continue to dedicate significant resources and incur significant expenses to maintain and update on an ongoing basis the systems and processes that are designed to mitigate the information security risks it faces and protect the security of its computer systems, software, networks and other technology assets against attempts by unauthorized parties to obtain access to confidential information, disrupt or degrade service or cause other damage. The impact of cyber attacks has not been material to the Company's operations or operating results through December 31, 2022. The Board and its Audit Committee and Nominating and Corporate Governance Committee are regularly informed regarding the Company's information security policies, practices and status.

Item 8. Financial Statements and Supplementary Data.

Index to Consolidated Financial Statements

Consolidated Statements of Operations

In millions, except per share amounts	For the Years Ended December 31, 2022	2021	2020
Revenues:			
Products	$ 226,616	$ 203,738	$ 190,688
Premiums	85,330	76,132	69,364
Services	9,683	11,042	7,856
Net investment income	838	1,199	798
Total revenues	322,467	292,111	268,706
Operating costs:			
Cost of products sold	196,892	175,803	163,981
Benefit costs	71,281	64,260	55,679
Opioid litigation charges	5,803	—	—
Loss on assets held for sale	2,533	—	—
Store impairments	—	1,358	—
Goodwill impairment	—	431	—
Operating expenses	38,212	37,066	35,135
Total operating costs	314,721	278,918	254,795
Operating income	7,746	13,193	13,911
Interest expense	2,287	2,503	2,907
Loss on early extinguishment of debt	—	452	1,440
Other income	(169)	(182)	(206)
Income before income tax provision	5,628	10,420	9,770
Income tax provision	1,463	2,522	2,569
Income from continuing operations	4,165	7,898	7,201
Loss from discontinued operations, net of tax	—	—	(9)
Net income	4,165	7,898	7,192
Net (income) loss attributable to noncontrolling interests	(16)	12	(13)
Net income attributable to CVS Health	$ 4,149	$ 7,910	$ 7,179
Basic earnings per share:			
Income from continuing operations attributable to CVS Health	$ 3.16	$ 6.00	$ 5.49
Loss from discontinued operations attributable to CVS Health	$ —	$ —	$ (0.01)
Net income attributable to CVS Health	$ 3.16	$ 6.00	$ 5.48
Weighted average basic shares outstanding	1,312	1,319	1,309
Diluted earnings per share:			
Income from continuing operations attributable to CVS Health	$ 3.14	$ 5.95	$ 5.47
Loss from discontinued operations attributable to CVS Health	$ —	$ —	$ (0.01)
Net income attributable to CVS Health	$ 3.14	$ 5.95	$ 5.46
Weighted average diluted shares outstanding	1,323	1,329	1,314
Dividends declared per share	$ 2.20	$ 2.00	$ 2.00

See accompanying notes to consolidated financial statements.

Consolidated Statements of Comprehensive Income

In millions	For the Years Ended December 31, 2022	2021	2020
Net income	$ 4,165	$ 7,898	$ 7,192
Other comprehensive income (loss), net of tax:			
Net unrealized investment gains (losses)	(2,279)	(436)	440
Foreign currency translation adjustments	—	(7)	3
Net cash flow hedges	17	(26)	(31)
Pension and other postretirement benefits	(168)	20	(17)
Other comprehensive income (loss)	(2,430)	(449)	395
Comprehensive income	1,735	7,449	7,587
Comprehensive (income) loss attributable to noncontrolling interests	(16)	12	(13)
Comprehensive income attributable to CVS Health	$ 1,719	$ 7,461	$ 7,574

See accompanying notes to consolidated financial statements.

Consolidated Balance Sheets

In millions, except per share amounts	At December 31, 2022	2021
Assets:		
Cash and cash equivalents	$ 12,945	$ 9,408
Investments	2,778	3,117
Accounts receivable, net	27,276	24,431
Inventories	19,090	17,760
Assets held for sale	908	—
Other current assets	2,685	5,292
Total current assets	65,682	60,008
Long-term investments	21,096	23,025
Property and equipment, net	12,873	12,896
Operating lease right-of-use assets	17,872	19,122
Goodwill	78,150	79,121
Intangible assets, net	24,754	29,026
Separate accounts assets	3,228	5,087
Other assets	4,620	4,714
Total assets	$ 228,275	$ 232,999
Liabilities:		
Accounts payable	$ 14,838	$ 12,544
Pharmacy claims and discounts payable	19,423	17,330
Health care costs payable	10,406	8,808
Policyholders' funds	1,500	4,301
Accrued expenses	18,745	17,670
Other insurance liabilities	1,140	1,303
Current portion of operating lease liabilities	1,678	1,646
Current portion of long-term debt	1,778	4,205
Liabilities held for sale	228	—
Total current liabilities	69,736	67,807
Long-term operating lease liabilities	16,800	18,177
Long-term debt	50,476	51,971
Deferred income taxes	3,880	6,270
Separate accounts liabilities	3,228	5,087
Other long-term insurance liabilities	6,108	6,402
Other long-term liabilities	6,732	1,904
Total liabilities	156,960	157,618
Commitments and contingencies (Note 16)		
Shareholders' equity:		
Preferred stock, par value $0.01: 0.1 shares authorized; none issued or outstanding	—	—
Common stock, par value $0.01: 3,200 shares authorized; 1,758 shares issued and 1,300 shares outstanding at December 31, 2022 and 1,744 shares issued and 1,322 shares outstanding at December 31, 2021 and capital surplus	48,193	47,377
Treasury stock, at cost: 458 and 422 shares at December 31, 2022 and 2021	(31,858)	(28,173)
Retained earnings	56,145	54,906
Accumulated other comprehensive income (loss)	(1,465)	965
Total CVS Health shareholders' equity	71,015	75,075
Noncontrolling interests	300	306
Total shareholders' equity	71,315	75,381
Total liabilities and shareholders' equity	$ 228,275	$ 232,999

See accompanying notes to consolidated financial statements.

Consolidated Statements of Cash Flows

In millions	For the Years Ended December 31, 2022	2021	2020
Cash flows from operating activities:			
Cash receipts from customers	$ 313,662	$ 284,219	$ 264,327
Cash paid for inventory and prescriptions dispensed by retail network pharmacies	(189,766)	(165,783)	(158,636)
Insurance benefits paid	(69,728)	(63,598)	(55,124)
Cash paid to other suppliers and employees	(32,662)	(31,652)	(29,763)
Interest and investment income received	1,026	743	894
Interest paid	(2,239)	(2,469)	(2,904)
Income taxes paid	(4,116)	(3,195)	(2,929)
Net cash provided by operating activities	16,177	18,265	15,865
Cash flows from investing activities:			
Proceeds from sales and maturities of investments	6,729	7,246	6,467
Purchases of investments	(7,746)	(9,963)	(9,639)
Purchases of property and equipment	(2,727)	(2,520)	(2,437)
Proceeds from sale-leaseback transactions	—	—	101
Acquisitions (net of cash acquired)	(139)	(146)	(866)
Proceeds from sale of subsidiaries (net of cash and restricted cash sold of $2,854, $0 and $9)	(1,249)	—	840
Other	85	122	—
Net cash used in investing activities	(5,047)	(5,261)	(5,534)
Cash flows from financing activities:			
Proceeds from issuance of long-term debt	—	987	9,958
Repayments of long-term debt	(4,211)	(10,254)	(15,631)
Derivative settlements	—	—	(7)
Repurchase of common stock	(3,500)	—	—
Dividends paid	(2,907)	(2,625)	(2,624)
Proceeds from exercise of stock options	551	549	264
Payments for taxes related to net share settlement of equity awards	(370)	(168)	(88)
Other	(79)	155	432
Net cash used in financing activities	(10,516)	(11,356)	(7,696)
Net increase in cash, cash equivalents and restricted cash	614	1,648	2,635
Cash, cash equivalents and restricted cash at the beginning of the period	12,691	11,043	8,408
Cash, cash equivalents and restricted cash at the end of the period	$ 13,305	$ 12,691	$ 11,043

In millions	For the Years Ended December 31, 2022	2021	2020
Reconciliation of net income to net cash provided by operating activities:			
Net income	$ 4,165	$ 7,898	$ 7,192
Adjustments required to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	4,247	4,512	4,441
Loss on assets held for sale	2,533	—	—
Store impairments	—	1,358	—
Goodwill impairment	—	431	—
Stock-based compensation	447	484	400
Gain on sale of subsidiaries	(475)	—	(269)
Loss on early extinguishment of debt	—	452	1,440
Deferred income taxes	(2,075)	(428)	(570)
Other noncash items	332	(390)	72
Change in operating assets and liabilities, net of effects from acquisitions:			
Accounts receivable, net	(2,971)	(2,703)	(1,510)
Inventories	(1,435)	735	(973)
Other assets	(566)	(3)	364
Accounts payable and pharmacy claims and discounts payable	4,260	2,898	2,769
Health care costs payable and other insurance liabilities	1,247	169	(231)
Other liabilities	6,468	2,852	2,740
Net cash provided by operating activities	$ 16,177	$ 18,265	$ 15,865

See accompanying notes to consolidated financial statements.

Consolidated Statements of Shareholders' Equity

	Number of shares outstanding		Attributable to CVS Health						
In millions	Common Shares	Treasury Shares [1]	Common Stock and Capital Surplus [2]	Treasury Stock [1]	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Total CVS Health Shareholders' Equity	Noncontrolling Interests	Total Shareholders' Equity
Balance at December 31, 2019	**1,727**	**(425)**	**$ 45,972**	**$ (28,235)**	**$ 45,108**	**$ 1,019**	**$ 63,864**	**$ 306**	**$ 64,170**
Adoption of new accounting standard [3]	—	—	—	—	(3)	—	(3)	—	(3)
Net income	—	—	—	—	7,179	—	7,179	13	7,192
Other comprehensive income (Note 13)	—	—	—	—	—	395	395	—	395
Stock option activity, stock awards and other	6	—	541	—	—	—	541	—	541
ESPP issuances, net of purchase of treasury shares	—	2	—	57	—	—	57	—	57
Common stock dividends	—	—	—	—	(2,644)	—	(2,644)	—	(2,644)
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(7)	(7)
Balance at December 31, 2020	1,733	(423)	46,513	(28,178)	49,640	1,414	69,389	312	69,701
Net income	—	—	—	—	7,910	—	7,910	(12)	7,898
Other comprehensive loss (Note 13)	—	—	—	—	—	(449)	(449)	—	(449)
Stock option activity, stock awards and other	11	—	864	—	—	—	864	—	864
ESPP issuances, net of purchase of treasury shares	—	1	—	5	—	—	5	—	5
Common stock dividends	—	—	—	—	(2,644)	—	(2,644)	—	(2,644)
Other increases in noncontrolling interests	—	—	—	—	—	—	—	6	6
Balance at December 31, 2021	1,744	(422)	47,377	(28,173)	54,906	965	75,075	306	75,381
Net income	—	—	—	—	4,149	—	4,149	16	4,165
Other comprehensive loss (Note 13)	—	—	—	—	—	(2,430)	(2,430)	—	(2,430)
Stock option activity, stock awards and other	14	—	816	—	—	—	816	—	816
Purchase of treasury shares, net of ESPP issuances	—	(36)	—	(3,685)	—	—	(3,685)	—	(3,685)
Common stock dividends	—	—	—	—	(2,910)	—	(2,910)	—	(2,910)
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(22)	(22)
Balance at December 31, 2022	**1,758**	**(458)**	**$ 48,193**	**$ (31,858)**	**$ 56,145**	**$ (1,465)**	**$ 71,015**	**$ 300**	**$ 71,315**

(1) Treasury shares include 1 million shares held in trust for each of the years ended December 31, 2022, 2021 and 2020. Treasury stock includes $29 million related to shares held in trust for each of the years ended December 31, 2022, 2021 and 2020. See Note 1 ''Significant Accounting Policies'' for additional information.

(2) Common stock and capital surplus includes the par value of common stock of $18 million as of December 31, 2022 and $17 million as of December 31, 2021 and 2020.

(3) Reflects the adoption of Accounting Standards Update ("ASU") 2016-13, *Financial Instruments - Credit Losses* (Topic 326), which resulted in a reduction to retained earnings of $3 million during the year ended December 31, 2020.

See accompanying notes to consolidated financial statements.

Notes to Consolidated Financial Statements

1. Significant Accounting Policies

Description of Business

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health" or the "Company"), has more than 9,000 retail locations, more than 1,100 walk-in medical clinics, a leading pharmacy benefits manager with over 110 million plan members with expanding specialty pharmacy solutions and a dedicated senior pharmacy care business serving more than one million patients per year. The Company also serves an estimated 35 million people through traditional, voluntary and consumer-directed health insurance products and related services, including expanding Medicare Advantage offerings and a leading standalone Medicare Part D prescription drug plan ("PDP"). The Company believes its integrated health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

The coronavirus disease 2019 ("COVID-19") and its emerging new variants continue to impact the economies of the U.S. and other countries around the world. The impact of COVID-19 on the Company's businesses, operating results, cash flows and financial condition in the years ended December 31, 2022, 2021 and 2020, as well as information regarding certain expected impacts of COVID-19 on the Company, is discussed throughout this Annual Report on Form 10-K.

The Company has four reportable segments: Health Care Benefits, Pharmacy Services, Retail/LTC and Corporate/Other, which are described below.

Health Care Benefits Segment
The Health Care Benefits segment operates as one of the nation's leading diversified health care benefits providers. The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make more informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental and behavioral health plans, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services and health information technology products and services. The Health Care Benefits segment also provided workers' compensation administrative services through its Coventry Health Care Workers' Compensation business ("Workers' Compensation business") prior to the sale of this business on July 31, 2020. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates. The Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk for medical and dental care costs) as "ASC." In addition, effective January 2022, the Company entered the individual public health insurance exchanges ("Public Exchanges") in eight states through which it sells Insured plans directly to individual consumers. The Company entered Public Exchanges in four additional states effective January 2023.

Pharmacy Services Segment
The Pharmacy Services segment provides a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services and mail order pharmacy. In addition, through the Pharmacy Services segment, the Company provides specialty pharmacy and infusion services, clinical services, disease management services, medical spend management and pharmacy and/or other administrative services for providers and federal 340B drug pricing program covered entities ("Covered Entities"). The Company operates a group purchasing organization that negotiates pricing for the purchase of pharmaceuticals and rebates with pharmaceutical manufacturers on behalf of its participants. The Company also provides various administrative, management and reporting services to pharmaceutical manufacturers. The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, PDPs, Medicaid managed care plans, plans offered on Public Exchanges and private health insurance exchanges, other sponsors of health benefit plans throughout the United States and Covered Entities. The Pharmacy Services segment operates retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services.

Retail/LTC Segment
The Retail/LTC segment sells prescription drugs and a wide assortment of health and wellness products and general merchandise, provides health care services through its MinuteClinic® walk-in medical clinics, provides medical diagnostic testing, administers vaccinations for illnesses such as influenza, COVID-19 and shingles and conducts long-term care pharmacy ("LTC") operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to

long-term care facilities and other care settings. As of December 31, 2022, the Retail/LTC segment operated more than 9,000 retail locations, more than 1,100 MinuteClinic locations as well as online retail pharmacy websites, LTC pharmacies and on-site pharmacies.

Corporate/Other Segment
The Company presents the remainder of its financial results in the Corporate/Other segment, which primarily consists of:

- Management and administrative expenses to support the Company's overall operations, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments, expenses associated with the Company's investments in its transformation and enterprise modernization programs and acquisition-related integration costs; and
- Products for which the Company no longer solicits or accepts new customers such as its large case pensions and long-term care insurance products.

Basis of Presentation

The accompanying consolidated financial statements of CVS Health and its subsidiaries have been prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP"). The consolidated financial statements include the accounts of the Company and its majority-owned subsidiaries and variable interest entities ("VIEs") for which the Company is the primary beneficiary. All material intercompany balances and transactions have been eliminated.

Use of Estimates

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and temporary investments with maturities of three months or less when purchased. The Company invests in short-term money market funds, commercial paper and time deposits, as well as other debt securities that are classified as cash equivalents within the accompanying consolidated balance sheets, as these funds are highly liquid and readily convertible to known amounts of cash.

Restricted Cash

Restricted cash included in other current assets on the consolidated balance sheets represents funds held on behalf of members, including health savings account ("HSA") funds associated with high deductible health plans. Restricted cash included in other assets on the consolidated balance sheets represents amounts held in a trust in one of the Company's captive insurance companies to satisfy collateral requirements associated with the assignment of certain insurance policies. All restricted cash is invested in time deposits and money market funds.

The following is a reconciliation of cash and cash equivalents on the consolidated balance sheets to total cash, cash equivalents and restricted cash on the consolidated statements of cash flows as of December 31, 2022, 2021 and 2020:

In millions	**2022**	**2021**	**2020**
Cash and cash equivalents	$ 12,945	$ 9,408	$ 7,854
Restricted cash (included in other current assets)	144	3,065	2,913
Restricted cash (included in other assets)	216	218	276
Total cash, cash equivalents and restricted cash in the consolidated statements of cash flows	$ 13,305	$ 12,691	$ 11,043

The decrease in restricted cash included in other current assets as of December 31, 2022 compared to December 31, 2021 was primarily due to a decrease in HSA funds held on behalf of customers as a result of the sale of Payflex Holdings, Inc. ("PayFlex"). See Note 2 ''Acquisitions, Divestitures and Asset Sales'' for additional information on the Company's sale of PayFlex.

Investments

Debt Securities
Debt securities consist primarily of U.S. Treasury and agency securities, mortgage-backed securities, corporate and foreign bonds and other debt securities. Debt securities are classified as either current or long-term investments based on their contractual maturities unless the Company intends to sell an investment within the next twelve months, in which case it is classified as current on the consolidated balance sheets. Debt securities are classified as available for sale and are carried at fair value. See Note 4 ‘‘Fair Value’’ for additional information on how the Company estimates the fair value of these investments.

If a debt security is in an unrealized loss position and the Company has the intent to sell the security, or it is more likely than not that the Company will have to sell the security before recovery of its amortized cost basis, the amortized cost basis of the security is written down to its fair value and the difference is recognized in net income. If a debt security is in an unrealized loss position and the Company does not have the intent to sell and it is more likely than not that the Company will not have to sell such security before recovery of its amortized cost basis, the Company bifurcates the impairment into credit-related and non-credit related (yield-related) components. In evaluating whether a credit related loss exists, the Company considers a variety of factors including: the extent to which the fair value is less than the amortized cost basis; adverse conditions specifically related to the issuer of a security, an industry or geographic area; the payment structure of the security; the failure of the issuer of the security to make scheduled interest or principal payments; and any changes to the rating of the security by a rating agency. The amount of the credit-related component is recorded as an allowance for credit losses and recognized in net income, and the amount of the non-credit related component is included in other comprehensive income (loss). Interest is not accrued on debt securities when management believes the collection of interest is unlikely.

The credit-related component is determined by comparing the present value of cash flows expected to be collected from the security, considering all reasonably available information relevant to the collectability of the security, with the amortized cost basis of the security. If the present value of cash flows expected to be collected is less than the amortized cost basis of the security, the Company records an allowance for credit losses, which is limited by the amount that the fair value is less than amortized cost basis.

For mortgage-backed and other asset-backed securities, the Company recognizes 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 Company’s investment in the security is adjusted to the amount that would have existed had the new effective yield been applied since the acquisition of the security, with adjustments recognized in net income.

Equity Securities
Equity securities with readily available fair values are measured at fair value with changes in fair value recognized in net income.

Mortgage Loans
Mortgage loan investments on the consolidated balance sheets are valued at the unpaid principal balance, net of an allowance for credit losses. Mortgage loans with a maturity date or a committed prepayment date within twelve months are classified as current on the consolidated balance sheets. The Company assesses whether its loans share similar risk characteristics and, if so, groups such loans in a risk pool when measuring expected credit losses. The Company considers the following characteristics when evaluating whether its loans share similar risk characteristics: loan-to-value ratios, property type (e.g., office, retail, apartment, industrial), geographic location, vacancy rates and property condition.

Credit loss reserves are determined using a loss rate method that multiplies the unpaid principal balance of each loan within a risk pool group by an estimated loss rate percentage. The loss rate percentage considers both the expected loan loss severity and the probability of loan default. For periods where the Company is able to make or obtain reasonable and supportable forecasts of expected economic conditions (e.g., gross domestic product, employment), the Company adjusts its expected loss rates to reflect these forecasted economic conditions. For periods beyond which the Company is able to make or obtain reasonable and supportable forecasts of expected economic conditions, the Company reverts to historical loss rates in determining expected credit losses.

Interest income on a potential problem loan (i.e., high probability of default) or restructured loan is accrued to the extent it is deemed to be collectible and the loan continues to perform under its original or restructured terms. Interest income on problem loans (i.e., more than 60 days delinquent, in bankruptcy or in process of foreclosure) is recognized on a cash basis. Cash payments on loans in the process of foreclosure are treated as a return of principal.

Other Investments
Other investments consist primarily of the following:

- Private equity and hedge fund limited partnerships, which are accounted for using the equity method of accounting. Under this method, the carrying value of the investment is based on the value of the Company's equity ownership of the underlying investment funds provided by the general partner or manager of the investments, the financial statements of which generally are audited. As a result of the timing of the receipt of the valuation information provided by the fund managers, these investments are generally reported on up to a three month lag. The Company reviews investments for impairment at least quarterly and monitors their performance throughout the year through discussions with the administrators, managers and/or general partners. If the Company becomes aware of an impairment of a limited partnership's investments through its review or prior to receiving the limited partnership's financial statements at the financial statement date, an impairment will be recognized by recording a reduction in the carrying value of the limited partnership with a corresponding charge to net investment income.
- Investment real estate, which is carried on the consolidated balance sheets at depreciated cost, including capital additions, net of write-downs for other-than-temporary declines in fair value. Depreciation is calculated using the straight-line method based on the estimated useful life of each asset. If any real estate investment is considered held-for-sale, it is carried at the lower of its carrying value or fair value less estimated selling costs. The Company generally estimates fair value using net operating income and applying a capitalization rate in conjunction with comparable sales information. At the time of the sale, the difference between the sales price and the carrying value is recorded as a realized capital gain or loss.
- Privately-placed equity securities, which are carried on the consolidated balance sheets at cost less impairments, plus or minus subsequent adjustments for observable price changes. Additionally, as a member of the Federal Home Loan Bank of Boston ("FHLBB"), a subsidiary of the Company is required to purchase and hold shares of the FHLBB. These shares are restricted and carried at cost.

Net Investment Income
Net investment income on the Company's investments is recorded when earned and is reflected in the Company's net income (other than net investment income on assets supporting experience-rated products). Experience-rated products are products in the large case pensions business where the contract holder, not the Company, assumes investment and other risks, subject to, among other things, minimum guarantees provided by the Company. The effect of investment performance on experience-rated products is allocated to contract holders' accounts daily, based on the underlying investment experience and, therefore, does not impact the Company's net income (as long as the contract's minimum guarantees are not triggered). Net investment income on assets supporting large case pensions' experience-rated products is included in net investment income in the consolidated statements of operations and is credited to contract holders' accounts through a charge to benefit costs. The contract holders' accounts are reflected in policyholders' funds on the consolidated balance sheets.

Realized capital gains and losses on investments (other than realized capital gains and losses on investments supporting experience-rated products) are included as a component of net investment income in the consolidated statements of operations. Realized capital gains and losses are determined on a specific identification basis. Purchases and sales of debt and equity securities and alternative investments are reflected on the trade date. Purchases and sales of mortgage loans and investment real estate are reflected on the closing date.

Realized capital gains and losses on investments supporting large case pensions' experience-rated products are not included in realized capital gains and losses in the consolidated statements of operations and instead are credited directly to contract holders' accounts. The contract holders' accounts are reflected in policyholders' funds on the consolidated balance sheets.

Unrealized capital gains and losses on investments (other than unrealized capital gains and losses on investments supporting experience-rated products) are reflected in shareholders' equity, net of tax, as a component of accumulated other comprehensive income (loss). Unrealized capital gains and losses on investments supporting large case pensions' experience-rated products are credited directly to contract holders' accounts. The contract holders' accounts are reflected in policyholders' funds on the consolidated balance sheets.

Derivative Financial Instruments

The Company uses derivative financial instruments in order to manage interest rate and foreign exchange risk and credit exposure. The Company's use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps.

Accounts Receivable

Accounts receivable are stated net of allowances for credit losses, customer credit allowances, contractual allowances and estimated terminations. Accounts receivable, net was composed of the following at December 31, 2022 and 2021:

In millions	2022	2021
Trade receivables	$ 8,983	$ 7,932
Vendor and manufacturer receivables	12,395	10,573
Premium receivables	2,676	2,537
Other receivables	3,449	3,389
Total accounts receivable, net [1]	$ 27,503	$ 24,431

(1) Includes accounts receivable of $227 million which have been accounted for as assets held for sale and are included in assets held for sale on the consolidated balance sheet at December 31, 2022. See Note 2 ‘‘Acquisitions, Divestitures and Asset Sales’’ for additional information.

The Company’s allowance for credit losses was $333 million and $339 million as of December 31, 2022 and 2021, respectively. When developing an estimate of the Company’s expected credit losses, the Company considers all available relevant information regarding the collectability of cash flows, including historical information, current conditions and reasonable and supportable forecasts of future economic conditions over the contractual life of the receivable. The Company’s accounts receivable are short duration in nature and typically settle in less than 30 days.

Inventories

Inventories are valued at the lower of cost or net realizable value using the weighted average cost method. Physical inventory counts are taken on a regular basis in each retail store and LTC pharmacy, and a continuous cycle count process is the primary procedure used to validate the inventory balances on hand in each distribution center and mail facility to ensure that the amounts reflected in the consolidated financial statements are properly stated. During the interim period between physical inventory counts, the Company accrues for anticipated physical inventory losses on a location-by-location basis based on historical results and current physical inventory trends.

Reinsurance Recoverables

The Company utilizes reinsurance agreements primarily to: (a) reduce required capital and (b) facilitate the acquisition or disposition of certain insurance contracts. Ceded reinsurance agreements permit the Company to recover a portion of its losses from reinsurers, although they do not discharge the Company’s primary liability as the direct insurer of the risks reinsured. Failure of reinsurers to indemnify the Company could result in losses; however, the Company does not expect charges for unrecoverable reinsurance to have a material effect on its consolidated operating results or financial condition. The Company evaluates the financial condition of its reinsurers and monitors concentrations of credit risk arising from similar geographic regions, activities or economic characteristics of its reinsurers. At December 31, 2022, the Company’s reinsurance recoverables consisted primarily of amounts due from third parties that are rated consistent with companies that are considered to have the ability to meet their obligations. Reinsurance recoverables are recorded as other current assets or other assets on the consolidated balance sheets.

Health Care Contract Acquisition Costs

Insurance products included in the Health Care Benefits segment are cancellable by either the customer or the member monthly upon written notice. Acquisition costs related to prepaid health care and health indemnity contracts are generally expensed as incurred. Acquisition costs for certain long-duration insurance contracts are deferred and are recorded as other current assets or other assets on the consolidated balance sheets and are amortized over the estimated life of the contracts. The amortization of deferred acquisition costs is recorded in operating expenses in the consolidated statements of operations. At December 31, 2022 and 2021, the balance of deferred acquisition costs was $1.2 billion and $895 million, respectively, comprised primarily of commissions paid on Medicare Supplement products within the Health Care Benefits segment.

Property and Equipment

Property and equipment is reported at historical cost, net of accumulated depreciation. Property, equipment and improvements to leased premises are depreciated using the straight-line method over the estimated useful lives of the assets, or when applicable, the term of the lease, whichever is shorter. Estimated useful lives generally range from 1 to 40 years for buildings,

building improvements and leasehold improvements and 3 to 10 years for fixtures, equipment and internally developed software. Repair and maintenance costs are charged directly to expense as incurred. Major renewals or replacements that substantially extend the useful life of an asset are capitalized and depreciated. Application development stage costs for significant internally developed software projects are capitalized and depreciated.

Property and equipment consisted of the following at December 31, 2022 and 2021:

In millions	**2022**	**2021**
Land	$ 1,996	$ 2,038
Building and improvements	4,545	4,225
Fixtures and equipment	12,978	13,619
Leasehold improvements	6,238	6,242
Software	8,843	7,426
Total property and equipment	34,600	33,550
Accumulated depreciation and amortization	(21,483)	(20,654)
Property and equipment, net [(1)]	$ 13,117	$ 12,896

(1) Includes property and equipment of $244 million which have been accounted for as assets held for sale and are included in assets held for sale on the consolidated balance sheet at December 31, 2022. See Note 2 ‘‘Acquisitions, Divestitures and Asset Sales’’ for additional information.

Depreciation expense (which includes the amortization of property and equipment under finance or capital leases) totaled $2.4 billion, $2.3 billion and $2.1 billion for the years ended December 31, 2022, 2021 and 2020, respectively. During the year ended December 31, 2021, the Company recorded an impairment on property and equipment of $261 million in connection with the planned closure of certain retail stores. See Note 6 ‘‘Leases’’ for additional information about these impairment charges as well as the Company’s finance leases.

Right-of-Use Assets and Lease Liabilities

The Company determines if an arrangement contains a lease at the inception of a contract. Right-of-use assets represent the Company’s right to use an underlying asset for the lease term and lease liabilities represent the Company’s obligation to make lease payments arising from the lease. Right-of-use assets and lease liabilities are recognized at the commencement date of the lease, renewal date of the lease or significant remodeling of the lease space based on the present value of the remaining future minimum lease payments. As the interest rate implicit in the Company’s leases is not readily determinable, the Company utilizes its incremental borrowing rate, determined by class of underlying asset, to discount the lease payments. The operating lease right-of-use assets also include lease payments made before commencement and are reduced by lease incentives.

The Company’s real estate leases typically contain options that permit renewals for additional periods of up to five years each. For real estate leases, the options to extend are not considered reasonably certain at lease commencement because the Company reevaluates each lease on a regular basis to consider the economic and strategic incentives of exercising the renewal options and regularly opens or closes stores to align with its operating strategy. Generally, the renewal option periods are not included within the lease term and the associated payments are not included in the measurement of the right-of-use asset and lease liability. Similarly, renewal options are not included in the lease term for non-real estate leases because they are not considered reasonably certain of being exercised at lease commencement. Leases with an initial term of 12 months or less are not recorded on the balance sheets, and lease expense is recognized on a straight-line basis over the term of the short-term lease.

For real estate leases, the Company accounts for lease components and nonlease components as a single lease component. Certain real estate leases require additional payments based on sales volume, as well as reimbursement for real estate taxes, common area maintenance and insurance, which are expensed as incurred as variable lease costs. Other real estate leases contain one fixed lease payment that includes real estate taxes, common area maintenance and insurance. These fixed payments are considered part of the lease payment and included in the right-of-use assets and lease liabilities.

See Note 6 ‘‘Leases’’ for additional information about right-of-use assets and lease liabilities.

Goodwill

The Company accounts for business combinations using the acquisition method of accounting, which requires the excess cost of an acquisition over the fair value of net assets acquired and identifiable intangible assets to be recorded as goodwill. Goodwill is

not amortized, but is subject to impairment reviews annually, or more frequently, if necessary, as further described in "Recoverability of Long-Lived Assets" below. See Note 5 ''Goodwill and Other Intangibles'' for additional information about goodwill.

Intangible Assets

The Company's identifiable intangible assets consist primarily of trademarks, trade names, customer contracts/relationships, covenants not to compete, technology, provider networks and value of business acquired ("VOBA"). These intangible assets arise primarily from the determination of their respective fair market values at the date of acquisition. Amounts assigned to identifiable intangible assets, and their related useful lives, are derived from established valuation techniques and management estimates.

The Company's definite-lived intangible assets are amortized over their estimated useful lives based upon the pattern of future cash flows attributable to the asset. Other than VOBA, definite-lived intangible assets are amortized using the straight-line method. VOBA is amortized over the expected life of the acquired contracts in proportion to estimated premiums. Indefinite-lived intangible assets are not amortized but are tested for impairment annually, or more frequently, if necessary, as further described in "Recoverability of Long-Lived Assets" below.

See Note 5 ''Goodwill and Other Intangibles'' for additional information about intangible assets.

Recoverability of Long-Lived Assets

The Company evaluates the recoverability of long-lived assets, excluding goodwill and indefinite-lived intangible assets, which are tested for impairment using separate tests described below, whenever events or changes in circumstances indicate that the carrying value of such asset may not be recoverable. The Company groups and evaluates these long-lived assets for impairment at the lowest level at which individual cash flows can be identified. If indicators of impairment are present, the Company first compares the carrying amount of the asset group to the estimated future cash flows associated with the asset group (undiscounted). If the estimated future cash flows used in this analysis are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to the asset group's estimated future cash flows (discounted). If required, an impairment loss is recorded for the portion of the asset group's carrying value that exceeds the asset group's estimated future cash flows (discounted).

During the year ended December 31, 2022, the Company recorded office real estate optimization charges of $117 million primarily related to the abandonment of leased real estate and the related right-of-use assets and property and equipment in connection with the planned reduction of corporate office real estate space in response to its new flexible work arrangement.

During the year ended December 31, 2021, the Company recorded a store impairment charge of approximately $1.4 billion primarily related to the write down of operating lease right-of-use assets and property and equipment in connection with the planned closure of approximately 900 retail stores between 2022 and 2024. There were no material impairment charges recognized on long-lived assets during the year ended December 31, 2020.

See Note 6 ''Leases'' for additional information about the right-of-use asset charges.

When evaluating goodwill for potential impairment, the Company compares the fair value of its reporting units to their respective carrying amounts. The Company estimates the fair value of its reporting units using a combination of a discounted cash flow method and a market multiple method. If the carrying amount of a reporting unit exceeds its estimated fair value, an impairment loss is recognized in an amount equal to that excess. During the third quarter of both 2022 and 2020, the Company performed its required annual impairment tests of goodwill and concluded there were no goodwill impairments as of the testing dates or during the years ended December 31, 2022 and 2020. During the third quarter of 2021, the Company performed its required annual impairment tests of goodwill, the results of which indicated an impairment of the goodwill associated with the LTC reporting unit. Accordingly, during the third quarter of 2021, the Company recorded a $431 million goodwill impairment charge on the remaining goodwill of the LTC reporting unit. The results of the impairment tests indicated that there was no impairment of goodwill of the remaining reporting units as of the testing date or during the year ended December 31, 2021. See Note 5 ''Goodwill and Other Intangibles'' for additional information about the goodwill impairment charge recorded during the year ended December 31, 2021.

Indefinite-lived intangible assets are tested for impairment by comparing the estimated fair value of the asset to its carrying value. The Company estimates the fair value of its indefinite-lived trademarks using the relief from royalty method under the

income approach. If the carrying value of the asset exceeds its estimated fair value, an impairment loss is recognized, and the asset is written down to its estimated fair value. There were no impairment losses recognized on indefinite-lived intangible assets in any of the years ended December 31, 2022, 2021 or 2020.

Separate Accounts

Separate Accounts assets and liabilities related to large case pensions products represent funds maintained to meet specific objectives of contract holders who bear the investment risk. These assets and liabilities are carried at fair value. Net investment income (including net realized capital gains and losses) accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from the Company's other businesses. Deposits, withdrawals and net investment income (including net realized and net unrealized capital gains and losses) on Separate Accounts assets are not reflected in the consolidated statements of operations or cash flows. Management fees charged to contract holders are included in services revenue and recognized over the period earned.

Health Care Costs Payable

Health care costs payable consist principally of unpaid fee-for-service medical, dental and pharmacy claims, capitation costs, other amounts due to providers pursuant to risk-sharing arrangements related to the Health Care Benefits segment's Insured Commercial, Medicare and Medicaid products and accruals for state assessments. Unpaid health care claims include an estimate of payments the Company will make for (i) services rendered to the Company's Insured members but not yet reported to the Company and (ii) claims which have been reported to the Company but not yet paid, each as of the financial statement date (collectively, "IBNR"). Health care costs payable also include an estimate of the cost of services that will continue to be rendered after the financial statement date if the Company is obligated to pay for such services in accordance with contractual or regulatory requirements. Such estimates are developed using actuarial principles and assumptions which consider, among other things, historical and projected claim submission and processing patterns, assumed and historical medical cost trends, historical utilization of medical services, claim inventory levels, changes in Insured membership and product mix, seasonality and other relevant factors. The Company reflects changes in these estimates in benefit costs in the Company's consolidated operating results in the period they are determined. Capitation costs represent contractual monthly fees paid to participating physicians and other medical providers for providing medical care, regardless of the volume of medical services provided to the Insured member. Amounts due under risk-sharing arrangements are based on the terms of the underlying contracts with the providers and consider claims experience under the contracts through the financial statement date.

The Company develops its estimate of IBNR using actuarial principles and assumptions that consider numerous factors. Of those factors, the Company considers the analysis of historical and projected claim payment patterns (including claims submission and processing patterns) and the assumed health care cost trend rate (the year-over-year change in per member per month health care costs) to be the most critical assumptions. In developing its IBNR estimate, the Company consistently applies these actuarial principles and assumptions each period, with consideration to the variability of related factors. There have been no significant changes to the methodologies or assumptions used to develop the Company's estimate of IBNR in 2022.

The Company analyzes historical claim payment patterns by comparing claim incurred dates (i.e., the date services were provided) to claim payment dates to estimate "completion factors." The Company uses completion factors predominantly to estimate the ultimate cost of claims incurred more than three months before the financial statement date. The Company estimates completion factors by aggregating claim data based on the month of service and month of claim payment and estimating the percentage of claims incurred for a given month that are complete by each month thereafter. For any given month, substantially all claims are paid within six months of the date of service, but it can take up to 48 months or longer after the date of service before all of the claims are completely resolved and paid. These historically-derived completion factors are then applied to claims paid through the financial statement date to estimate the ultimate claim cost for a given month's incurred claim activity. The difference between the estimated ultimate claim cost and the claims paid through the financial statement date represents the Company's estimate of claims remaining to be paid as of the financial statement date and is included in the Company's health care costs payable. The completion factors the Company uses reflect judgments and possible adjustments based on data such as claim inventory levels, claim submission and processing patterns and, to a lesser extent, other factors such as changes in health care cost trend rates, changes in Insured membership and changes in product mix. If claims are submitted or processed on a faster (slower) pace than prior periods, the actual claims may be more (less) complete than originally estimated using the Company's completion factors, which may result in reserves that are higher (lower) than the ultimate cost of claims.

Because claims incurred within three months before the financial statement date are less mature, the Company uses a combination of historically-derived completion factors and the assumed health care cost trend rate to estimate the ultimate cost

of claims incurred for these months. The Company applies its actuarial judgment and places a greater emphasis on the assumed health care cost trend rate for the most recent claim incurred dates as these months may be influenced by seasonal patterns and changes in membership and product mix.

The Company's health care cost trend rate is affected by changes in per member utilization of medical services as well as changes in the unit cost of such services. Many factors influence the health care cost trend rate, including the Company's ability to manage benefit costs through product design, negotiation of favorable provider contracts and medical management programs, as well as the mix of the Company's business. The health status of the Company's Insured members, aging of the population and other demographic characteristics, advances in medical technology and other factors continue to contribute to rising per member utilization and unit costs. Changes in health care practices, inflation, new technologies, increases in the cost of prescription drugs (including specialty pharmacy drugs), direct-to-consumer marketing by pharmaceutical companies, clusters of high-cost cases, claim intensity, changes in the regulatory environment, health care provider or member fraud and numerous other factors also contribute to the cost of health care and the Company's health care cost trend rate.

For each reporting period, the Company uses an extensive degree of judgment in the process of estimating its health care costs payable. As a result, considerable variability and uncertainty is inherent in such estimates, particularly with respect to claims with claim incurred dates of three months or less before the financial statement date; and the adequacy of such estimates is highly sensitive to changes in assumed completion factors and the assumed health care cost trend rates. For each reporting period the Company recognizes the actuarial best estimate of health care costs payable considering the potential volatility in assumed completion factors and health care cost trend rates, as well as other factors. The Company believes its estimate of health care costs payable is reasonable and adequate to cover its obligations at December 31, 2022; however, actual claim payments may differ from the Company's estimates. A worsening (or improvement) of the Company's health care cost trend rates or changes in completion factors from those that the Company assumed in estimating health care costs payable at December 31, 2022 would cause these estimates to change in the near term, and such a change could be material.

Each quarter, the Company re-examines previously established health care costs payable estimates based on actual claim payments for prior periods and other changes in facts and circumstances. Given the extensive degree of judgment in this estimate, it is possible that the Company's estimates of health care costs payable could develop either favorably (that is, its actual benefit costs for the period were less than estimated) or unfavorably. The changes in the Company's estimate of health care costs payable may relate to a prior quarter, prior year or earlier periods. For a roll forward of the Company's health care costs payable, see Note 7 ''Health Care Costs Payable.'' The Company's reserving practice is to consistently recognize the actuarial best estimate of its ultimate liability for health care costs payable.

Other Insurance Liabilities

Unpaid Claims

Unpaid claims consist primarily of reserves associated with certain short-duration group disability and term life insurance contracts, including an estimate for IBNR as of the financial statement date. Reserves associated with certain short-duration group disability and term life insurance contracts are based upon the Company's estimate of the present value of future benefits, which is based on assumed investment yields and assumptions regarding mortality, morbidity and recoveries from the U.S. Social Security Administration. The Company develops its estimate of IBNR using actuarial principles and assumptions which consider, among other things, contractual requirements, claim incidence rates, claim recovery rates, seasonality and other relevant factors. The Company discounts certain claim liabilities related to group long-term disability and life insurance waiver of premium contracts. The discount rates generally reflect the Company's expected investment returns for the investments supporting all incurral years of these liabilities. The discount rates for retrospectively-rated contracts are set at contractually specified levels. The Company's estimates of unpaid claims are subject to change due to changes in the underlying experience of the insurance contracts, changes in investment yields or other factors, and these changes are recorded in current and future benefits in the consolidated statements of operations in the period they are determined. The Company estimates its reserve for claims IBNR for life products largely based on completion factors. The completion factors used are based on the Company's historical experience and reflect judgments and possible adjustments based on data such as claim inventory levels, claim payment patterns, changes in business volume and other factors. If claims are submitted or processed on a faster (slower) pace than historical periods, the actual claims may be more (less) complete than originally estimated using completion factors, which may result in reserves that are higher (lower) than required to cover future life benefit payments. There have been no significant changes to the methodologies or assumptions used to develop the Company's estimate of unpaid claims IBNR in 2022. As of December 31, 2022, unpaid claims balances of $243 million and $1.1 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively. As of December 31, 2021, unpaid claims balances of $324 million and $1.3 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively.

Substantially all life and disability insurance liabilities have been fully ceded to unrelated third parties through indemnity reinsurance agreements; however, the Company remains directly obligated to the policyholders.

Future Policy Benefits
Future policy benefits consist primarily of reserves for limited payment pension and annuity contracts and long-term care insurance contracts. Reserves for limited payment pension and annuity contracts are computed using actuarial principles that consider, among other things, assumptions reflecting anticipated mortality, retirement, expense and interest rate experience. Such assumptions generally vary by plan, year of issue and policy duration. Assumed interest rates on such contracts ranged from 3.0% to 11.3% in both the years ended December 31, 2022 and 2021. The Company periodically reviews mortality assumptions against both industry standards and its experience. Reserves for long-duration long-term care contracts represent the Company's estimate of the present value of future benefits and essential maintenance expenses to be paid to or on behalf of policyholders less the present value of future gross premiums. The assumed interest rate on such contracts was 4.9% and 5.1% in the years ended December 31, 2022 and 2021, respectively. The Company's estimate of the present value of future benefits under such contracts is based upon mortality, morbidity and interest rate assumptions. As of December 31, 2022, future policy benefits balances of $385 million and $5.0 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively. As of December 31, 2021, future policy benefits balances of $416 million and $5.1 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively.

Premium Deficiency Reserves

The Company evaluates its insurance contracts to determine if it is probable that a loss will be incurred. A premium deficiency loss is recognized when it is probable that expected future claims, including maintenance costs (for example, direct costs such as claim processing costs), will exceed existing reserves plus anticipated future premiums and reinsurance recoveries. Anticipated investment income is not considered in the calculation of premium deficiency losses for short-duration contracts. For purposes of determining premium deficiency losses, contracts are grouped consistent with the Company's method of acquiring, servicing and measuring the profitability of such contracts. The Company did not have any premium deficiency reserves as of December 31, 2022. As of December 31, 2021, the Company established a premium deficiency reserve of $16 million related to Medicaid products in the Health Care Benefits segment.

Policyholders' Funds

Policyholders' funds consist primarily of reserves for pension and annuity investment contracts and customer funds associated with certain health contracts. Reserves for such contracts are equal to cumulative deposits less withdrawals and charges plus interest credited thereon, net of experience-rated adjustments. In both 2022 and 2021, interest rates for pension and annuity investment contracts ranged from 3.5% to 4.8%. Reserves for contracts subject to experience rating reflect the Company's rights as well as the rights of policyholders and plan participants. The Company also held funds for HSAs on behalf of members associated with high deductible health plans prior to the sale of PayFlex in June 2022. These amounts were held to pay for qualified health care expenses incurred by these members. At December 31, 2022, the Company did not hold any HSA funds as a result of the PayFlex sale. The HSA balance was approximately $2.9 billion at December 31, 2021 and was reflected in other current assets with a corresponding liability in policyholders' funds. These assets were considered restricted cash for cash flow statement purposes.

Policyholders' funds liabilities that are expected to be paid within twelve months from the balance sheet date are classified as current on the consolidated balance sheets. Policyholders' funds liabilities that are expected to be paid greater than twelve months from the balance sheet date are included in other long-term liabilities on the consolidated balance sheets.

Self-Insurance Liabilities

The Company is self-insured for certain losses related to general liability, workers' compensation and auto liability. The Company obtains third party insurance coverage to limit exposure from these claims. The Company is also self-insured for certain losses related to health and medical liabilities. The Company's self-insurance accruals, which include reported claims and claims incurred but not reported, are calculated using standard insurance industry actuarial assumptions and the Company's historical claims experience. As of both December 31, 2022 and 2021, self-insurance liabilities totaled $1.1 billion and were recorded in accrued expenses and other long-term liabilities on the consolidated balance sheets.

Foreign Currency Translation and Transactions

For non-U.S. dollar functional currency locations, (i) assets and liabilities are translated at end-of-period exchange rates, (ii) revenues and expenses are translated at average exchange rates in effect during the period and (iii) equity is translated at historical exchange rates. The resulting cumulative translation adjustments are included as a component of accumulated other comprehensive income (loss).

For U.S. dollar functional currency locations, foreign currency assets and liabilities are remeasured into U.S. dollars at end-of-period exchange rates, except for nonmonetary balance sheet accounts which are remeasured at historical exchange rates. Revenues and expenses are remeasured at average exchange rates in effect during each period, except for those expenses related to the nonmonetary balance sheet amounts which are remeasured at historical exchange rates. Gains or losses from foreign currency remeasurement are included in net income.

Gains and losses from foreign currency transactions and the effects of foreign currency remeasurements were not material in the years ended December 31, 2022, 2021 or 2020.

Revenue Recognition

Health Care Benefits Segment
Health Care Benefits revenue is principally derived from insurance premiums and fees billed to customers. Revenue is recognized based on customer billings, which, in the Company's Commercial business, reflect contracted rates per member and the number of covered members recorded in the Company's records at the time the billings are prepared. Billings are generally sent monthly for coverage during the following month. Revenue related to the Company's Government business is collected monthly from the U.S. federal government and various government agencies based on fixed payment rates and member eligibility.

The Company's billings may be subsequently adjusted to reflect enrollment changes due to member terminations or other factors. These adjustments are known as retroactivity adjustments. In each period, the Company estimates the amount of future retroactivity and adjusts the recorded revenue accordingly. As information regarding actual retroactivity amounts becomes known, the Company refines its estimates and records any required adjustments to revenues in the period in which they arise.

Premium Revenue
Premiums are recognized as revenue in the month in which the enrollee is entitled to receive health care services. Premiums are reported net of an allowance for estimated terminations and uncollectible amounts. Additionally, premium revenue subject to the minimum medical loss ratio ("MLR") rebate requirements of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (as amended, collectively, the "ACA") is recorded net of the estimated minimum MLR rebates for the current calendar year. Premiums related to unexpired contractual coverage periods (unearned premiums) are reported as other insurance liabilities on the consolidated balance sheets and recognized as revenue when earned.

Some of the Company's contracts allow for premiums to be adjusted to reflect actual experience or the relative health status of Insured members. Such adjustments are reasonably estimable at the outset of the contract, and adjustments to those estimates are made based on actual experience of the customer emerging under the contract and the terms of the underlying contract.

Services Revenue
Services revenue relates to contracts that can include various combinations of services or series of services which generally are capable of being distinct and accounted for as separate performance obligations. The Health Care Benefits segment's services revenue primarily consists of ASC fees received in exchange for performing certain claim processing and member services for ASC members. ASC fee revenue is recognized over the period the service is provided. Some of the Company's administrative services contracts include guarantees with respect to certain functions, such as customer service response time, claim processing accuracy and claim processing turnaround time, as well as certain guarantees that a plan sponsor's benefit claim experience will fall within a certain range. With any of these guarantees, the Company is financially at risk if the conditions of the arrangements are not met, although the maximum amount at risk typically is limited to a percentage of the fees otherwise payable to the Company by the customer involved. Each period the Company estimates its obligations under the terms of these guarantees and records its estimate as an offset to services revenues.

Accounting for Medicare Part D
Revenues include insurance premiums earned by the Company's PDPs, which are determined based on the PDP's annual bid and related contractual arrangements with the U.S. Centers for Medicare & Medicaid Services ("CMS"). The insurance

premiums include a beneficiary premium, which is the responsibility of the PDP member, and can be subsidized by CMS in the case of low-income members, and a direct premium paid by CMS. Premiums collected in advance are initially recorded within other insurance liabilities and are then recognized ratably as revenue over the period in which members are entitled to receive benefits.

Revenues also include a risk-sharing feature of the Medicare Part D program design referred to as the risk corridor. The Company estimates variable consideration in the form of amounts payable to, or receivable from, CMS under the risk corridor, and adjusts revenue based on calculations of additional subsidies to be received from or owed to CMS at the end of the reporting year.

In addition to Medicare Part D premiums, the Company receives additional payments each month from CMS related to catastrophic reinsurance, low-income cost-sharing subsidies and coverage gap benefits. If the subsidies received differ from the amounts earned from actual prescriptions transferred, the difference is recorded in either accounts receivable, net or accrued expenses.

Pharmacy Services Segment
The Pharmacy Services segment sells prescription drugs directly through its mail service dispensing pharmacies and indirectly through the Company's retail pharmacy network. The Company's pharmacy benefit arrangements are accounted for in a manner consistent with a master supply arrangement as there are no contractual minimum volumes and each prescription is considered a separate purchasing decision and distinct performance obligation transferred at a point in time. PBM services performed in connection with each prescription claim are considered part of a single performance obligation which culminates in the dispensing of prescription drugs.

The Company recognizes revenue using the gross method at the contract price negotiated with its clients when the Company has concluded it controls the prescription drug before it is transferred to the client plan members. The Company controls prescriptions dispensed indirectly through its retail pharmacy network because it has separate contractual arrangements with those pharmacies, has discretion in setting the price for the transaction and assumes primary responsibility for fulfilling the promise to provide prescription drugs to its client plan members while also performing the related PBM services.

Revenues include (i) the portion of the price the client pays directly to the Company, net of any discounts earned on brand name drugs or other discounts and refunds paid back to the client (see "Drug Discounts" and "Guarantees" below), (ii) the price paid to the Company by client plan members for mail order prescriptions and the price paid to retail network pharmacies by client plan members for retail prescriptions ("retail co-payments"), and (iii) claims based administrative fees for retail pharmacy network contracts. Sales taxes are not included in revenues.

The Company recognizes revenue when control of the prescription drugs is transferred to customers, in an amount that reflects the consideration the Company expects to be entitled to receive in exchange for those prescription drugs. The Company has established the following revenue recognition policies for the Pharmacy Services segment:

- Revenues generated from prescription drugs sold by mail service dispensing pharmacies are recognized when the prescription drug is delivered to the client plan member. At the time of delivery, the Company has performed substantially all of its performance obligations under its client contracts and does not experience a significant level of returns or reshipments.
- Revenues generated from prescription drugs sold by third party pharmacies in the Company's retail pharmacy network and associated administrative fees are recognized at the Company's point-of-sale, which is when the claim is adjudicated by the Company's online claims processing system and the Company has transferred control of the prescription drug and completed all of its performance obligations.

For contracts under which the Company acts as an agent or does not control the prescription drugs prior to transfer to the client plan member, revenue is recognized using the net method.

Drug Discounts
The Company records revenue net of manufacturers' rebates earned by its clients based on their plan members' utilization of brand-name formulary drugs. The Company estimates these rebates at period-end based on actual and estimated claims data and its estimates of the manufacturers' rebates earned by its clients. The estimates are based on the best available data at period-end and recent history for the various factors that can affect the amount of rebates due to the client. The Company adjusts its rebates payable to clients to the actual amounts paid when these rebates are paid or as significant events occur. Any cumulative effect of these adjustments is recorded against revenues at the time it is identified. Adjustments generally result from contract changes

with clients or manufacturers that have retroactive rebate adjustments, differences between the estimated and actual product mix subject to rebates, or whether the brand name drug was included in the applicable formulary. The effect of adjustments between estimated and actual manufacturers' rebate amounts has not been material to the Company's operating results or financial condition.

Guarantees

The Company also adjusts revenues for refunds owed to clients resulting from pricing guarantees and performance against defined service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's operating results or financial condition.

Retail/LTC Segment

Retail Pharmacy

The Company's retail drugstores recognize revenue at the time the customer takes possession of the merchandise. For pharmacy sales, each prescription claim is its own arrangement with the customer and is a performance obligation, separate and distinct from other prescription claims under other retail network arrangements. Revenues are adjusted for refunds owed to third party payers resulting from pricing guarantees and performance against defined value-based service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's operating results or financial condition.

Revenue from Company gift cards purchased by customers is deferred as a contract liability until goods or services are transferred. Any amounts not expected to be redeemed by customers (i.e., breakage) are recognized based on historical redemption patterns.

Customer returns are not material to the Company's operating results or financial condition. Sales taxes are not included in revenues.

Loyalty and Other Programs

The Company's customer loyalty program, ExtraCare®, consists of two components, ExtraSavings™ and ExtraBucks® Rewards. ExtraSavings are coupons that are recorded as a reduction of revenue when redeemed as the Company concluded that they do not represent a promise to the customer to deliver additional goods or services at the time of issuance because they are not tied to a specific transaction or spending level.

ExtraBucks Rewards are accumulated by customers based on their historical spending levels. Thus, the Company has determined that there is an additional performance obligation to those customers at the time of the initial transaction. The Company allocates the transaction price to the initial transaction and the ExtraBucks Rewards transaction based upon the relative standalone selling price, which considers historical redemption patterns for the rewards. Revenue allocated to ExtraBucks Rewards is recognized as those rewards are redeemed. At the end of each period, unredeemed ExtraBucks Rewards are reflected as a contract liability.

The Company also offers a subscription-based membership program, CarePass®, under which members are entitled to a suite of benefits delivered over the course of the subscription period, as well as a promotional reward that can be redeemed for future goods and services. Subscriptions are paid for on a monthly or annual basis at the time of or in advance of the Company delivering the goods and services. Revenue from these arrangements is recognized as the performance obligations are satisfied.

Long-term Care

Revenue is recognized when control of the promised goods or services is transferred to customers in an amount that reflects the consideration the Company expects to be entitled to receive in exchange for those goods or services. Each prescription claim represents a separate performance obligation of the Company, separate and distinct from other prescription claims under customer arrangements. A significant portion of long-term care revenue from sales of pharmaceutical and medical products is reimbursed by the federal Medicare Part D program and, to a lesser extent, state Medicaid programs. The Company monitors its revenues and receivables from these reimbursement sources, as well as long-term care facilities and other third party insurance payors, and reduces revenue at the revenue recognition date to properly account for the variable consideration due to anticipated differences between billed and reimbursed amounts. Accordingly, the total revenues and receivables reported in the Company's consolidated financial statements are recorded at the amount expected to be ultimately received from these payors.

Patient co-payments associated with Medicare Part D, certain state Medicaid programs, Medicare Part B and certain third party payors typically are not collected at the time products are delivered or services are rendered, but are billed to the individuals as part of normal billing procedures and subject to normal accounts receivable collections procedures.

Walk-In Medical Clinics

For services provided by the Company's walk-in medical clinics, revenue recognition occurs for completed services provided to patients, with adjustments taken for third party payor contractual obligations and patient direct bill historical collection rates.

Disaggregation of Revenue

The following table disaggregates the Company's revenue by major source in each segment for the years ended December 31, 2022, 2021 and 2020:

In millions	**Health Care Benefits**	**Pharmacy Services**	**Retail/ LTC**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
2022						
Major goods/services lines:						
Pharmacy	$ —	$ 168,134	$ 82,010	$ —	$ (45,023)	$ 205,121
Front Store	—	—	22,780	—	—	22,780
Premiums	85,274	—	—	56	—	85,330
Net investment income (loss)	476	—	(44)	406	—	838
Other	5,659	1,102	1,848	68	(279)	8,398
Total	$ 91,409	$ 169,236	$ 106,594	$ 530	$ (45,302)	$ 322,467
Pharmacy Services distribution channel:						
Pharmacy network [1]		$ 97,668				
Mail choice [2]		70,466				
Other		1,102				
Total		$ 169,236				
2021						
Major goods/services lines:						
Pharmacy	$ —	$ 152,262	$ 76,121	$ —	$ (43,765)	$ 184,618
Front Store	—	—	21,315	—	—	21,315
Premiums	76,064	—	—	68	—	76,132
Net investment income	586	—	17	596	—	1,199
Other	5,536	760	2,652	57	(158)	8,847
Total	$ 82,186	$ 153,022	$ 100,105	$ 721	$ (43,923)	$ 292,111
Pharmacy Services distribution channel:						
Pharmacy network [1]		$ 91,715				
Mail choice [2]		60,547				
Other		760				
Total		$ 153,022				
2020						
Major goods/services lines:						
Pharmacy	$ —	$ 141,116	$ 70,176	$ —	$ (40,003)	$ 171,289
Front Store	—	—	19,655	—	—	19,655
Premiums	69,301	—	—	63	—	69,364
Net investment income	483	—	—	315	—	798
Other	5,683	822	1,367	48	(320)	7,600
Total	$ 75,467	$ 141,938	$ 91,198	$ 426	$ (40,323)	$ 268,706
Pharmacy Services distribution channel:						
Pharmacy network [1]		$ 85,045				
Mail choice [2]		56,071				
Other		822				
Total		$ 141,938				

(1) Pharmacy Services pharmacy network is defined as claims filled at retail and specialty retail pharmacies, including the Company's retail pharmacies and LTC pharmacies, but excluding Maintenance Choice® activity, which is included within the mail choice category. Maintenance Choice permits eligible client plan members to fill their maintenance prescriptions through mail order delivery or at a CVS pharmacy retail store for the same price as mail order.

(2) Pharmacy Services mail choice is defined as claims filled at a Pharmacy Services mail order facility, which includes specialty mail claims inclusive of Specialty Connect® claims picked up at a retail pharmacy, as well as prescriptions filled at the Company's retail pharmacies under the Maintenance Choice program.

Contract Balances

Contract liabilities primarily represent the Company's obligation to transfer additional goods or services to a customer for which the Company has received consideration, and include ExtraBucks Rewards and unredeemed Company gift cards. The consideration received remains a contract liability until goods or services have been provided to the customer. In addition, the Company recognizes breakage on Company gift cards based on historical redemption patterns.

The following table provides information about receivables and contract liabilities from contracts with customers as of December 31, 2022 and 2021:

In millions	**2022**	**2021**
Trade receivables (included in accounts receivable, net)	$ 8,983	$ 7,932
Contract liabilities (included in accrued expenses)	71	87

During the years ended December 31, 2022 and 2021, the contract liabilities balance includes increases related to customers' earnings in ExtraBucks Rewards or issuances of Company gift cards and decreases for revenues recognized during the period as a result of the redemption of ExtraBucks Rewards or Company gift cards and breakage of Company gift cards. Below is a summary of such changes:

In millions	**2022**	**2021**
Contract liabilities, beginning of period	$ 87	$ 71
Rewards earnings and gift card issuances	340	387
Redemption and breakage	(356)	(371)
Contract liabilities, end of period	$ 71	$ 87

Cost of Products Sold

The Company accounts for cost of products sold as follows:

Pharmacy Services Segment

Cost of products sold includes: (i) the cost of prescription drugs sold during the reporting period directly through the Company's mail service dispensing pharmacies and indirectly through the Company's retail pharmacy network, (ii) shipping and handling costs, and (iii) the operating costs of the Company's mail service dispensing pharmacies and client service operations and related information technology support costs including depreciation and amortization. The cost of prescription drugs sold component of cost of products sold includes: (i) the cost of the prescription drugs purchased from manufacturers or distributors and shipped to members in clients' benefit plans from the Company's mail service dispensing pharmacies, net of any volume-related or other discounts (see "Vendor Allowances and Purchase Discounts" below) and (ii) the cost of prescription drugs sold (including retail co-payments) through the Company's retail pharmacy network under contracts where the Company is the principal, net of any volume-related or other discounts.

Retail/LTC Segment

Cost of products sold includes: the cost of merchandise sold during the reporting period, including prescription drug costs, and the related purchasing costs, warehousing and delivery costs (including depreciation and amortization) and actual and estimated inventory losses.

Vendor Allowances and Purchase Discounts

The Company accounts for vendor allowances and purchase discounts as follows:

Pharmacy Services Segment

The Pharmacy Services segment receives purchase discounts on products purchased. Contractual arrangements with vendors, including manufacturers, wholesalers and retail pharmacies, normally provide for the Pharmacy Services segment to receive

purchase discounts from established list prices in one, or a combination, of the following forms: (i) a direct discount at the time of purchase, (ii) a discount for the prompt payment of invoices or (iii) when products are purchased indirectly from a manufacturer (e.g., through a wholesaler or retail pharmacy), a discount (or rebate) paid subsequent to dispensing. These rebates are recognized when prescriptions are dispensed and are generally calculated and billed to manufacturers within 30 days of the end of each completed quarter. Historically, the effect of adjustments resulting from the reconciliation of rebates recognized to the amounts billed and collected has not been material to the Company's operating results or financial condition. The Company accounts for the effect of any such differences as a change in accounting estimate in the period the reconciliation is completed. The Pharmacy Services segment also receives additional discounts under its wholesaler contracts if it exceeds contractually defined purchase volumes. In addition, the Pharmacy Services segment receives fees from pharmaceutical manufacturers for administrative services. Purchase discounts and administrative service fees are recorded as a reduction of cost of products sold.

Retail/LTC Segment
Vendor allowances received by the Retail/LTC segment reduce the carrying cost of inventory and are recognized in cost of products sold when the related inventory is sold, unless they are specifically identified as a reimbursement of incremental costs for promotional programs and/or other services provided. Amounts that are directly linked to advertising commitments are recognized as a reduction of advertising expense (included in operating expenses) when the related advertising commitment is satisfied. Any amounts received in excess of the actual cost incurred also reduce the carrying cost of inventory. The total value of any upfront payments received from vendors that are linked to purchase commitments is initially deferred. The deferred amounts are then amortized to reduce cost of products sold over the life of the contract based upon sales volume. The total value of any upfront payments received from vendors that are not linked to purchase commitments is also initially deferred. The deferred amounts are then amortized to reduce cost of products sold on a straight-line basis over the life of the related contract. The total amortization of these upfront payments was not material to the Company's consolidated financial statements in any of the periods presented.

Health Care Reform

Health Insurer Fee
Beginning on January 1, 2014, the ACA imposed an annual premium-based health insurer fee ("HIF") for each calendar year, payable in September, which was not deductible for tax purposes. The Company was required to estimate a liability for the HIF at the beginning of the calendar year in which the fee was payable with a corresponding deferred asset that was amortized ratably to operating expenses over the calendar year. The Company recorded the liability for the HIF in accrued expenses and recorded the deferred asset in other current assets. In December 2019, the HIF was repealed for calendar years after 2020, therefore there was no expense related to the HIF in the years ended December 31, 2022 and 2021. In the year ended December 31, 2020, operating expenses included $1.0 billion related to the Company's share of the HIF.

Risk Adjustment
The ACA established a permanent risk adjustment program to transfer funds from qualified individual and small group insurance plans with below average risk scores to plans with above average risk scores. Based on the risk of the Company's qualified plan members relative to the average risk of members of other qualified plans in comparable markets, as defined by the ACA, the Company estimates its ultimate risk adjustment receivable (recorded in accounts receivable) or payable (recorded in accrued expenses) for the current calendar year and reflects the pro-rata year-to-date impact as an adjustment to premium revenue.

Risk Corridor
The ACA established a temporary risk corridor program, which expired at the end of 2016, for qualified individual and small group health insurance plans. Under this program, health insurance companies were to make payments to, or receive payments from, the U.S. Department of Health and Human Services ("HHS") based on their ratio of allowable costs to target costs (as defined by the ACA).

The Company filed a lawsuit in August 2019 to recover the $313 million it was owed under the ACA's risk corridor program, which had been stayed pending the Supreme Court decision. In April 2020, the U.S. Supreme Court ruled that health insurance companies may sue the federal government for amounts owed as calculated under the ACA's temporary risk corridor program.

In October 2020, the Company received the $313 million it was owed under the ACA's risk corridor program. The Company recorded the risk corridor payment as an increase to premium revenue in the year ended December 31, 2020. After considering offsetting items such as the ACA's minimum MLR rebate requirements and premium taxes, the Company recorded pre-tax income of $307 million and after-tax income of $223 million during the year ended December 31, 2020.

Advertising Costs

Advertising costs, which are reduced by the portion funded by vendors, are expensed when the related advertising takes place. Net advertising costs, which are included in operating expenses, were $745 million, $707 million and $613 million in 2022, 2021 and 2020, respectively.

Stock-Based Compensation

Stock-based compensation is measured at the grant date based on the fair value of the award and is recognized as expense over the requisite service period of the stock award (generally three to five years) using the straight-line method.

Income Taxes

The Company accounts for income taxes under the asset and liability method, which requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of events that have been included in the consolidated financial statements. Under this method, deferred tax assets and liabilities are determined on the basis of the differences between the consolidated financial statements and tax basis of assets and liabilities using enacted tax rates in effect for the year or years in which the differences are expected to reverse. The effect of a change in the tax rates on deferred tax assets and liabilities is recognized in income in the period that includes the enactment date of such change.

The Company recognizes deferred tax assets to the extent that it believes these assets are more likely than not to be realized. In making such a determination, the Company considers all available positive and negative evidence, including future reversals of existing taxable temporary differences, projected future taxable income, tax planning strategies, and the Company's recent operating results. The Company establishes a valuation allowance when it does not consider it more likely than not that a deferred tax asset will be recovered.

The Company records uncertain tax positions on the basis of a two-step process whereby (1) the Company determines whether it is more likely than not that the tax positions will be sustained on the basis of the technical merits of the position and (2) for those tax positions that meet the more-likely-than-not recognition threshold, the Company recognizes the largest amount of tax benefit that is more than 50% likely to be realized upon ultimate settlement with the related tax authority.

Interest and/or penalties related to uncertain tax positions are recognized in the income tax provision.

Measurement of Defined Benefit Pension and Other Postretirement Employee Benefit Plans

The Company sponsors defined benefit pension plans ("pension plans") and other postretirement employee benefit plans ("OPEB plans") for its employees and retirees. The Company recognizes the funded status of its pension and OPEB plans on the consolidated balance sheets based on the year-end measurements of plan assets and benefit obligations. When the fair value of plan assets are in excess of the plan benefit obligations, the amounts are reported in other current assets and other assets. When the fair value of plan benefit obligations are in excess of plan assets, the amounts are reported in accrued expenses and other long-term 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. The net periodic benefit income for the Company's pension and OPEB plans do not contain a service cost component as these plans have been frozen for an extended period of time. Non-service cost components of pension and postretirement net periodic benefit income are included in other income in the consolidated statements of operations.

Earnings per Share

Earnings per share is computed using the treasury stock method. The Company calculates basic earnings per share based on the weighted average number of common shares outstanding for the period. See Note 14 ''Earnings Per Share'' for additional information.

Shares Held in Trust

The Company maintains grantor trusts, which held approximately one million shares of its common stock at both December 31, 2022 and 2021. These shares are designated for use under various employee compensation plans. Since the Company holds these shares, they are excluded from the computation of basic and diluted shares outstanding.

Variable Interest Entities

The Company has investments in (i) a generic pharmaceutical sourcing entity, (ii) certain hedge fund and private equity investments and (iii) certain real estate partnerships that are considered VIEs. The Company does not have a future obligation to fund losses or debts on behalf of these investments; however, it may voluntarily contribute funds. In evaluating whether the Company is the primary beneficiary of a VIE, the Company considers several factors, including whether the Company has (a) the power to direct the activities that most significantly impact the VIE's economic performance and (b) the obligation to absorb losses and the right to receive benefits that could potentially be significant to the VIE.

Variable Interest Entities - Primary Beneficiary
In 2014, the Company and Cardinal Health, Inc. ("Cardinal") established Red Oak Sourcing, LLC ("Red Oak"), a generic pharmaceutical sourcing entity in which the Company and Cardinal each own 50%. The Red Oak arrangement had an initial term of ten years. In 2021, the Red Oak arrangement was amended to extend the initial term an additional five years, for a total term of 15 years. Under this arrangement, the Company and Cardinal contributed their sourcing and supply chain expertise to Red Oak and agreed to source and negotiate generic pharmaceutical supply contracts for both companies through Red Oak; however, Red Oak does not own or hold inventory on behalf of either company. No physical assets (e.g., property and equipment) were contributed to Red Oak by either company, and minimal funding was provided to capitalize Red Oak. The Company has determined that it is the primary beneficiary of this VIE because it has the ability to direct the activities of Red Oak. Consequently, the Company consolidates Red Oak in its consolidated financial statements within the Retail/LTC segment.

Cardinal is required to pay the Company quarterly payments, which began in October 2014 and will extend through June 2029. As milestones are met, the quarterly payments increase. The Company received $183 million from Cardinal during each of the years ended December 31, 2022, 2021 and 2020. The payments reduce the Company's carrying value of inventory and are recognized in cost of products sold when the related inventory is sold.

Variable Interest Entities - Other Variable Interest Holder
The Company has invested in certain VIEs for which it has determined that it is not the primary beneficiary, consisting of the following:

- *Hedge fund and private equity investments* - The Company invests in hedge fund and private equity investments in order to generate investment returns for its investment portfolio supporting its insurance businesses.
- *Real estate partnerships* - The Company invests in various real estate partnerships, including those that construct, own and manage low-income housing developments. For the low income housing development investments, substantially all of the projected benefits to the Company are from tax credits and other tax benefits.

The Company is not the primary beneficiary of these VIEs because the nature of the Company's involvement with the activities of these VIEs does not give the Company the power to direct the activities that most significantly impact their economic performance. The Company records the amount of its investment in these VIEs as long-term investments on the consolidated balance sheets and recognizes its share of each VIE's income or losses in net income. The Company's maximum exposure to loss from these VIEs is limited to its investment balances as disclosed below and the risk of recapture of previously recognized tax credits related to the real estate partnerships, which the Company does not consider significant.

Other variable interest holder VIE assets included in long-term investments on the consolidated balance sheets at December 31, 2022 and 2021 were as follows:

In millions	**2022**	**2021**
Hedge fund investments	$ 589	$ 463
Private equity investments	707	601
Real estate partnerships	241	225
Total	$ 1,537	$ 1,289

Related Party Transactions

The Company has an equity method investment in SureScripts, LLC ("SureScripts"), which operates a clinical health information network. The Company utilizes this clinical health information network in providing services to its client plan members and retail customers. The Company expensed fees for the use of this network of $60 million, $52 million and $56

million in the years ended December 31, 2022, 2021 and 2020, respectively. The Company's investment in and equity in the earnings of SureScripts for all periods presented is immaterial.

The Company has an equity method investment in Heartland Healthcare Services, LLC ("Heartland"). Heartland operates several LTC pharmacies in four states. Heartland paid the Company $87 million, $79 million and $77 million for pharmaceutical inventory purchases during the years ended December 31, 2022, 2021 and 2020, respectively. Additionally, the Company performs certain collection functions for Heartland and then transfers those customer cash collections to Heartland. The Company's investment in and equity in the earnings of Heartland for all periods presented is immaterial.

During the years ended December 31, 2022, 2021 and 2020, the Company made charitable contributions of $25 million, $50 million and $50 million, respectively, to the CVS Health Foundation, a non-profit entity that focuses on health, education and community involvement programs. The charitable contributions were recorded as operating expenses in the consolidated statements of operations within the Corporate/Other segment for the years ended December 31, 2022, 2021 and 2020.

Discontinued Operations

In connection with certain business dispositions completed between 1995 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Linens 'n Things and Bob's Stores, each of which subsequently filed for bankruptcy. The Company's loss from discontinued operations includes lease-related costs that the Company believes it will likely be required to satisfy pursuant to these lease guarantees. See "Lease Guarantees" in Note 16 ''Commitments and Contingencies'' for additional information.

Results from discontinued operations were immaterial for the years ended December 31, 2022 and 2021.

Below is a summary of the results of discontinued operations for the year ended December 31, 2020.

In millions	**2020**
Loss from discontinued operations	$ (12)
Income tax benefit	3
Loss from discontinued operations, net of tax	$ (9)

New Accounting Pronouncements Not Yet Adopted

Targeted Improvements to the Accounting for Long-Duration Insurance Contracts
In August 2018, the Financial Accounting Standards Board issued ASU 2018-12, *Targeted Improvements to the Accounting for Long-Duration Contracts* (Topic 944). 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 (loss). The rate used to discount the Company's liability 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 and requires additional disclosures regarding the long duration insurance contract liabilities in the Company's interim and annual financial statements. The standard is effective for public companies for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2022. The Company adopted this accounting standard on January 1, 2023, using the modified retrospective transition method as of the earliest period presented, January 1, 2021, also referred to as the transition date, for changes primarily related to the liability for future policy benefits and deferred acquisition costs. The Company is still in the process of finalizing the impact of the new standard on its historical financial statements, but expects to record an increase to its liability for future policy benefits with a corresponding change in accumulated other comprehensive income on the transition date of approximately $1 billion as a result of updating the rate used to discount the liabilities to reflect the yield for an upper-medium grade fixed-income instrument compared to the Company's expected investment yield under the existing guidance.

2. Acquisitions, Divestitures and Asset Sales

Proposed Oak Street Health Acquisition

On February 7, 2023, the Company entered into a definitive merger agreement to acquire all of the outstanding shares of Oak Street Health, Inc. ("Oak Street Health") for cash. Under the terms of the merger agreement, Oak Street Health stockholders will receive $39.00 per share in cash. The total value of the transaction is approximately $10.6 billion.

The proposed acquisition was approved by the Board of Directors at each of the respective companies and is subject to approval by a majority of Oak Street Health stockholders, receipt of regulatory approval and satisfaction of other customary closing conditions, including the expiration of the waiting period under the federal Hart-Scott-Rodino Antitrust Improvements Act of 1976. The transaction is expected to close in 2023.

If the merger agreement is terminated under certain specified circumstances and receipt of regulatory approval has not been obtained by such time, the Company will be required to pay Oak Street Health a termination fee of approximately $500 million. If the merger agreement is terminated under other certain specified circumstances, including due to Oak Street Health accepting a superior proposal, Oak Street Health will be required to pay the Company a termination fee of approximately $300 million.

Pending Signify Health Acquisition

On September 2, 2022, the Company entered into a definitive merger agreement to acquire all of the outstanding shares of Signify Health, Inc. ("Signify Health") for cash. Under the terms of the merger agreement, Signify Health stockholders will receive $30.50 per share in cash. The total value of the transaction is approximately $8 billion.

The pending acquisition was approved by the Board of Directors at each of the respective companies and the Signify Health stockholders and remains subject to receipt of regulatory approval and satisfaction of other customary closing conditions. On October 19, 2022, Signify Health and CVS Health each received a request for additional information (also known as a "second request") from the U.S. Department of Justice (the "DOJ") in connection with the review of the transactions contemplated by the merger agreement by the DOJ under the federal Hart-Scott-Rodino Antitrust Improvements Act of 1976. The transaction is expected to close in the second quarter of 2023.

If the merger agreement is terminated under certain specified circumstances and receipt of regulatory approval has not been obtained by such time, the Company will be required to pay Signify Health a termination fee in an amount equal to $380 million. If the merger agreement is terminated under other certain specified circumstances, including due to Signify Health accepting a superior proposal, Signify Health will be required to pay the Company a termination fee in an amount equal to $228 million.

Assets Held For Sale

The Company continually evaluates its portfolio for non-strategic assets. The Company determined that its Omnicare® long-term care business ("LTC business"), which is included within the Retail/LTC segment, was no longer a strategic asset and during the third quarter of 2022 committed to a plan to sell the LTC business. As of September 30, 2022, the LTC business met the criteria to be classified as held for sale and the carrying value of the LTC business was determined to be greater than its estimated fair value less costs to sell. Accordingly, the Company recorded a loss on assets held for sale of $2.5 billion during the third quarter of 2022. As of December 31, 2022, the net assets of the LTC business continued to meet the criteria for held-for-sale accounting and during the fourth quarter, an incremental loss on assets held for sale of $12 million was recorded to write down the carrying value of the LTC business to its estimated fair value less costs to sell. The loss on assets held for sale represents the write-down of its customer contracts/relationships intangible assets and was recorded in the Company's consolidated statement of operations within the Retail/LTC segment. The LTC business operating income was not material for the years ended December 31, 2022, 2021 and 2020.

The LTC business met the criteria to be classified as held for sale at December 31, 2022, but did not meet the criteria to be classified as discontinued operations. As a result, the related assets and liabilities were included in separate held-for-sale line items of the asset and liability sections of the consolidated balance sheet. As the assets held for sale are measured at fair value on a nonrecurring basis primarily using unobservable inputs as of the measurement date, they are classified in Level 3 of the fair value hierarchy. The following table summarizes the assets and liabilities held for sale at December 31, 2022:

In millions	**December 31, 2022**
Assets:	
Accounts receivable, net	$ 227
Inventories	188
Property and equipment, net	244
Deferred income taxes	131
Other	118
Total assets held for sale	$ 908
Liabilities:	
Accounts payable	$ 86
Accrued expenses	71
Other	71
Total liabilities held for sale	$ 228

Divestiture of bswift

In November 2022, the Company sold its wholly-owned subsidiary bswift LLC ("bswift") for approximately $735 million. bswift offers software and services that streamline benefits and human resource administration. The results of this business have historically been recorded within the Health Care Benefits segment. The Company recorded a pre-tax gain on the divestiture of $250 million in the year ended December 31, 2022, which is reflected as a reduction of operating expenses in the Company's consolidated statement of operations within the Health Care Benefits segment.

Divestiture of PayFlex

In June 2022, the Company sold PayFlex for approximately $775 million. PayFlex provides services to employers, their employees, and their former employees in the areas of tax-advantaged account reimbursement administration (flexible spending, health reimbursement, health savings, transit and parking), Consolidated Omnibus Budget Reconciliation Act ("COBRA") administration and special-member billing administration. The results of this business have historically been reported within the Health Care Benefits segment. The Company recorded a pre-tax gain on the divestiture of $225 million in the year ended December 31, 2022, which is reflected as a reduction of operating expenses in the Company's consolidated statement of operations within the Health Care Benefits segment.

Divestiture of Thailand Health Care Business

In March 2022, the Company reached an agreement to sell its international health care business domiciled in Thailand ("Thailand business"), comprised of approximately 266,000 medical members, which was included in the Commercial Business reporting unit within the Health Care Benefits segment. At that time, a portion of the Commercial Business goodwill was specifically allocated to the Thailand business. The net assets of the Thailand business were accounted for as assets held for sale at March 31, 2022. The carrying value of the Thailand business was determined to be greater than its estimated fair value less costs to sell and, accordingly, the Company recorded a $41 million loss on assets held for sale within the Health Care Benefits segment during the first quarter of 2022. The sale of the Thailand business closed in the second quarter of 2022, and the consideration received and ultimate loss on the sale were not material.

Divestiture of Workers' Compensation Business

On July 31, 2020, the Company sold its Workers' Compensation business for approximately $850 million. The results of this business were reported within the Health Care Benefits segment. The Company recorded a pre-tax gain on the divestiture of $269 million in the year ended December 31, 2020, which is reflected as a reduction in operating expenses in the Company's consolidated statement of operations within the Health Care Benefits segment.

International Health Care Benefits Renewal Rights Asset Sale

In May 2022, the Company sold the renewal rights of approximately 200,000 international medical members outside of the Americas, Thailand and India in connection with an Asset Purchase Agreement. As part of this agreement, the Company will introduce and help migrate these existing international medical members to the purchaser upon renewal. The Company expects the migration process to occur between July 2022 and November 2023. The Company ceased writing any new or renewal business for international medical members outside of the Americas during the fourth quarter of 2022. The consideration received related to this agreement was not material.

3. Investments

Total investments at December 31, 2022 and 2021 were as follows:

	2022			2021		
In millions	**Current**	**Long-term**	**Total**	**Current**	**Long-term**	**Total**
Debt securities available for sale	$ 2,718	$ 17,562	$ 20,280	$ 3,009	$ 20,231	$ 23,240
Mortgage loans	55	989	1,044	58	844	902
Other investments	5	2,562	2,567	50	1,950	2,000
Total investments [1]	$ 2,778	$ 21,113	$ 23,891	$ 3,117	$ 23,025	$ 26,142

(1) Includes long-term investments of $17 million which have been accounted for as assets held for sale and are included in assets held for sale on the consolidated balance sheet at December 31, 2022. See Note 2 ‘‘Acquisitions, Divestitures and Asset Sales’’ for additional information.

At December 31, 2022 and 2021, the Company held investments of $331 million and $450 million, respectively, related to the 2012 conversion of an existing group annuity contract from a participating to a non-participating contract. These investments are included in the total investments of large case pensions supporting non-experience-rated products. Although these investments are not accounted for as Separate Accounts assets, they are legally segregated and are not subject to claims that arise out of the Company’s business and only support future policy benefits obligations under that group annuity contract.

Debt Securities

Debt securities available for sale at December 31, 2022 and 2021 were as follows:

In millions	**Gross Amortized Cost**	**Allowance for Credit Losses**	**Net Amortized Cost**	**Gross Unrealized Gains**	**Gross Unrealized Losses**	**Fair Value**
December 31, 2022						
Debt securities:						
U.S. government securities	$ 2,074	$ —	$ 2,074	$ —	$ (182)	$ 1,892
States, municipalities and political subdivisions	2,393	—	2,393	8	(129)	2,272
U.S. corporate securities	9,838	(3)	9,835	26	(903)	8,958
Foreign securities	2,780	(1)	2,779	15	(244)	2,550
Residential mortgage-backed securities	845	—	845	1	(89)	757
Commercial mortgage-backed securities	1,172	—	1,172	1	(155)	1,018
Other asset-backed securities	2,940	—	2,940	6	(136)	2,810
Redeemable preferred securities	25	—	25	—	(2)	23
Total debt securities [1]	$ 22,067	$ (4)	$ 22,063	$ 57	$ (1,840)	$ 20,280
December 31, 2021						
Debt securities:						
U.S. government securities	$ 2,349	$ —	$ 2,349	$ 70	$ (3)	$ 2,416
States, municipalities and political subdivisions	2,947	—	2,947	148	(4)	3,091
U.S. corporate securities	9,093	—	9,093	682	(40)	9,735
Foreign securities	2,821	—	2,821	196	(24)	2,993
Residential mortgage-backed securities	870	—	870	15	(10)	875
Commercial mortgage-backed securities	1,278	—	1,278	44	(12)	1,310
Other asset-backed securities	2,791	—	2,791	14	(13)	2,792
Redeemable preferred securities	25	—	25	3	—	28
Total debt securities [1]	$ 22,174	$ —	$ 22,174	$ 1,172	$ (106)	$ 23,240

(1) Investment risks associated with the Company’s experience-rated products generally do not impact the Company’s consolidated operating results. At December 31, 2022, debt securities with a fair value of $609 million, gross unrealized capital gains of $3 million and gross unrealized capital losses of

$59 million, and at December 31, 2021, debt securities with a fair value of $864 million, gross unrealized capital gains of $94 million and gross unrealized capital losses of $2 million were included in total debt securities, but support experience-rated products. Changes in net unrealized capital gains (losses) on these securities are not reflected in accumulated other comprehensive income (loss).

The amortized cost and fair value of debt securities at December 31, 2022 are shown below by contractual maturity. Actual maturities may differ from contractual maturities because securities may be restructured, called or prepaid, or the Company intends to sell a security prior to maturity.

In millions	**Amortized Cost**	**Fair Value**
Due to mature:		
Less than one year	$ 1,315	$ 1,305
One year through five years	6,596	6,206
After five years through ten years	4,899	4,401
Greater than ten years	4,296	3,783
Residential mortgage-backed securities	845	757
Commercial mortgage-backed securities	1,172	1,018
Other asset-backed securities	2,940	2,810
Total	$ 22,063	$ 20,280

Mortgage-Backed and Other Asset-Backed Securities
All of the Company's residential mortgage-backed securities at December 31, 2022 were issued by the Government National Mortgage Association, the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation and carry agency guarantees and explicit or implicit guarantees by the U.S. Government. At December 31, 2022, the Company's residential mortgage-backed securities had an average credit quality rating of AAA and a weighted average duration of 5.7 years.

The Company's commercial mortgage-backed securities have underlying loans that are dispersed throughout the United States. Significant market observable inputs used to value these securities include loss severity and probability of default. At December 31, 2022, these securities had an average credit quality rating of AAA and a weighted average duration of 5.6 years.

The Company's other asset-backed securities have a variety of underlying collateral (e.g., automobile loans, credit card receivables, home equity loans and commercial loans). Significant market observable inputs used to value these securities include the unemployment rate, loss severity and probability of default. At December 31, 2022, these securities had an average credit quality rating of AA and a weighted average duration of 1.0 year.

Summarized below are the debt securities the Company held at December 31, 2022 and 2021 that were in an unrealized capital loss position, aggregated by the length of time the investments have been in that position:

	Less than 12 months			Greater than 12 months			Total		
In millions, except number of securities	Number of Securities	Fair Value	Unrealized Losses	Number of Securities	Fair Value	Unrealized Losses	Number of Securities	Fair Value	Unrealized Losses
December 31, 2022									
Debt securities:									
U.S. government securities	519	$ 1,620	$ 164	35	$ 191	$ 18	554	$ 1,811	$ 182
States, municipalities and political subdivisions	859	1,370	95	196	322	34	1,055	1,692	129
U.S. corporate securities	5,193	6,537	622	1,479	1,822	281	6,672	8,359	903
Foreign securities	1,168	1,715	147	403	592	97	1,571	2,307	244
Residential mortgage-backed securities	452	464	39	91	257	50	543	721	89
Commercial mortgage-backed securities	288	611	69	187	381	86	475	992	155
Other asset-backed securities	1,008	1,893	88	391	694	48	1,399	2,587	136
Redeemable preferred securities	13	18	2	2	5	—	15	23	2
Total debt securities	9,500	$14,228	$ 1,226	2,784	$4,264	$ 614	12,284	$18,492	$ 1,840
December 31, 2021									
Debt securities:									
U.S. government securities	43	$ 242	$ 2	10	$ 40	$ 1	53	$ 282	$ 3
States, municipalities and political subdivisions	233	428	3	13	33	1	246	461	4
U.S. corporate securities	1,610	2,296	31	165	238	9	1,775	2,534	40
Foreign securities	449	747	20	57	91	4	506	838	24
Residential mortgage-backed securities	165	593	9	10	36	1	175	629	10
Commercial mortgage-backed securities	188	462	7	35	112	5	223	574	12
Other asset-backed securities	1,011	2,030	12	26	31	1	1,037	2,061	13
Redeemable preferred securities	1	2	—	1	3	—	2	5	—
Total debt securities	3,700	$ 6,800	$ 84	317	$ 584	$ 22	4,017	$ 7,384	$ 106

The Company reviewed the securities in the table above and concluded that they are performing assets generating investment income to support the needs of the Company's business. In performing this review, the Company considered factors such as the quality of the investment security based on research performed by the Company's internal credit analysts and external rating agencies and the prospects of realizing the carrying value of the security based on the investment's current prospects for recovery. Unrealized capital losses at December 31, 2022 were generally caused by interest rate increases and not by unfavorable changes in the credit quality associated with these securities. As of December 31, 2022, the Company did not intend to sell these securities, and did not believe it was more likely than not that it would be required to sell these securities prior to the anticipated recovery of their amortized cost basis.

The maturity dates for debt securities in an unrealized capital loss position at December 31, 2022 were as follows:

	Supporting experience-rated products		Supporting remaining products		Total	
In millions	**Fair Value**	**Unrealized Losses**	**Fair Value**	**Unrealized Losses**	**Fair Value**	**Unrealized Losses**
Due to mature:						
Less than one year	$ 33	$ —	$ 1,161	$ 14	$ 1,194	$ 14
One year through five years	126	5	5,583	398	5,709	403
After five years through ten years	142	17	3,787	494	3,929	511
Greater than ten years	207	31	3,153	501	3,360	532
Residential mortgage-backed securities	11	1	710	88	721	89
Commercial mortgage-backed securities	32	3	960	152	992	155
Other asset-backed securities	17	2	2,570	134	2,587	136
Total	$ 568	$ 59	$ 17,924	$ 1,781	$ 18,492	$ 1,840

Mortgage Loans

The Company's mortgage loans are collateralized by commercial real estate. During the years ended December 31, 2022 and 2021, the Company had the following activity in its mortgage loan portfolio:

In millions	**2022**	**2021**
New mortgage loans	$ 356	$ 262
Mortgage loans fully repaid	178	373
Mortgage loans foreclosed	—	—

The Company assesses mortgage loans on a regular basis for credit impairments, and assigns a credit quality indicator to each loan. The Company's credit quality indicator is internally developed and categorizes each loan in its portfolio on a scale from 1 to 7. These indicators are based upon several factors, including current loan-to-value ratios, current and future property cash flow, property condition, market trends, creditworthiness of the borrower and deal structure.

- *Category 1* - Represents loans of superior quality.
- *Categories 2 to 4* - Represent loans where credit risk is minimal to acceptable; however, these loans may display some susceptibility to economic changes.
- *Categories 5 and 6* - Represent loans where credit risk is not substantial, but these loans warrant management's close attention.
- *Category 7* - Represents loans where collections are potentially at risk; if necessary, an impairment is recorded.

Based upon the Company's assessments at December 31, 2022 and 2021, the amortized cost basis of the Company's mortgage loans within each credit quality indicator by year of origination was as follows:

	Amortized Cost Basis by Year of Origination						
In millions, except credit quality indicator	**2022**	**2021**	**2020**	**2019**	**2018**	**Prior**	**Total**
December 31, 2022							
1	$ —	$ —	$ —	$ —	$ —	$ 15	$ 15
2 to 4	326	247	36	11	52	350	1,022
5 and 6	—	—	—	—	3	4	7
7	—	—	—	—	—	—	—
Total	$ 326	$ 247	$ 36	$ 11	$ 55	$ 369	$ 1,044
December 31, 2021							
1		$ —	$ —	$ —	$ —	$ 28	$ 28
2 to 4		255	48	40	72	446	861
5 and 6		—	—	—	3	10	13
7		—	—	—	—	—	—
Total		$ 255	$ 48	$ 40	$ 75	$ 484	$ 902

At December 31, 2022 scheduled mortgage loan principal repayments were as follows:

In millions	
2023	$ 55
2024	152
2025	90
2026	168
2027	203
Thereafter	376
Total	$ 1,044

Net Investment Income

Sources of net investment income for the years ended December 31, 2022, 2021 and 2020 were as follows:

In millions	**2022**	**2021**	**2020**
Debt securities	$ 702	$ 634	$ 598
Mortgage loans	51	55	60
Other investments	448	381	123
Gross investment income	1,201	1,070	781
Investment expenses	(43)	(47)	(35)
Net investment income (excluding net realized capital gains or losses)	1,158	1,023	746
Net realized capital gains (losses) [(1)]	(320)	176	52
Net investment income [(2)]	$ 838	$ 1,199	$ 798

(1) Net realized capital losses include credit-related losses on debt securities of $13 million and yield-related impairment losses on debt securities of $143 million in the year ended December 31, 2022. Net realized capital gains are net of yield-related impairment losses on debt securities of $42 million and $49 million for the years ended December 31, 2021 and 2020, respectively. There were no credit-related losses on debt securities in the years ended December 31, 2021 and 2020.

(2) Net investment income includes $35 million, $38 million and $42 million for the years ended December 31, 2022, 2021 and 2020, respectively, related to investments supporting experience-rated products.

Capital gains and losses recognized during the year ended December 31, 2022 related to investments in equity securities held as of December 31, 2022 were not material.

Excluding amounts related to experience-rated products, proceeds from the sale of available-for-sale debt securities and the related gross realized capital gains and losses in the years ended December 31, 2022, 2021 and 2020 were as follows:

In millions	**2022**	**2021**	**2020**
Proceeds from sales	$ 4,243	$ 3,572	$ 3,913
Gross realized capital gains	24	72	80
Gross realized capital losses	177	14	62

4. Fair Value

The preparation of the Company's consolidated financial statements requires certain assets and liabilities to be reflected at their fair value and others to be reflected on another basis, such as an adjusted historical cost basis. In this note, the Company provides details on the fair value of financial assets and liabilities and how it determines those fair values. The Company presents this information for those financial instruments that are measured at fair value for which the change in fair value impacts net income attributable to CVS Health or other comprehensive income (loss) separately from other financial assets and liabilities.

Financial Instruments Measured at Fair Value on the Consolidated Balance Sheets

Certain of the Company's financial instruments are measured at fair value on the consolidated balance sheets. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by GAAP. The following are the levels of the hierarchy and a brief description of the type of valuation information ("valuation inputs") that qualifies a financial asset or liability for each level:

- Level 1 – Unadjusted quoted prices for identical assets or liabilities in active markets.
- Level 2 – Valuation inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, valuation inputs that are observable that are not prices (such as interest rates and credit risks) and valuation inputs that are derived from or corroborated by observable markets.
- Level 3 – Developed from unobservable data, reflecting the Company's assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, the Company uses these quoted market prices to determine the fair value of financial assets and liabilities and classifies these assets and liabilities in Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, the Company estimates fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities are classified in Level 2. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

The following is a description of the valuation methodologies used for the Company's financial assets and liabilities that are measured at fair value, including the general classification of such assets and liabilities pursuant to the valuation hierarchy.

Cash and Cash Equivalents – The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. When quoted prices are available in an active market, cash equivalents are classified in Level 1 of the fair value hierarchy. Fair values of cash equivalent instruments that do not trade on a regular basis in active markets are classified as Level 2.

Debt Securities – Where quoted prices are available in an active market, debt securities are classified in Level 1 of the fair value hierarchy. The Company's Level 1 debt securities consist primarily of U.S. Treasury securities.

The fair values of the Company's Level 2 debt securities are obtained using models, such as matrix pricing, which use quoted market prices of debt securities with similar characteristics or discounted cash flows to estimate fair value. The

Company reviews these prices to ensure they are based on observable market inputs that include quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets and inputs that are observable that are not prices (such as interest rates and credit risks). The Company also reviews the methodologies and the assumptions used to calculate prices from these observable inputs. On a quarterly basis, the Company selects a sample of its Level 2 debt securities' prices and compares them to prices provided by a secondary source. Variances over a specified threshold are identified and reviewed to confirm the price provided by the primary source represents an appropriate estimate of fair value. In addition, the Company's internal investment team consistently compares the prices obtained for select Level 2 debt securities to the team's own independent estimates of fair value for those securities. The Company obtained one price for each of its Level 2 debt securities and did not adjust any of those prices at December 31, 2022 or 2021.

The Company also values certain debt securities using Level 3 inputs. For Level 3 debt securities, fair values are determined by outside brokers or, in the case of certain private placement securities, are priced internally. Outside brokers determine the value of these debt securities through a combination of their knowledge of the current pricing environment and market flows. The Company did not have any broker quoted debt securities for the years ended December 31, 2022 and 2021. For some private placement securities, the Company's internal staff determines the value of these debt securities by analyzing spreads of corporate and sector indices as well as interest spreads of comparable public bonds. Examples of these private placement Level 3 debt securities include certain U.S. and foreign securities and certain tax-exempt municipal securities.

Equity Securities – The Company currently has two classifications of equity securities: those that are publicly traded and those that are privately placed. Publicly-traded equity securities are classified in Level 1 because quoted prices are available for these securities in an active market. For privately placed equity securities, there is no active market; therefore, these securities are classified in Level 3 because the Company prices these securities through an internal analysis of each investment's financial statements and cash flow projections. Significant unobservable inputs consist of earnings and revenue multiples, discount for lack of marketability and comparability adjustments. An increase or decrease in any of these unobservable inputs would have resulted in a change in the fair value measurement.

There were no financial liabilities measured at fair value on a recurring basis on the consolidated balance sheets at December 31, 2022 or 2021. Financial assets measured at fair value on a recurring basis on the consolidated balance sheets at December 31, 2022 and 2021 were as follows:

In millions	**Level 1**	**Level 2**	**Level 3**	**Total**
December 31, 2022				
Cash and cash equivalents [1]	$ 6,902	$ 6,049	$ —	$ 12,951
Debt securities:				
U.S. government securities	1,860	32	—	1,892
States, municipalities and political subdivisions	—	2,272	—	2,272
U.S. corporate securities	—	8,897	61	8,958
Foreign securities	—	2,542	8	2,550
Residential mortgage-backed securities	—	757	—	757
Commercial mortgage-backed securities	—	1,018	—	1,018
Other asset-backed securities	—	2,810	—	2,810
Redeemable preferred securities	—	23	—	23
Total debt securities	1,860	18,351	69	20,280
Equity securities	116	—	60	176
Total	$ 8,878	$ 24,400	$ 129	$ 33,407
December 31, 2021				
Cash and cash equivalents	$ 4,954	$ 4,454	$ —	$ 9,408
Debt securities:				
U.S. government securities	2,372	44	—	2,416
States, municipalities and political subdivisions	—	3,086	5	3,091
U.S. corporate securities	—	9,697	38	9,735
Foreign securities	—	2,983	10	2,993
Residential mortgage-backed securities	—	875	—	875
Commercial mortgage-backed securities	—	1,310	—	1,310
Other asset-backed securities	—	2,789	3	2,792
Redeemable preferred securities	—	28	—	28
Total debt securities	2,372	20,812	56	23,240
Equity securities	114	—	55	169
Total	$ 7,440	$ 25,266	$ 111	$ 32,817

(1) Includes cash and cash equivalents of $6 million which have been accounted for as assets held for sale and are included in assets held for sale on the consolidated balance sheet at December 31, 2022. See Note 2 ‘‘Acquisitions, Divestitures and Asset Sales’’ for additional information.

The changes in the balances of Level 3 financial assets during the year ended December 31, 2022 were as follows:

In millions	States, municipalities and political subdivisions	U.S. corporate securities	Foreign securities	Other asset-backed securities	Equity securities	Total
Beginning balance	$ 5	$ 38	$ 10	$ 3	$ 55	$ 111
Net realized and unrealized capital losses:						
Included in earnings	—	(8)	—	—	(1)	(9)
Included in other comprehensive loss	—	(5)	(2)	(2)	—	(9)
Purchases	—	36	—	30	29	95
Sales	(5)	—	—	(2)	(23)	(30)
Settlements	—	—	—	—	—	—
Transfers out of Level 3, net	—	—	—	(29)	—	(29)
Ending balance	$ —	$ 61	$ 8	$ —	$ 60	$ 129

The change in net unrealized capital losses included in other comprehensive loss associated with Level 3 financial assets which were held as of December 31, 2022 was $9 million during the year ended December 31, 2022.

The changes in the balances of Level 3 financial assets during the year ended December 31, 2021 were as follows:

In millions	States, municipalities and political subdivisions	U.S. corporate securities	Foreign securities	Other asset-backed securities	Redeemable preferred securities	Equity securities	Total
Beginning balance	$ 1	$ 52	$ —	$ —	$ 1	$ 30	$ 84
Net realized and unrealized capital gains (losses):							
Included in earnings	—	(10)	—	—	2	13	5
Included in other comprehensive income	—	(3)	—	—	(1)	—	(4)
Purchases	—	1	—	3	—	13	17
Sales	(1)	(1)	—	—	(2)	(1)	(5)
Settlements	—	(1)	—	—	—	—	(1)
Transfers into Level 3, net	5	—	10	—	—	—	15
Ending balance	$ 5	$ 38	$ 10	$ 3	$ —	$ 55	$ 111

The change in net unrealized capital losses included in other comprehensive income associated with Level 3 financial assets which were held as of December 31, 2021 was $4 million during the year ended December 31, 2021.

The total gross transfers into (out of) Level 3 during the years ended December 31, 2022 and 2021 were as follows:

In millions	2022	2021
Gross transfers into Level 3	$ —	$ 15
Gross transfers out of Level 3	(29)	—
Net transfers into (out of) Level 3	$ (29)	$ 15

Financial Instruments Not Measured at Fair Value on the Consolidated Balance Sheets

The carrying value and estimated fair value classified by level of fair value hierarchy for financial instruments carried on the consolidated balance sheets at adjusted cost or contract value at December 31, 2022 and 2021 were as follows:

In millions	Carrying Value	Estimated Fair Value			
		Level 1	Level 2	Level 3	Total
December 31, 2022					
Assets:					
Mortgage loans	$ 1,044	$ —	$ —	$ 978	$ 978
Equity securities [1]	411	N/A	N/A	N/A	N/A
Liabilities:					
Investment contract liabilities:					
With a fixed maturity	3	—	—	3	3
Without a fixed maturity	332	—	—	305	305
Long-term debt [2]	52,257	47,653	—	—	47,653
December 31, 2021					
Assets:					
Mortgage loans	$ 902	$ —	$ —	$ 907	$ 907
Equity securities [1]	126	N/A	N/A	N/A	N/A
Liabilities:					
Investment contract liabilities:					
With a fixed maturity	5	—	—	5	5
Without a fixed maturity	336	—	—	373	373
Long-term debt	56,176	64,157	—	—	64,157

(1) It was not practical to estimate the fair value of these cost-method investments as it represents shares of unlisted companies. See Note 1 ‘‘Significant Accounting Policies’’ for additional information regarding the valuation of cost method investments.

(2) Includes long-term debt of $3 million which has been accounted for as liabilities held for sale and is included in liabilities held for sale on the consolidated balance sheet at December 31, 2022. See Note 2 ‘‘Acquisitions, Divestitures and Asset Sales’’ for additional information.

Separate Accounts Measured at Fair Value on the Consolidated Balance Sheets

Separate Accounts assets relate to the Company’s large case pensions products which represent funds maintained to meet specific objectives of contract holders. Since contract holders bear the investment risk of these assets, a corresponding Separate Accounts liability has been established equal to the assets. These assets and liabilities are carried at fair value. Net investment income and capital gains and losses on Separate Accounts assets accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from the Company’s other businesses. Deposits, withdrawals, net investment income and realized and unrealized capital gains and losses on Separate Accounts assets are not reflected in the consolidated statements of operations, shareholders’ equity or cash flows.

Separate Accounts assets include debt and equity securities. The valuation methodologies used for these assets are similar to the methodologies described above in this Note 4 ‘‘Fair Value.’’ Separate Accounts assets also include investments in common/collective trusts that are carried at fair value. Common/collective trusts invest in other investment funds otherwise known as the underlying funds. The Separate Accounts’ interests in the common/collective trust funds are based on the fair values of the investments of the underlying funds and therefore are classified in Level 2. The assets in the underlying funds primarily consist of equity securities. Investments in common/collective trust funds are valued at their respective net asset value (“NAV”) per share/unit on the valuation date.

Separate Accounts financial assets at December 31, 2022 and 2021 were as follows:

	December 31, 2022				December 31, 2021			
In millions	**Level 1**	**Level 2**	**Level 3**	**Total**	**Level 1**	**Level 2**	**Level 3**	**Total**
Cash and cash equivalents	$ 2	$ 154	$ —	$ 156	$ 2	$ 186	$ —	$ 188
Debt securities	712	1,965	—	2,677	1,233	3,048	—	4,281
Equity securities	—	—	—	—	—	1	—	1
Common/collective trusts	—	480	—	480	—	547	—	547
Total [1]	$ 714	$ 2,599	$ —	$ 3,313	$ 1,235	$ 3,782	$ —	$ 5,017

(1) Excludes $85 million of other payables and $70 million of other receivables at December 31, 2022 and 2021, respectively.

During the years ended December 31, 2022 and 2021, the Company had no gross transfers of Separate Accounts financial assets into or out of Level 3.

5. Goodwill and Other Intangibles

Goodwill

Below is a summary of the changes in the carrying amount of goodwill by segment for the years ended December 31, 2022 and 2021:

In millions	**Health Care Benefits**	**Pharmacy Services**	**Retail/ LTC**	**Total**
Balance at December 31, 2020	$ 45,130	$ 23,615	$ 10,807	$ 79,552
Impairment	—	—	(431)	(431)
Balance at December 31, 2021	45,130	23,615	10,376	79,121
Divestitures	(971)	—	—	(971)
Balance at December 31, 2022	$ 44,159	$ 23,615	$ 10,376	$ 78,150

During the year ended December 31, 2022, the decrease in the carrying amount of goodwill was primarily driven by the divestitures of bswift, PayFlex and the Thailand business. See Note 2 ‘‘Acquisitions, Divestitures and Asset Sales’’ for additional information. During the year ended December 31, 2021, the decrease in the carrying amount of goodwill was primarily driven by the impairment of the remaining goodwill of the LTC reporting unit within the Retail/LTC segment.

During the third quarter of 2022, the Company performed its required annual impairment tests of goodwill. The results of the impairment tests indicated that there was no impairment of goodwill.

During the third quarter of 2021, the Company performed its required annual impairment tests of goodwill. The results of the impairment tests indicated an impairment of the goodwill associated with the LTC reporting unit, as the reporting unit’s carrying value exceeded its fair value as of the testing date. The results of the impairment tests of the remaining reporting units indicated that there was no impairment of goodwill as of the testing date.

During 2021, the LTC reporting unit continued to face challenges that have impacted the Company’s ability to grow the LTC reporting unit’s business at the rate estimated when its 2020 goodwill impairment test was performed. These challenges include lower net facility admissions, net long-term care facility customer losses and the prolonged adverse impact of the COVID-19 pandemic and the emerging new variants, which resulted in more significant declines in occupancy rates experienced by the Company’s long-term care facility customers than previously anticipated. During the third quarter of 2021, LTC management updated their 2021 annual forecast and submitted their long-term plan which showed deterioration in the financial results for the remainder of 2021 and beyond. The Company utilized these updated projections in performing its annual impairment test, which indicated that the fair value of the LTC reporting unit was lower than its carrying value, resulting in a $431 million goodwill impairment charge in the third quarter of 2021. The fair value of the LTC reporting unit was determined using a combination of a discounted cash flow method and a market multiple method. As of December 31, 2021, there was no remaining goodwill balance in the LTC reporting unit.

At both December 31, 2022 and 2021, cumulative goodwill impairments were $6.6 billion.

Intangible Assets

The following table is a summary of the Company's intangible assets as of December 31, 2022 and 2021:

In millions, except weighted average life	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Weighted Average Life (years)
2022				
Trademarks (indefinite-lived)	$ 10,498	$ —	$ 10,498	N/A
Customer contracts/relationships and covenants not to compete	21,206	(10,668)	10,538	13.3
Technology	1,060	(1,060)	—	—
Provider networks	4,203	(862)	3,341	20.0
Value of Business Acquired	590	(223)	367	20.0
Other	302	(264)	38	12.4
Total [1]	$ 37,859	$ (13,077)	$ 24,782	13.9
2021				
Trademarks (indefinite-lived)	$ 10,498	$ —	$ 10,498	N/A
Customer contracts/relationships and covenants not to compete	25,084	(10,564)	14,520	15.0
Technology	1,060	(1,060)	—	—
Provider networks	4,203	(651)	3,552	20.0
Value of Business Acquired	590	(173)	417	20.0
Other	318	(279)	39	8.4
Total	$ 41,753	$ (12,727)	$ 29,026	15.3

(1) Includes intangible assets of $28 million which have been accounted for as assets held for sale and are included in assets held for sale on the consolidated balance sheet at December 31, 2022. See Note 2 ''Acquisitions, Divestitures and Asset Sales'' for additional information.

During the year ended December 31, 2022, the reduction in the customer contracts/relationships intangible assets is primarily related to the Company's loss on assets held for sale of $2.5 billion to write-down the LTC business to its estimated fair value less costs to sell. See Note 2 ''Acquisitions, Divestitures and Asset Sales'' for additional information.

Amortization expense for intangible assets totaled $1.8 billion, $2.3 billion and $2.3 billion for the years ended December 31, 2022, 2021 and 2020, respectively. The projected annual amortization expense for the Company's intangible assets for the next five years is as follows:

In millions	
2023	$ 1,620
2024	1,577
2025	1,526
2026	1,290
2027	1,200

6. Leases

The Company leases most of its retail stores and mail order facilities and certain distribution centers and corporate offices under operating or finance leases, typically with initial terms of 15 to 25 years. The Company also leases certain equipment and other assets under operating or finance leases, typically with initial terms of 3 to 10 years.

In addition, the Company leases pharmacy space at the stores of another retail chain for which the noncancelable contractual term of the pharmacy lease arrangement exceeds the remaining estimated economic life of the buildings. For these pharmacy lease arrangements, the Company concluded that for accounting purposes the lease term was the remaining estimated economic life of the buildings. Consequently, most of these individual pharmacy leases are finance leases.

The following table is a summary of the components of net lease cost for the years ended December 31, 2022, 2021 and 2020:

In millions	**2022**	**2021**	**2020**
Operating lease cost	$ 2,579	$ 2,633	$ 2,670
Finance lease cost:			
Amortization of right-of-use assets	79	62	56
Interest on lease liabilities	68	62	58
Total finance lease costs	147	124	114
Short-term lease costs	27	25	22
Variable lease costs	610	604	599
Less: sublease income	(61)	(59)	(55)
Net lease cost	$ 3,302	$ 3,327	$ 3,350

Supplemental cash flow information related to leases for the years ended December 31, 2022, 2021 and 2020 were as follows:

In millions	**2022**	**2021**	**2020**
Cash paid for amounts included in the measurement of lease liabilities:			
Operating cash flows paid for operating leases	$ 2,689	$ 2,714	$ 2,724
Operating cash flows paid for interest portion of finance leases	68	62	58
Financing cash flows paid for principal portion of finance leases	62	50	34
Right-of-use assets obtained in exchange for lease obligations:			
Operating leases	591	1,254	1,679
Finance leases	232	278	313

Supplemental balance sheet information related to leases as of December 31, 2022 and 2021 is as follows:

In millions, except remaining lease term and discount rate	2022	2021
Operating leases:		
Operating lease right-of-use assets [1]	$ 17,928	$ 19,122
Current portion of operating lease liabilities	$ 1,699	$ 1,646
Long-term operating lease liabilities	16,839	18,177
Total operating lease liabilities [2]	$ 18,538	$ 19,823
Finance leases:		
Property and equipment, gross	$ 1,608	$ 1,375
Accumulated depreciation	(284)	(188)
Property and equipment, net	$ 1,324	$ 1,187
Current portion of long-term debt	$ 59	$ 50
Long-term debt	1,406	1,250
Total finance lease liabilities	$ 1,465	$ 1,300
Weighted average remaining lease term *(in years)*		
Operating leases	12.2	12.8
Finance leases	19.4	20.0
Weighted average discount rate		
Operating leases	4.4 %	4.4 %
Finance leases	4.9 %	5.0 %

(1) Includes operating lease right-of-use assets of $56 million which have been accounted for as assets held for sale and are included in assets held for sale on the consolidated balance sheet at December 31, 2022. See Note 2 ‘‘Acquisitions, Divestitures and Asset Sales’’ for additional information.

(2) Includes current portion of operating lease liabilities of $21 million and long-term operating lease liabilities of $39 million which have been accounted for as liabilities held for sale and are included in liabilities held for sale on the consolidated balance sheet at December 31, 2022. See Note 2 ‘‘Acquisitions, Divestitures and Asset Sales’’ for additional information.

The following table summarizes the maturity of lease liabilities under finance and operating leases as of December 31, 2022:

In millions	Finance Leases	Operating Leases [1]	Total
2023	$ 139	$ 2,685	$ 2,824
2024	130	2,499	2,629
2025	128	2,313	2,441
2026	127	2,142	2,269
2027	124	1,989	2,113
Thereafter	1,640	12,411	14,051
Total lease payments [2]	2,288	24,039	26,327
Less: imputed interest	(823)	(5,501)	(6,324)
Total lease liabilities	$ 1,465	$ 18,538	$ 20,003

(1) Future operating lease payments have not been reduced by minimum sublease rentals of $290 million due in the future under noncancelable subleases.

(2) The Company leases pharmacy and clinic space from Target Corporation. Amounts related to such finance and operating leases are reflected above. Pharmacy lease amounts due in excess of the remaining estimated economic life of the buildings of approximately $2.5 billion are not reflected in this table since the estimated economic life of the buildings is shorter than the contractual term of the pharmacy lease arrangement.

Sale-Leaseback Transactions
The Company finances a portion of its store development program through sale-leaseback transactions. The properties are generally sold at net book value, which generally approximates fair value, and the resulting leases generally qualify and are accounted for as operating leases. The operating leases that resulted from these transactions are included in the tables above. The Company does not have any retained or contingent interests in the stores and does not provide any guarantees, other than a guarantee of lease payments, in connection with the sale-leaseback transactions. There were no sale-leaseback transactions in 2022 or 2021. Proceeds from sale-leaseback transactions totaled $101 million in the year ended December 31, 2020. Gains from sale-leaseback transactions totaled $3 million in the year ended December 31, 2020.

Office Real Estate Optimization Charges
During the fourth quarter of 2022, the Company undertook an initiative to evaluate its corporate office real estate space in response to its new flexible work arrangement. As part of this initiative, the Company evaluated its current real estate space and changes in employee work arrangement requirements to ensure it had the appropriate space to support the business. As a result of this assessment, the Company determined that it would vacate and abandon certain leased corporate office spaces. Accordingly, in the three months ended December 31, 2022, the Company recorded office real estate optimization charges of $117 million, primarily consisting of $71 million related to operating lease right-of-use assets and $44 million related to property and equipment, within the Health Care Benefits, Corporate/Other and Pharmacy Services segments.

Store Impairment Charges
The Company evaluates its retail store right-of-use and property and equipment assets for impairment at the retail store level, which is the lowest level at which cash flows can be identified. For retail stores where there is an indicator of impairment present, the Company first compares the carrying amount of the asset group to the estimated future cash flows associated with the asset group (undiscounted). If the estimated undiscounted future cash flows used in the analysis are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to its estimated fair value which is the greater of the asset group's estimated future cash flows (discounted), or the consideration of what a market participant would pay to lease the assets, net of leasing costs. The Company's estimate of fair value considers historical results, current operating trends, consolidated sales, profitability and cash flow results and forecasts. For assets which the Company has determined it will be able to sublease, the estimated future cash flows include the estimated sublease income, net of estimated leasing costs.

When the carrying value of an asset group exceeds its estimated fair value, an impairment loss is recorded to reduce the value of the asset group to its estimated fair value. As the impaired assets are measured at fair value on a nonrecurring basis primarily using unobservable inputs as of the measurement date, the assets are classified in Level 3 of the fair value hierarchy.

During the fourth quarter of 2021, the Company completed a strategic review of its retail business and announced the creation of new formats for its stores to continue to drive higher engagement with customers. As part of this review, the Company evaluated changes in population, consumer buying patterns and future health needs to ensure it has the right kinds of stores in the right locations for consumers and for the business. In connection with this initiative, on November 17, 2021, the Board of Directors of CVS Health Corporation (the "Board") authorized the closing of approximately 900 retail stores, approximately 300 stores each year, between 2022 and 2024. As a result, management determined that there were indicators of impairment with respect to the impacted stores' asset groups, including the associated operating lease right-of-use assets and property and equipment. A long-lived asset impairment test was performed during the fourth quarter of 2021 and the results of the impairment test indicated that the fair value of certain retail store asset groups was lower than their respective carrying values. Accordingly, in the three months ended December 31, 2021, the Company recorded a store impairment charge of approximately $1.4 billion, consisting of a write down of approximately $1.1 billion related to operating lease right-of-use assets and $261 million related to property and equipment, within the Retail/LTC segment. Subsequent to the impairment loss, the fair value of the associated operating lease right-of use assets and property and equipment were $356 million and $185 million, respectively.

7. Health Care Costs Payable

The following is information about incurred and cumulative paid health care claims development as of December 31, 2022, net of reinsurance, and the total IBNR liabilities plus expected development on reported claims included within the net incurred claims amounts. See Note 1 ‘‘Significant Accounting Policies’’ for information on how the Company estimates IBNR reserves and health care costs payable as well as changes to those methodologies, if any. The Company’s estimate of IBNR liabilities is primarily based on trend and completion factors. Claim frequency is not used in the calculation of the Company’s liability. In addition, it is impracticable to disclose claim frequency information for health care claims due to the Company’s inability to gather consistent claim frequency information across its multiple claims processing systems. Any claim frequency count disclosure would not be comparable across the Company’s different claim processing systems and would not be consistent from period to period based on the volume of claims processed through each system. As a result, health care claim count frequency is not included in the disclosures below.

The information about incurred and paid health care claims development for the year ended December 31, 2021 is presented as required unaudited supplemental information.

In millions	**Incurred Health Care Claims, Net of Reinsurance For the Years Ended December 31,**	
Date of Service	**2021**	**2022**
	(Unaudited)	
2021	$ 62,830	$ 62,259
2022		69,185
	Total	$ 131,444

In millions	**Cumulative Paid Health Care Claims, Net of Reinsurance For the Years Ended December 31,**	
Date of Service	**2021**	**2022**
	(Unaudited)	
2021	$ 54,600	$ 62,144
2022		59,570
	Total	$ 121,714
All outstanding liabilities for health care costs payable prior to 2021, net of reinsurance		196
Total outstanding liabilities for health care costs payable, net of reinsurance		$ 9,926

At December 31, 2022, the Company’s liabilities for IBNR plus expected development on reported claims totaled approximately $7.8 billion. Substantially all of the Company’s liabilities for IBNR plus expected development on reported claims at December 31, 2022 related to the current calendar year.

The reconciliation of the December 31, 2022 health care net incurred and paid claims development tables to the health care costs payable liability on the consolidated balance sheet were as follows:

In millions	**December 31, 2022**
Short-duration health care costs payable, net of reinsurance	$ 9,926
Reinsurance recoverables	5
Insurance lines other than short duration	475
Total health care costs payable	$ 10,406

The following table shows the components of the change in health care costs payable during the years ended December 31, 2022, 2021 and 2020:

In millions	**2022**	**2021**	**2020**
Health care costs payable, beginning of period	$ 8,808	$ 7,936	$ 6,879
Less: Reinsurance recoverables	8	10	5
Health care costs payable, beginning of period, net	8,800	7,926	6,874
Acquisitions, net	—	—	414
Add: Components of incurred health care costs			
Current year	71,541	64,761	55,835
Prior years	(654)	(788)	(429)
Total incurred health care costs [(1)]	70,887	63,973	55,406
Less: Claims paid			
Current year	61,640	56,323	48,770
Prior years	7,646	6,792	6,009
Total claims paid	69,286	63,115	54,779
Add: Premium deficiency reserve	—	16	11
Health care costs payable, end of period, net	10,401	8,800	7,926
Add: Reinsurance recoverables	5	8	10
Health care costs payable, end of period	$ 10,406	$ 8,808	$ 7,936

(1) Total incurred health care costs for the years ended December 31, 2022, 2021 and 2020 in the table above exclude $75 million, $59 million and $41 million, respectively, of benefit costs recorded in the Health Care Benefits segment that are included in other insurance liabilities on the consolidated balance sheets and $319 million, $212 million and $221 million, respectively, of benefit costs recorded in the Corporate/Other segment that are included in other insurance liabilities on the consolidated balance sheets. The incurred health care costs for the years ended December 31, 2021 and 2020 also exclude $16 million and $11 million, respectively, for premium deficiency reserves related to the Company's Medicaid products.

The Company's estimates of prior years' health care costs payable decreased by $654 million, $788 million and $429 million in 2022, 2021 and 2020, respectively, because claims were settled for amounts less than originally estimated (i.e., the amount of claims incurred was lower than originally estimated), primarily due to lower health care cost trends as well as the actual claim submission time being faster than originally assumed (i.e., the Company's completion factors were higher than originally assumed) in estimating health care costs payable at the end of the prior year. This development does not directly correspond to an increase in the Company's operating results as these reductions were offset by estimated current period health care costs when the Company established the estimate of the current year health care costs payable.

8. Borrowings and Credit Agreements

The following table is a summary of the Company's borrowings as of December 31, 2022 and 2021:

In millions	2022	2021
Long-term debt		
3.5% senior notes due July 2022	$ —	$ 1,500
2.75% senior notes due November 2022	—	1,000
2.75% senior notes due December 2022	—	1,250
4.75% senior notes due December 2022	—	399
2.8% senior notes due June 2023	1,300	1,300
4% senior notes due December 2023	414	414
3.375% senior notes due August 2024	650	650
2.625% senior notes due August 2024	1,000	1,000
3.5% senior notes due November 2024	750	750
5% senior notes due December 2024 (1)	299	299
4.1% senior notes due March 2025	950	950
3.875% senior notes due July 2025	2,828	2,828
2.875% senior notes due June 2026	1,750	1,750
3% senior notes due August 2026	750	750
3.625% senior notes due April 2027	750	750
6.25% senior notes due June 2027	372	372
1.3% senior notes due August 2027	2,250	2,250
4.3% senior notes due March 2028	5,000	5,000
3.25% senior notes due August 2029	1,750	1,750
3.75% senior notes due April 2030	1,500	1,500
1.75% senior notes due August 2030	1,250	1,250
1.875% senior notes due February 2031	1,250	1,250
2.125% senior notes due September 2031	1,000	1,000
4.875% senior notes due July 2035	652	652
6.625% senior notes due June 2036	771	771
6.75% senior notes due December 2037	533	533
4.78% senior notes due March 2038	5,000	5,000
6.125% senior notes due September 2039	447	447
4.125% senior notes due April 2040	1,000	1,000
2.7% senior notes due August 2040	1,250	1,250
5.75% senior notes due May 2041	133	133
4.5% senior notes due May 2042	500	500
4.125% senior notes due November 2042	500	500
5.3% senior notes due December 2043	750	750
4.75% senior notes due March 2044	375	375
5.125% senior notes due July 2045	3,500	3,500
3.875% senior notes due August 2047	1,000	1,000
5.05% senior notes due March 2048	8,000	8,000
4.25% senior notes due April 2050	750	750
Finance lease liabilities	1,465	1,300
Other	314	320
Total debt principal	52,753	56,743
Debt premiums	200	219
Debt discounts and deferred financing costs	(696)	(786)
	52,257	56,176
Less:		
Current portion of long-term debt	(1,778)	(4,205)
Long-term debt (1)	$ 50,479	$ 51,971

(1) Includes long-term debt of $3 million which has been accounted for as liabilities held for sale and is included in liabilities held for sale on the consolidated balance sheet at December 31, 2022. See Note 2 ''Acquisitions, Divestitures and Asset Sales'' for additional information.

The following is a summary of the Company's required repayments of debt principal due during each of the next five years and thereafter, as of December 31, 2022:

In millions	
2023	$ 1,719
2024	2,706
2025	3,785
2026	2,507
2027	3,379
Thereafter	37,192
Subtotal	51,288
Finance lease liabilities [(1)]	1,465
Total debt principal	$ 52,753

(1) See Note 6 ''Leases'' for a summary of maturities of the Company's finance lease liabilities.

Short-term Borrowings

Commercial Paper and Back-up Credit Facilities
The Company did not have any commercial paper outstanding as of December 31, 2022 or 2021. In connection with its commercial paper program, the Company maintains a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 16, 2025, a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 11, 2026, and a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 16, 2027. The credit facilities allow for borrowings at various rates that are dependent, in part, on the Company's public debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately 0.03%, regardless of usage. As of December 31, 2022 and 2021, there were no borrowings outstanding under any of the Company's back-up credit facilities.

Federal Home Loan Bank of Boston ("FHLBB")
A subsidiary of the Company is a member of the FHLBB. As a member, the subsidiary has the ability to obtain cash advances, subject to certain minimum collateral requirements. The maximum borrowing capacity available from the FHLBB as of December 31, 2022 was approximately $915 million. At both December 31, 2022 and 2021, there were no outstanding advances from the FHLBB.

Long-term Borrowings

Exercise of Par Call Redemptions
In May 2022, the Company exercised the par call redemption on its outstanding 3.5% senior notes due July 2022 to redeem for cash on hand the entire $1.5 billion aggregate principal amount.

In August 2022, the Company exercised the par call redemption on its outstanding 2.75% senior notes due November 2022 (issued by Aetna Inc. ("Aetna")) to redeem for cash on hand the entire $1.0 billion aggregate principal amount.

In September 2022, the Company exercised the par call redemptions on its outstanding 2.75% senior notes due December 2022 and 4.75% senior notes due December 2022 (including notes issued by Omnicare, Inc.) to redeem for cash on hand the entire aggregate principal amount of $1.25 billion and $399 million, respectively.

2021 Notes
On August 18, 2021, the Company issued $1.0 billion aggregate principal amount of 2.125% unsecured senior notes due September 15, 2031 for total proceeds of $987 million, net of discounts, underwriting fees and offering expenses. The net proceeds of this offering were used for the purchase of senior notes in connection with the Company's cash tender offer in August 2021 as described below.

Cash Flow Hedges
During March 2020, the Company entered into several interest rate swap transactions to manage interest rate risk. These agreements were designated as cash flow hedges and were used to hedge the exposure to variability in future cash flows

resulting from changes in interest rates related to the anticipated issuance of $750 million aggregate principal amount of 3.625% unsecured senior notes due April 1, 2027, $1.5 billion aggregate principal amount of 3.75% unsecured senior notes due April 1, 2030, $1.0 billion aggregate principal amount of 4.125% unsecured senior notes due April 1, 2040 and $750 million aggregate principal amount of 4.25% unsecured senior notes due April 1, 2050 (collectively, the "March 2020 Notes"). In connection with the issuance of the March 2020 Notes on March 31, 2020, the Company terminated all outstanding cash flow hedges. The Company paid a net amount of $7 million to the hedge counterparties upon termination, which was recorded as a loss, net of tax, of $5 million in accumulated other comprehensive income and will be reclassified as interest expense over the life of the March 2020 Notes. See Note 13 ''Other Comprehensive Income (Loss)'' for additional information.

Early Extinguishments of Debt
In December 2021, the Company redeemed for cash the remaining $2.3 billion of its outstanding 3.7% senior notes due 2023. In connection with the early redemption of such senior notes, the Company paid a make-whole premium of $80 million in excess of the aggregate principal amount of the senior notes that were redeemed, wrote-off $8 million of unamortized deferred financing costs and incurred $1 million in fees, for a total loss on early extinguishment of debt of $89 million.

In August 2021, the Company purchased approximately $2.0 billion of its outstanding 4.3% senior notes due 2028 through a cash tender offer. In connection with the purchase of such senior notes, the Company paid a premium of $332 million in excess of the aggregate principal amount of the senior notes that were purchased, wrote-off $26 million of unamortized deferred financing costs and incurred $5 million in fees, for a total loss on early extinguishment of debt of $363 million.

In December 2020, the Company purchased $4.5 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $113 million of its 4.0% senior notes due 2023, $1.4 billion of its 3.7% senior notes due 2023, $1.0 billion of its 4.1% senior notes due 2025 and $2.0 billion of its 4.3% senior notes due 2028. In connection with the purchase of such senior notes, the Company paid a premium of $619 million in excess of the aggregate principal amount of the senior notes that were purchased, wrote-off $45 million of unamortized deferred financing costs and incurred $10 million in fees, for a total loss on early extinguishment of debt of $674 million.

In August 2020, the Company purchased $6.0 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $723 million of its 4.0% senior notes due 2023, $2.3 billion of its 3.7% senior notes due 2023 and $3.0 billion of its 4.1% senior notes due 2025. In connection with the purchase of such senior notes, the Company paid a premium of $706 million in excess of the aggregate principal amount of the senior notes that were purchased, wrote-off $47 million of unamortized deferred financing costs and incurred $13 million in fees, for a total loss on early extinguishment of debt of $766 million.

Debt Covenants

The Company's back-up revolving credit facilities and unsecured senior notes contain customary restrictive financial and operating covenants. These covenants do not include an acceleration of the Company's debt maturities in the event of a downgrade in the Company's credit ratings. The Company does not believe the restrictions contained in these covenants materially affect its financial or operating flexibility. As of December 31, 2022, the Company was in compliance with all of its debt covenants.

9. Pension Plans and Other Postretirement Benefits

Defined Contribution Plans

As of December 31, 2022, the Company sponsors several active 401(k) savings plans that cover all employees who meet plan eligibility requirements.

The Company makes matching contributions consistent with the provisions of the respective plans. At the participant's option, account balances, including the Company's matching contribution, can be invested among various investment options under each plan. The CVS Health Future Fund 401(k) Plan offers CVS Health Corporation's common stock fund as an investment option. The Company also maintains nonqualified, unfunded deferred compensation plans for certain key employees. The plans provide participants the opportunity to defer portions of their eligible compensation and for certain nonqualified plans, participants receive matching contributions equivalent to what they could have received under the CVS Health Future Fund 401(k) Plan absent certain restrictions and limitations under the Internal Revenue Code. The Company's contributions under its defined contribution plans were $567 million, $552 million and $520 million in the years ended December 31, 2022, 2021 and 2020, respectively.

Defined Benefit Pension Plans

The Company sponsors a tax-qualified defined benefit pension plan that was frozen in 2010 and a nonqualified supplemental pension plan that was frozen in 2007. The Company also sponsors several other defined benefit pension plans that are unfunded nonqualified supplemental retirement plans.

Pension Benefit Obligation and Plan Assets
The following tables outline the change in pension benefit obligation and plan assets over the specified periods:

In millions	**2022**	**2021**
Change in benefit obligation:		
Benefit obligation, beginning of year	$ 6,009	$ 6,462
Interest cost	132	110
Actuarial gain	(1,011)	(102)
Benefit payments	(387)	(408)
Settlements	(3)	(53)
Benefit obligation, end of year	4,740	6,009
Change in plan assets:		
Fair value of plan assets, beginning of year	6,677	6,845
Actual return on plan assets	(968)	215
Employer contributions	27	78
Benefit payments	(387)	(408)
Settlements	(3)	(53)
Fair value of plan assets, end of year	5,346	6,677
Funded status	$ 606	$ 668

The change in the pension benefit obligation during the years ended December 31, 2022 and 2021 was primarily driven by the change in the discount rate during each respective period.

The assets (liabilities) recognized on the consolidated balance sheets at December 31, 2022 and 2021 for the defined benefit pension plans consisted of the following:

In millions	**2022**	**2021**
Noncurrent assets reflected in other assets	$ 827	$ 946
Current liabilities reflected in accrued expenses	(24)	(28)
Noncurrent liabilities reflected in other long-term liabilities	(197)	(250)
Net assets	$ 606	$ 668

Net Periodic Benefit Cost (Income)
The components of net periodic benefit cost (income) for the years ended December 31, 2022, 2021 and 2020 are shown below:

In millions	**2022**	**2021**	**2020**
Components of net periodic benefit cost (income):			
Interest cost	$ 132	$ 110	$ 168
Expected return on plan assets	(309)	(317)	(388)
Amortization of net actuarial loss	3	5	2
Settlement losses	1	16	—
Net periodic benefit cost (income)	$ (173)	$ (186)	$ (218)

Pension Plan Assumptions
The Company uses a series of actuarial assumptions to determine its benefit obligation and net periodic benefit income, the most significant of which include discount rates and expected return on plan assets assumptions.

Discount Rates - The discount rate is determined using a yield curve as of the annual measurement date. The yield curve consists of a series of individual discount rates, with each discount rate corresponding to a single point in time, based on high-quality bonds. Projected benefit payments are discounted to the measurement date using the corresponding rate from the yield curve that is consistent with the maturity profile of the expected liability cash flows.

Expected Return on Plan Assets - The expected long-term rate of return on plan assets is determined by using the plan's target allocation and return expectations based on many factors including forecasted long-term capital market real returns and the inflationary outlook on a plan by plan basis. See "Pension Plan Assets" below for additional details regarding the pension plan assets as of December 31, 2022 and 2021.

The Company also considers other assumptions including mortality, interest crediting rate, termination and retirement rates and cost of living adjustments.

The Company determined its benefit obligation based on the following weighted average assumptions as of December 31, 2022 and 2021:

	2022	2021
Discount rate	5.2 %	2.8 %

The Company determined its net periodic benefit cost (income) based on the following weighted average assumptions for the years ended December 31, 2022, 2021 and 2020:

	2022	2021	2020
Discount rate	2.3 %	1.8 %	2.9 %
Expected long-term rate of return on plan assets	4.8 %	4.8 %	6.3 %

Pension Plan Assets
The Company's pension plan assets primarily include debt and equity securities held in separate accounts, common/collective trusts and real estate investments. The valuation methodologies used to value these debt and equity securities and common/collective trusts are similar to the methodologies described in Note 4 "Fair Value." Pension plan assets also include investments in other assets that are carried at fair value. The following is a description of the valuation methodologies used to value real estate investments and these additional investments, including the general classification pursuant to the fair value hierarchy.

Real Estate - Real estate investments are valued by independent third party appraisers. The appraisals comply with the Uniform Standards of Professional Appraisal Practice, which include, among other things, the income, cost, and sales comparison approaches to estimating property value. Therefore, these investments are classified in Level 3.

Private equity and hedge fund limited partnerships - Private equity and hedge fund limited partnerships are carried at fair value which is estimated using the NAV per unit as reported by the administrator of the underlying investment fund as a practical expedient to fair value. Therefore, these investments have been excluded from the fair value table below.

Pension plan assets with changes in fair value measured on a recurring basis at December 31, 2022 were as follows:

In millions	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 7	$ 81	$ —	$ 88
Debt securities:				
U.S. government securities	566	4	—	570
States, municipalities and political subdivisions	—	102	—	102
U.S. corporate securities	—	2,611	—	2,611
Foreign securities	—	101	—	101
Residential mortgage-backed securities	—	6	—	6
Commercial mortgage-backed securities	—	1	—	1
Other asset-backed securities	—	11	—	11
Redeemable preferred securities	—	1	—	1
Total debt securities	566	2,837	—	3,403
Equity securities:				
U.S. domestic	133	—	—	133
International	43	—	—	43
Domestic real estate	—	—	—	—
Total equity securities	176	—	—	176
Other investments:				
Real estate	—	—	325	325
Common/collective trusts [1]	—	307	—	307
Total other investments	—	307	325	632
Total pension investments [2]	$ 749	$ 3,225	$ 325	$ 4,299

(1) The assets in the underlying funds of common/collective trusts consist of $104 million of equity securities and $203 million of debt securities.
(2) Excludes $390 million of other receivables as well as $432 million of private equity limited partnership investments and $225 million of hedge fund limited partnership investments as these amounts are measured at NAV per share or an equivalent and are not subject to leveling within the fair value hierarchy.

Pension plan assets with changes in fair value measured on a recurring basis at December 31, 2021 were as follows:

In millions	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 60	$ 97	$ —	$ 157
Debt securities:				
U.S. government securities	1,223	1	—	1,224
States, municipalities and political subdivisions	—	150	—	150
U.S. corporate securities	—	2,458	—	2,458
Foreign securities	—	202	—	202
Residential mortgage-backed securities	—	277	—	277
Commercial mortgage-backed securities	—	76	—	76
Other asset-backed securities	—	162	—	162
Redeemable preferred securities	—	4	—	4
Total debt securities	1,223	3,330	—	4,553
Equity securities:				
U.S. domestic	201	—	—	201
International	81	—	—	81
Domestic real estate	1	—	—	1
Total equity securities	283	—	—	283
Other investments:				
Real estate	—	—	378	378
Common/collective trusts [1]	—	410	—	410
Total other investments	—	410	378	788
Total pension investments [2]	$ 1,566	$ 3,837	$ 378	$ 5,781

(1) The assets in the underlying funds of common/collective trusts consist of $261 million of equity securities and $149 million of debt securities.
(2) Excludes $76 million of other receivables as well as $583 million of private equity limited partnership investments and $237 million of hedge fund limited partnership investments as these amounts are measured at NAV per share or an equivalent and are not subject to leveling within the fair value hierarchy.

The changes in the balances of Level 3 pension plan assets during the year ended December 31, 2022 were as follows:

In millions	Real estate	Total
Beginning balance	$ 378	$ 378
Actual return on plan assets	21	21
Purchases, sales and settlements	(74)	(74)
Transfers out of Level 3	—	—
Ending balance	$ 325	$ 325

The changes in the balances of Level 3 pension plan assets during the year ended December 31, 2021 were as follows:

In millions	Real estate	Total
Beginning balance	$ 343	$ 343
Actual return on plan assets	43	43
Purchases, sales and settlements	(8)	(8)
Transfers out of Level 3	—	—
Ending balance	$ 378	$ 378

The Company's pension plan invests in a diversified mix of assets designed to generate returns that will enable the plan to meet its future benefit obligations. The risk of unexpected investment and actuarial outcomes is regularly evaluated. This evaluation

is performed through forecasting and assessing ranges of investment outcomes over short- and long-term horizons and by assessing the pension plan's liability characteristics. Complementary investment styles and strategies are utilized by professional investment management firms to further improve portfolio and operational risk characteristics. Public and private equity investments are used primarily to increase overall plan returns. Real estate investments are viewed favorably for their diversification benefits and above-average dividend generation. Fixed income investments provide diversification benefits and liability hedging attributes that are desirable, especially in falling interest rate environments.

At December 31, 2022, target investment allocations for the Company's pension plan were: 12% in equity securities, 77% in fixed income and debt securities, 5% in real estate, 3% in private equity limited partnerships and 3% in hedge funds. Actual asset allocations may differ from target allocations due to tactical decisions to overweight or underweight certain assets or as a result of normal fluctuations in asset values. Asset allocations are consistent with stated investment policies and, as a general rule, periodically rebalanced back to target asset allocations. Asset allocations and investment performance are formally reviewed periodically throughout the year by the pension plan's Investment Subcommittee. Forecasting of asset and liability growth is performed at least annually.

Cash Flows
The Company generally contributes to its tax-qualified pension plan based on minimum funding requirements determined under applicable federal laws and regulations. Employer contributions related to the nonqualified supplemental pension plans generally represent payments to retirees for current benefits. The Company contributed $27 million, $78 million and $25 million to its pension plans during 2022, 2021 and 2020, respectively. No contributions are required for the tax-qualified pension plan in 2023. The Company expects to make an immaterial amount of contributions for all other pension plans in 2023.

The Company estimates the following future benefit payments, which are calculated using the same actuarial assumptions used to measure the pension benefit obligation as of December 31, 2022:

In millions	
2023	$ 368
2024	369
2025	372
2026	369
2027	367
2028-2032	1,776

Multiemployer Pension Plans
The Company also contributes to a number of multiemployer pension plans under the terms of collective-bargaining agreements that cover its union-represented employees. The risks of participating in these multiemployer plans are different from single-employer pension plans in the following respects: (i) assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers, (ii) if a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers, and (iii) if the Company chooses to stop participating in some of its multiemployer plans, the Company may be required to pay those plans an amount based on the underfunded status of the applicable plan, which is referred to as a withdrawal liability.

None of the multiemployer pension plans in which the Company participates are individually significant to the Company. The Company's contributions to multiemployer pension plans were $20 million, $19 million and $19 million in 2022, 2021 and 2020, respectively.

Other Postretirement Benefits

The Company provides postretirement health care and life insurance benefits to certain retirees who meet eligibility requirements. The Company's funding policy is generally to pay covered expenses as they are incurred. For retiree medical plan accounting, the Company reviews external data and its own historical trends for health care costs to determine the health care cost trend rates. As of December 31, 2022 and 2021, the Company's other postretirement benefits had an accumulated postretirement benefit obligation of $159 million and $207 million, respectively. Net periodic benefit costs related to these other postretirement benefits were $4 million, $4 million and $12 million in 2022, 2021 and 2020, respectively.

The Company estimates the following future benefit payments, which are calculated using the same actuarial assumptions used to measure the accumulated other postretirement benefit obligation as of December 31, 2022:

In millions	
2023	$ 12
2024	12
2025	12
2026	12
2027	12
2028-2032	59

Pursuant to various collective bargaining agreements, the Company also contributes to multiemployer health and welfare plans that cover certain union-represented employees. The plans provide postretirement health care and life insurance benefits to certain employees who meet eligibility requirements. The Company's contributions to multiemployer health and welfare plans totaled $62 million, $60 million and $54 million in 2022, 2021 and 2020, respectively.

10. Income Taxes

The income tax provision for continuing operations consisted of the following for the years ended December 31, 2022, 2021 and 2020:

In millions	**2022**	**2021**	**2020**
Current:			
Federal	$ 2,803	$ 2,285	$ 2,615
State	735	665	518
	3,538	2,950	3,133
Deferred:			
Federal	(1,569)	(306)	(450)
State	(506)	(122)	(114)
	(2,075)	(428)	(564)
Total	$ 1,463	$ 2,522	$ 2,569

The following table is a reconciliation of the statutory income tax rate to the Company's effective income tax rate for continuing operations for the years ended December 31, 2022, 2021 and 2020:

	2022	**2021**	**2020**
Statutory income tax rate	21.0 %	21.0 %	21.0 %
State income taxes, net of federal tax benefit	3.2	4.1	3.2
Health insurer fee	—	—	2.2
Legal charges	3.5	—	—
Basis difference upon disposition of subsidiary	1.7	—	(1.2)
Prior year refunds and unrecognized tax benefits	(2.7)	(1.2)	—
Other	(0.7)	0.3	1.1
Effective income tax rate	26.0 %	24.2 %	26.3 %

The following table is a summary of the components of the Company's deferred income tax assets and liabilities as of December 31, 2022 and 2021:

In millions	**2022**	**2021**
Deferred income tax assets:		
Lease and rents	$ 5,242	$ 5,563
Legal charges	1,260	19
Inventory	103	99
Employee benefits	153	193
Bad debts and other allowances	480	489
Net operating loss and capital loss carryforwards	266	416
Deferred income	66	78
Insurance reserves	455	501
Investments	293	—
Payroll tax deferral	—	87
Other	335	377
Valuation allowance	(532)	(325)
Total deferred income tax assets [1]	8,121	7,497
Deferred income tax liabilities:		
Retirement benefits	(92)	(105)
Investments	—	(334)
Lease and rents	(4,639)	(4,947)
Depreciation and amortization	(7,139)	(8,381)
Total deferred income tax liabilities	(11,870)	(13,767)
Net deferred income tax liabilities	$ (3,749)	$ (6,270)

(1) Includes deferred income tax assets of $131 million which have been accounted for as assets held for sale and are included in assets held for sale on the consolidated balance sheet at December 31, 2022. See Note 2 ''Acquisitions, Divestitures and Asset Sales'' for additional information.

When evaluating the realizability of deferred tax assets, the Company considers all available positive and negative evidence, including future reversals of existing taxable temporary differences, projected future taxable income, tax planning strategies and the Company's recent operating results. The Company established valuation allowances of $532 million and $325 million as of December 31, 2022 and 2021, respectively, because it does not consider it more likely than not that certain deferred tax assets will be recovered.

As of December 31, 2022, the Company had net operating and capital loss carryovers of $266 million, which expire between 2023 and 2042.

A reconciliation of the beginning and ending balance of unrecognized tax benefits in 2022, 2021 and 2020 is as follows:

In millions	**2022**	**2021**	**2020**
Beginning balance	$ 782	$ 768	$ 655
Additions based on tax positions related to the current year	5	3	3
Additions based on tax positions related to prior years	42	52	182
Reductions for tax positions of prior years	(166)	(33)	(56)
Expiration of statutes of limitation	(4)	(1)	(2)
Settlements	(213)	(7)	(14)
Ending balance	$ 446	$ 782	$ 768

CVS Health Corporation and most of its subsidiaries are subject to U.S. federal income tax as well as income tax of numerous state and local jurisdictions. CVS Health Corporation participated in the Compliance Assurance Process through 2019, which is

a program made available by the U.S. Internal Revenue Service ("IRS") to certain qualifying large taxpayers, under which participants work collaboratively with the IRS to identify and resolve potential tax issues through open, cooperative and transparent interaction prior to the annual filing of their federal income tax returns. The IRS has completed its examinations of the Company's consolidated U.S. federal income tax returns for tax years through and including 2013 and 2018 through 2019. The IRS has substantially completed its examinations of the Company's consolidated U.S. federal income tax returns for tax years 2014 through 2017.

CVS Health Corporation and its subsidiaries are also currently under income tax examinations by a number of state and local tax authorities. As of December 31, 2022, no examination has resulted in any proposed adjustments that would result in a material change to the Company's operating results, financial condition or liquidity.

Substantially all material state and local income tax matters have been concluded for fiscal years through 2015. Certain state exams are likely to be concluded and certain state statutes of limitations will lapse in 2023, but the change in the balance of the Company's uncertain tax positions is projected to be immaterial. In addition, it is reasonably possible that the Company's unrecognized tax benefits could change within the next twelve months due to the anticipated conclusion of various examinations with the IRS for certain previous years. An estimate of the range of the possible change cannot be made at this time.

The Company records interest expense related to unrecognized tax benefits and penalties in the income tax provision. The Company accrued interest expense of approximately $29 million, $40 million and $34 million in 2022, 2021 and 2020, respectively. The Company had approximately $112 million and $151 million accrued for interest and penalties as of December 31, 2022 and 2021, respectively.

As of December 31, 2022, the total amount of unrecognized tax benefits that, if recognized, would affect the Company's effective income tax rate is approximately $336 million, after considering the federal benefit of state income taxes.

11. Stock Incentive Plans

The terms of the CVS Health 2017 Incentive Compensation Plan ("ICP") provide for grants of annual incentive and long-term performance awards to executive officers and other officers and employees of the Company or any subsidiary of the Company, as well as equity compensation to outside directors of CVS Health Corporation. Payment of such annual incentive and long-term performance awards will be in cash, stock, other awards or other property, at the discretion of the Management Planning and Development Committee (the "MP&D Committee") of the Board. The ICP allows for a maximum of 58 million shares of CVS Health Corporation common stock to be reserved and available for grants. As of December 31, 2022, there were approximately 21 million shares of CVS Health Corporation common stock available for future grants under the ICP.

Upon the acquisition of Aetna (the "Aetna Acquisition") on November 28, 2018, approximately 22 million shares of Aetna common stock subject to awards outstanding under the Amended Aetna Inc. 2010 Stock Incentive Plan ("SIP") were assumed by CVS Health Corporation. In addition, in accordance with the merger agreement, shares which were available for future issuance under the SIP were converted into approximately 32 million shares of CVS Health Corporation common stock reserved and available for issuance pursuant to future awards. Subsequent to the expiration of the SIP on May 21, 2020, the ICP was the only compensation plan under which the Company grants stock options, restricted stock and other stock-based awards to its employees.

Stock-Based Compensation Expense

Stock-based compensation is measured at the grant date based on the fair value of the award and is recognized as expense over the requisite service period of the stock award (generally three to five years) using the straight-line method. The following table is a summary of stock-based compensation for the years ended December 31, 2022, 2021 and 2020:

In millions	**2022**	**2021**	**2020**
Restricted stock units and performance stock units	$ 369	$ 404	$ 329
Stock options and stock appreciation rights ("SARs") [1]	78	80	71
Total stock-based compensation	$ 447	$ 484	$ 400

(1) Includes the ESPP.

Restricted Stock Units and Performance Stock Units

The Company's restricted stock units and performance stock units are considered nonvested share awards and require no payment from the employee. The fair value of the restricted stock units is based on the market price of CVS Health Corporation common stock on the grant date and is recognized on a straight-line basis over the vesting period. For each restricted stock unit granted, employees receive one share of common stock, net of taxes, at the end of the vesting period.

The Company's performance stock units contain performance vesting conditions in addition to a service vesting condition. Vesting of the Company's performance stock units is dependent upon the degree to which the Company achieves its performance goals, which are generally set for a three-year performance period and are approved at the time of grant by the MP&D Committee.

The fair value of performance stock units granted with service and performance vesting conditions is based on the market price of CVS Health Corporation common stock on the grant date and is recognized over the vesting period. Certain of the performance stock units also contain a market vesting condition based on the performance of CVS Health Corporation common stock relative to a comparator group. The fair value of these performance stock units is determined using a Monte Carlo simulation as of the grant date and is recognized over the vesting period.

As of December 31, 2022, there was $619 million of total unrecognized compensation cost related to the Company's restricted stock units and performance stock units that are expected to vest. These costs are expected to be recognized over a weighted-average period of 2.1 years. The total fair value of restricted stock units vested during 2022, 2021 and 2020 was $328 million, $406 million and $229 million, respectively.

The following table is a summary of the restricted stock unit and performance stock unit activity for the year ended December 31, 2022:

In thousands, except weighted average grant date fair value	**Units**	**Weighted Average Grant Date Fair Value**
Outstanding at beginning of year, nonvested	14,330	$ 63.02
Granted	5,398	$ 101.13
Vested [(1)]	(5,626)	$ 58.28
Forfeited	(1,421)	$ 72.76
Outstanding at end of year, nonvested	12,681	$ 80.25

(1) Vested performance stock units have been included at target level performance. Based on actual performance, the number of restricted stock units and performance stock units vested during the year ended December 31, 2022 was 8.0 million.

Stock Options and SARs

All stock option grants are awarded at fair value on the date of grant. The fair value of stock options is estimated using the Black-Scholes option pricing model, and stock-based compensation is recognized on a straight-line basis over the requisite service period. Stock options granted generally become exercisable over a four-year period from the grant date. Stock options granted through 2018 generally expire seven years after the grant date. Stock options granted subsequent to 2018 generally expire ten years after the grant date.

All unvested Aetna SARs outstanding upon the acquisition of Aetna were converted into replacement CVS Health Corporation SARs. The replacement SARs granted are settled in CVS Health Corporation common stock, net of taxes, based on the appreciation of the stock price on the exercise date over the market price on the date of grant. The fair value of SARs is estimated using the Black-Scholes option pricing model, and stock-based compensation is recognized on a straight-line basis over the requisite service period. SARs generally become exercisable over a three-year period from the grant date. SARs generally expire ten years after the grant date. No SARs have been granted subsequent to the Aetna Acquisition.

The following table is a summary of stock option and SAR activity that occurred for the years ended December 31, 2022, 2021 and 2020:

In millions	2022	2021	2020
Cash received from stock options exercised (including ESPP)	$ 551	$ 549	$ 264
Payments for taxes for net share settlement of equity awards	370	168	88
Intrinsic value of stock options and SARs exercised	118	105	24
Fair value of stock options and SARs vested	219	224	252

The fair value of each stock option is estimated using the Black-Scholes option pricing model based on the following assumptions at the time of grant:

	2022	2021	2020
Dividend yield [1]	2.18 %	2.68 %	3.42 %
Expected volatility [2]	27.34 %	27.10 %	25.22 %
Risk-free interest rate [3]	2.46 %	1.13 %	0.61 %
Expected life (in years) [4]	6.3	6.3	6.3
Weighted-average grant date fair value	$ 24.15	$ 14.57	$ 8.78

(1) The dividend yield is based on annual dividends paid and the fair market value of CVS Health Corporation stock at the grant date.
(2) The expected volatility is estimated based on the historical volatility of CVS Health Corporation's daily stock price over a period equal to the expected life of each option grant after adjustments for infrequent events such as stock splits.
(3) The risk-free interest rate is selected based on yields from U.S. Treasury zero-coupon issues with a remaining term equal to the expected term of the options being valued.
(4) The expected life represents the number of years the options are expected to be outstanding from grant date based on historical option or SAR holder exercise experience.

As of December 31, 2022, unrecognized compensation expense related to unvested stock options totaled $41 million, which the Company expects to be recognized over a weighted-average period of 1.9 years. After considering anticipated forfeitures, the Company expects approximately 7 million of the unvested stock options to vest over the requisite service period.

The following table is a summary of the Company's stock option and SAR activity for the year ended December 31, 2022:

In thousands, except weighted average exercise price and remaining contractual term	Shares	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term	Aggregate Intrinsic Value
Outstanding at beginning of year	19,061	$ 71.74		
Granted	1,993	$ 101.04		
Exercised	(4,921)	$ 75.91		
Forfeited	(478)	$ 70.78		
Expired	(615)	$ 99.78		
Outstanding at end of year	15,040	$ 73.15	4.52	$ 340,507
Exercisable at end of year	7,730	$ 72.39	2.76	184,904
Vested at end of year and expected to vest in the future	14,757	$ 72.96	4.47	336,664

ESPP

The Company's Employee Stock Purchase Plan ("ESPP") provides for the purchase of up to 60 million shares of CVS Health Corporation common stock. Under the ESPP, eligible employees may purchase common stock at the end of each six month offering period at a purchase price equal to 90% of the lower of the fair market value on the first day or the last day of the offering period. During 2022, approximately 2 million shares of common stock were purchased under the provisions of the ESPP at an average price of $78.55 per share. As of December 31, 2022, approximately 29 million shares of common stock were available for issuance under the ESPP.

The fair value of stock-based compensation associated with the ESPP is estimated on the date of grant (the first day of the six month offering period) using the Black-Scholes option pricing model.

The following table is a summary of the assumptions used to value the ESPP awards for the years ended December 31, 2022, 2021 and 2020:

	2022	2021	2020
Dividend yield [1]	1.12 %	1.34 %	1.46 %
Expected volatility [2]	23.54 %	25.27 %	37.21 %
Risk-free interest rate [3]	1.42 %	0.08 %	0.81 %
Expected life (in years) [4]	0.5	0.5	0.5
Weighted-average grant date fair value	$ 16.25	$ 12.55	$ 13.85

(1) The dividend yield is calculated based on semi-annual dividends paid and the fair market value of CVS Health Corporation stock at the grant date.
(2) The expected volatility is estimated based on the historical volatility of CVS Health Corporation's daily stock price over the previous six month period.
(3) The risk-free interest rate is selected based on the Treasury constant maturity interest rate whose term is consistent with the expected term of ESPP purchases (i.e., six months).
(4) The expected life is based on the semi-annual purchase period.

12. Shareholders' Equity

Share Repurchases

The following share repurchase programs have been authorized by the Board:

In billions Authorization Date	Authorized	Remaining as of December 31, 2022
November 17, 2022 ("2022 Repurchase Program")	$ 10.0	$ 10.0
December 9, 2021 ("2021 Repurchase Program")	10.0	6.5

Each of the share Repurchase Programs was effective immediately and permit the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase ("ASR") transactions, and/or other derivative transactions. Both the 2022 and 2021 Repurchase Programs can be modified or terminated by the Board at any time.

During the year ended December 31, 2022, the Company repurchased an aggregate of 34.1 million shares of common stock for approximately $3.5 billion pursuant to the 2021 Repurchase Program, including share repurchases under the $1.5 billion fixed dollar ASR transaction described below. During the years ended December 31, 2021 and 2020, the Company did not repurchase any shares of common stock.

Pursuant to the authorization under the 2021 Repurchase Program, the Company entered into a $2.0 billion fixed dollar ASR with Citibank, N.A. ("Citibank"). Upon payment of the $2.0 billion purchase price on January 4, 2023, the Company received a number of shares of CVS Health Corporation's common stock equal to 80% of the $2.0 billion notional amount of the ASR or approximately 17.4 million shares at a price of $92.19 per share, which were placed into treasury stock in January 2023. At the conclusion of the ASR, the Company may receive additional shares representing the remaining 20% of the $2.0 billion notional amount. The ultimate number of shares the Company may receive will depend on the daily volume-weighted average price of the Company's stock over an averaging period, less a discount. It is also possible, depending on such weighted average price, that the Company will have an obligation to Citibank which, at the Company's option, could be settled in additional cash or by issuing shares. Under the terms of the ASR, the maximum number of shares that could be delivered to the Company is 43.4 million.

Pursuant to the authorization under the 2021 Repurchase Program, the Company entered into a $1.5 billion fixed dollar ASR with Barclays Bank PLC. Upon payment of the $1.5 billion purchase price on January 4, 2022, the Company received a number of shares of CVS Health Corporation's common stock equal to 80% of the $1.5 billion notional amount of the ASR or approximately 11.6 million shares at a price of $103.34 per share, which were placed into treasury stock in January 2022. The ASR was accounted for as an initial treasury stock transaction for $1.2 billion and a forward contract for $0.3 billion. The forward contract was classified as an equity instrument and was recorded within capital surplus. In February 2022, the Company received approximately 2.7 million shares of CVS Health Corporation's common stock, representing the remaining

20% of the $1.5 billion notional amount of the ASR, thereby concluding the ASR. These shares were placed into treasury stock and the forward contract was reclassified from capital surplus to treasury stock in February 2022.

At the time they were received, the initial and final receipt of shares resulted in an immediate reduction of the outstanding shares used to calculate the weighted average common shares outstanding for basic and diluted earnings per share.

Dividends

The quarterly cash dividend declared by the Board was $0.55 and $0.50 per share in 2022 and 2021, respectively. In December 2022, the Board authorized a 10% increase in the quarterly cash dividend to $0.605 per share effective in 2023. CVS Health Corporation has paid cash dividends every quarter since becoming a public company. Future dividend payments will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

Regulatory Requirements

The Company's insurance business operations are conducted through subsidiaries that principally consist of health maintenance organizations ("HMOs") and insurance companies. The Company's HMO and insurance subsidiaries report their financial statements in accordance with accounting practices prescribed by state regulatory authorities which may differ from GAAP. The combined statutory net income for the years ended and estimated combined statutory and capital surplus at December 31, 2022, 2021 and 2020 for the Company's insurance and HMO subsidiaries were as follows:

In millions	**2022**	**2021**	**2020**
Statutory net income	$ 2,851	$ 3,302	$ 3,667
Estimated statutory capital and surplus	15,503	14,879	13,238

The Company's insurance and HMO subsidiaries paid $3.2 billion of gross dividends to the Company for the year ended December 31, 2022.

In addition to general state law restrictions on payments of dividends and other distributions to stockholders applicable to all corporations, HMOs and insurance companies are subject to further regulations that, among other things, may require those companies to maintain certain levels of equity and restrict the amount of dividends and other distributions that may be paid to their equity holders. In addition, in connection with the Aetna Acquisition, the Company made certain undertakings that require prior regulatory approval of dividends by certain of its HMOs and insurance companies. At December 31, 2022, these amounts were as follows:

In millions	
Estimated minimum statutory surplus required by regulators	$ 7,741
Investments on deposit with regulatory bodies	652
Estimated maximum dividend distributions permitted in 2023 without prior regulatory approval	2,706

Noncontrolling Interests

At December 31, 2022 and 2021, noncontrolling interests were $300 million and $306 million, respectively, primarily related to third party interests in the Company's operating entities. The noncontrolling entities' share is included in total shareholders' equity on the consolidated balance sheets.

13. Other Comprehensive Income (Loss)

Shareholders' equity included the following activity in accumulated other comprehensive income (loss) in 2022, 2021 and 2020:

	At December 31,		
In millions	**2022**	**2021**	**2020**
Net unrealized investment gains (losses):			
Beginning of year balance	$ 778	$ 1,214	$ 774
Other comprehensive income (loss) before reclassifications *($(2,972), $(489) and $497 pretax)*	(2,518)	(410)	415
Amounts reclassified from accumulated other comprehensive income *($315, $(32) and $31 pretax)* [1]	239	(26)	25
Other comprehensive income (loss)	(2,279)	(436)	440
End of year balance	(1,501)	778	1,214
Foreign currency translation adjustments:			
Beginning of year balance	—	7	4
Other comprehensive income (loss) before reclassifications	—	(7)	3
Other comprehensive income (loss)	—	(7)	3
End of year balance	—	—	7
Net cash flow hedges:			
Beginning of year balance	222	248	279
Other comprehensive income (loss) before reclassifications *($38, $0 and $(7) pretax)*	28	—	(5)
Amounts reclassified from accumulated other comprehensive income *($(15), $(34) and $(35) pretax)* [2]	(11)	(26)	(26)
Other comprehensive income (loss)	17	(26)	(31)
End of year balance	239	222	248
Pension and other postretirement benefits:			
Beginning of year balance	(35)	(55)	(38)
Other comprehensive income (loss) before reclassifications *($(229), $20 and $(30) pretax)*	(170)	15	(22)
Amounts reclassified from accumulated other comprehensive loss *($3, $6 and $7 pretax)* [3]	2	5	5
Other comprehensive income (loss)	(168)	20	(17)
End of year balance	(203)	(35)	(55)
Total beginning of year accumulated other comprehensive income	965	1,414	1,019
Total other comprehensive income (loss)	(2,430)	(449)	395
Total end of year accumulated other comprehensive income (loss)	$ (1,465)	$ 965	$ 1,414

(1) Amounts reclassified from accumulated other comprehensive income for specifically identified debt securities are included in net investment income in the consolidated statements of operations.

(2) Amounts reclassified from accumulated other comprehensive income for specifically identified cash flow hedges are included within interest expense in the consolidated statements of operations. The Company expects to reclassify $11 million, net of tax, in net gains associated with its cash flow hedges into net income within the next 12 months.

(3) Amounts reclassified from accumulated other comprehensive loss for specifically identified pension and other postretirement benefits are included in other income in the consolidated statements of operations.

14. Earnings Per Share

Earnings per share is computed using the treasury stock method. Stock options and SARs to purchase 4 million, 7 million, and 15 million shares of common stock were outstanding, but were excluded from the calculation of diluted earnings per share for the years ended December 31, 2022, 2021 and 2020, respectively, because their exercise prices were greater than the average market price of the common shares and, therefore, the effect would be antidilutive.

The following is a reconciliation of basic and diluted earnings per share from continuing operations for the years ended December 31, 2022, 2021 and 2020:

In millions, except per share amounts	**2022**	**2021**	**2020**
Numerator for earnings per share calculation:			
Income from continuing operations	$ 4,165	$ 7,898	$ 7,201
Net (income) loss attributable to noncontrolling interests	(16)	12	(13)
Income from continuing operations attributable to CVS Health	$ 4,149	$ 7,910	$ 7,188
Denominator for earnings per share calculation:			
Weighted average shares, basic	1,312	1,319	1,309
Restricted stock units and performance stock units	6	6	4
Stock options and SARs	5	4	1
Weighted average shares, diluted	1,323	1,329	1,314
Earnings per share from continuing operations:			
Basic	$ 3.16	$ 6.00	$ 5.49
Diluted	$ 3.14	$ 5.95	$ 5.47

15. Reinsurance

The Company utilizes reinsurance agreements primarily to: (a) reduce required capital and (b) facilitate the acquisition or disposition of certain insurance contracts. Ceded reinsurance agreements permit the Company to recover a portion of its losses from reinsurers, although they do not discharge the Company's primary liability as the direct insurer of the risks reinsured.

In January 2023, the Company entered into two four-year reinsurance agreements with an unrelated reinsurer that allow it to reduce required capital and provide collateralized excess of loss reinsurance coverage on a portion of the Health Care Benefits segment's group Commercial Insured business.

Reinsurance recoverables (recorded as other current assets or other assets on the consolidated balance sheets) at December 31, 2022 and 2021 were as follows:

In millions	**2022**	**2021**
Reinsurer		
Hartford Life and Accident Insurance Company	$ 1,593	$ 1,887
Lincoln Life & Annuity Company of New York	385	395
VOYA Retirement Insurance and Annuity Company	159	167
Fresenius Medical Care Reinsurance Company (Cayman) Ltd.	102	46
All Other	55	54
Total	$ 2,294	$ 2,549

Direct, assumed and ceded premiums earned for the years ended December 31, 2022, 2021 and 2020 were as follows:

In millions	**2022**	**2021**	**2020**
Direct	$ 85,670	$ 76,320	$ 69,711
Assumed	432	492	478
Ceded	(772)	(680)	(825)
Net premiums	$ 85,330	$ 76,132	$ 69,364

The impact of reinsurance on benefit costs for the years ended December 31, 2022, 2021 and 2020 were as follows:

In millions	**2022**	**2021**	**2020**
Direct	$ 71,567	$ 64,414	$ 56,077
Assumed	379	398	329
Ceded	(665)	(552)	(727)
Net benefit costs	$ 71,281	$ 64,260	$ 55,679

There is not a material difference between premiums on a written basis versus an earned basis.

The Company also has various agreements with unrelated reinsurers that do not qualify for reinsurance accounting under GAAP, and consequently are accounted for using deposit accounting. The Company entered into these contracts to reduce the risk of catastrophic loss which in turn reduces the Company's capital and surplus requirements. Total deposit assets and liabilities related to reinsurance agreements that do not qualify for reinsurance accounting under GAAP were not material as of December 31, 2022 or 2021.

16. Commitments and Contingencies

COVID-19

The COVID-19 pandemic continues to evolve. The Company believes COVID-19's impact on its businesses, operating results, cash flows and/or financial condition primarily will be driven by the geographies impacted and the severity and duration of the pandemic; the pandemic's impact on the U.S. and global economies and consumer behavior and health care utilization patterns; and the timing, scope and impact of legislation as well as other federal, state and local governmental responses to the pandemic. Those primary drivers are beyond the Company's knowledge and control. As a result, the impact COVID-19 will have on the Company's businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be adverse and material. COVID-19 also may result in legal and regulatory proceedings, investigations and claims against the Company.

Guarantees

The Company has the following significant guarantee arrangements at December 31, 2022:

- ASC Claim Funding Accounts - The Company has arrangements with certain banks for the processing of claim payments for its ASC customers. The banks maintain accounts to fund claims of the Company's ASC customers. The customer is responsible for funding the amount paid by the bank each day. In these arrangements, the Company guarantees that the banks will not sustain losses if the responsible ASC customer does not properly fund its account. The aggregate maximum exposure under these arrangements is generally limited to $250 million. The Company can limit its exposure to these guarantees by suspending the payment of claims for ASC customers that have not adequately funded the amount paid by the bank.
- Separate Accounts Assets - Certain Separate Accounts assets associated with the large case pensions business in the Corporate/Other segment represent funds maintained as a contractual requirement to fund specific pension annuities that the Company has guaranteed. Minimum contractual obligations underlying the guaranteed benefits in these Separate Accounts were approximately $941 million and $1.3 billion at December 31, 2022 and 2021, respectively. See Note 1 ''Significant Accounting Policies'' for additional information on Separate Accounts. Contract holders assume all investment and mortality risk and are required to maintain Separate Accounts balances at or above a specified level. The level of required funds is a function of the risk underlying the Separate Account's investment strategy. If contract holders do not maintain the required level of Separate Accounts assets to meet the annuity guarantees, the Company would establish an additional liability. Contract holders' balances in the Separate Accounts at December 31, 2022 exceeded the

value of the guaranteed benefit obligation. As a result, the Company was not required to maintain any additional liability for its related guarantees at December 31, 2022.

Lease Guarantees

Between 1995 and 1997, the Company sold or spun off a number of subsidiaries, including Bob's Stores and Linens 'n Things, each of which subsequently filed for bankruptcy, and Marshalls. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the former subsidiary's lease obligations for the initial lease term and any extension thereof pursuant to a renewal option provided for in the lease prior to the time of the disposition. When the subsidiaries were disposed of and accounted for as discontinued operations, the Company's guarantees remained in place, although each initial purchaser agreed to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries fail to make the required payments under a store lease, the Company could be required to satisfy those obligations, and any significant adverse impact of COVID-19 on such purchasers and/or former subsidiaries increases the risk that the Company will be required to satisfy those obligations. As of December 31, 2022, the Company guaranteed 67 such store leases (excluding the lease guarantees related to Linens 'n Things, which have been recorded as a liability on the consolidated balance sheets), with the maximum remaining lease term extending through 2034.

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers and life insurers as well as health insurers. The Company's assessments generally are based on a formula relating to the Company's health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

In 2009, the Pennsylvania Insurance Commissioner placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. Penn Treaty was placed in liquidation in March 2017. The Company has recorded a liability for its estimated share of future assessments by applicable life and health insurance guaranty associations. It is reasonably possible that in the future the Company may record a liability and expense relating to other insolvencies which could have a material adverse effect on the Company's operating results, financial condition and cash flows, and the risk is heightened by any significant adverse impact of the COVID-19 pandemic on the solvency of other insurers, including long-term care and life insurers. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that limit future offsets.

HMOs in certain states in which the Company does business are subject to assessments, including market stabilization and other risk-sharing pools, for which the Company is assessed charges based on incurred claims, demographic membership mix and other factors. The Company establishes liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments the Company pays are dependent upon the Company's experience relative to other entities subject to the assessment, and the ultimate liability is not known at the financial statement date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, the Company believes it has adequate reserves to cover such assessments.

The Company's total guaranty fund assessments liability was immaterial at both December 31, 2022 and 2021.

Litigation and Regulatory Proceedings

The Company has been involved or is currently involved in numerous legal proceedings, including litigation, arbitration, government investigations, audits, reviews and claims. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, the U.S. Department of Justice (the "DOJ"), state Attorneys General, the U.S. Drug Enforcement Administration (the "DEA"), the U.S. Federal Trade Commission (the "FTC") and other governmental authorities.

Legal proceedings, in general, and securities, class action and multi-district litigation, in particular, and governmental special investigations, audits and reviews can be expensive and disruptive. Some of the litigation matters may purport or be determined

to be class actions and/or involve parties seeking large and/or indeterminate amounts, including punitive or exemplary damages, and may remain unresolved for several years. The Company also may be named from time to time in *qui tam* actions initiated by private third parties that could also be separately pursued by a governmental body. The results of legal proceedings, including government investigations, are often uncertain and difficult to predict, and the costs incurred in these matters can be substantial, regardless of the outcome.

The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and reasonably estimable, the Company does not establish an accrued liability. None of the Company's accruals for outstanding legal matters are material individually or in the aggregate to the Company's financial condition.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and the Company is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters. The Company believes that its defenses and assertions in pending legal proceedings have merit and does not believe that any of these pending matters, after consideration of applicable reserves and rights to indemnification, will have a material adverse effect on the Company's financial position. Substantial unanticipated verdicts, fines and rulings, however, do sometimes occur, which could result in judgments against the Company, entry into settlements or a revision to its expectations regarding the outcome of certain matters, and such developments could have a material adverse effect on its results of operations. In addition, as a result of governmental investigations or proceedings, the Company may be subject to damages, civil or criminal fines or penalties, or other sanctions including possible suspension or loss of licensure and/or exclusion from participating in government programs. The outcome of such governmental investigations of proceedings could be material to the Company.

Usual and Customary Pricing Litigation

The Company and certain current and former directors and officers are named as a defendant in a number of lawsuits that allege that the Company's retail pharmacies overcharged for prescription drugs by not submitting the correct usual and customary price during the claims adjudication process. These actions are brought by a number of different types of plaintiffs, including plan members, private payors, government payors, and shareholders based on different legal theories. Some of these cases are brought as putative class actions, and in some instances, classes have been certified. In October 2022, one of the litigating shareholders made a litigation demand to the Board related to these and other issues after his amended derivative complaint was dismissed for failing to demonstrate demand futility. The Company is defending itself against these claims.

PBM Litigation and Investigations

The Company is named as a defendant in a number of lawsuits and is subject to a number of investigations concerning its PBM practices.

The Company is facing multiple lawsuits, including by state Attorneys General, governmental subdivisions and several putative class actions, regarding drug pricing and its rebate arrangements with drug manufacturers. These complaints, brought by a number of different types of plaintiffs under a variety of legal theories, generally allege that rebate agreements between the drug manufacturers and PBMs caused inflated prices for certain drug products. The Company is defending itself against these claims. The Company has also received subpoenas, civil investigative demands ("CIDs"), and other requests for documents and information from, and is being investigated by, the FTC and Attorneys General of several states and the District of Columbia regarding its PBM practices, including pricing and rebates. The Company has been providing documents and information in response to these subpoenas, CIDs, and requests for information.

United States ex rel. Behnke v. CVS Caremark Corporation, et al. (U.S. District Court for the Eastern District of Pennsylvania). In April 2018, the Court unsealed a complaint filed in February 2014. The government has declined to intervene in this case. The relator alleges that the Company submitted, or caused to be submitted, to Part D of the Medicare program Prescription Drug Event data and/or Direct and Indirect Remuneration reports that misrepresented true prices paid by the Company's PBM to pharmacies for drugs dispensed to Part D beneficiaries with prescription benefits administered by the Company's PBM. The Company is defending itself against these claims.

Controlled Substances Litigation, Audits and Subpoenas

In December 2017, the U.S. Judicial Panel on Multidistrict Litigation consolidated numerous cases filed against various defendants by plaintiffs such as counties, cities, hospitals, Indian tribes and third-party payors, alleging claims beginning as far back as the early 2000s generally concerning the impacts of widespread prescription opioid abuse. The consolidated multidistrict litigation captioned In re National Prescription Opiate Litigation (MDL No. 2804) is pending in the U.S. District Court for the Northern District of Ohio. This multidistrict litigation presumptively includes hundreds of relevant federal court cases that name the Company as a defendant. A significant number of similar cases that name the Company as a defendant in some capacity are pending in state courts.

In addition, the Company has been named as a defendant in similar cases brought by certain state Attorneys General. The Company is defending itself against all such claims. Additionally, the Company has received subpoenas, CIDs, and/or other requests for information regarding opioids from state Attorneys General and insurance and other regulators of several U.S. jurisdictions. The Company has been cooperating with the government with respect to these subpoenas, CIDs, and other requests for information.

In November 2021, the Company was among the chain pharmacies found liable by a jury in a trial in federal court in Ohio; in August 2022, the court issued a judgment jointly against the three defendants in the amount of $651 million to be paid over 15 years, and also ordered certain injunctive relief. The Company is appealing the judgment and has not accrued a liability for this matter. In March 2022, CVS Health Corporation and CVS Pharmacy, Inc. entered into a settlement agreement with the State of Florida to resolve claims related to opioid medications dating back more than a decade. Under the terms of the settlement agreement, CVS Health Corporation settled all opioid claims against it and its subsidiaries by the State of Florida for $484 million, which is to be paid over a period of 18 years. During the three months ended March 31, 2022, the Company recorded a $484 million liability associated with this legal settlement. In August 2022, CVS Pharmacy, Inc. entered into an agreement with the State of New Mexico to settle all opioid claims against it and its parents and subsidiaries by the State of New Mexico and participating subdivisions. In September 2022, CVS Pharmacy, Inc. entered into an agreement with the State of West Virginia to settle all opioid claims against it and its parents and subsidiaries by the State of West Virginia and participating subdivisions. Also in September 2022, CVS Pharmacy, Inc. entered into an agreement with the Cherokee Nation to settle all opioid claims against it and its parents and subsidiaries by the Cherokee Nation.

In December 2022, the Company agreed to a formal settlement agreement, the financial amounts of which were agreed to in principle in October 2022, with a leadership group of a number of state Attorneys General and the Plaintiffs' Executive Committee ("PEC"). The agreement would resolve substantially all opioid claims against Company entities by states and political subdivisions, but not private plaintiffs. The maximum amount payable by the Company under the settlement would be approximately $4.3 billion in opioid remediation and $625 million in attorneys' fees and costs and additional remediation. The amounts would be payable over 10 years, beginning in 2023. The agreement also contains injunctive terms relating to the dispensing of opioid medications. The settlement agreement is available at nationalopioidsettlement.com.

Under the settlement agreement, before the Company determines whether to enter into any final settlement, it will assess the number and identities of the governmental entities that will participate in any such settlement. The settlement agreement contemplates that if certain governmental entities do not agree to the settlement, but the Company nonetheless concludes that there is sufficient participation to warrant going forward with the settlement, there would be a corresponding reduction in the amount due from the Company to account for the governmental entities that did not agree. Those non-participating governmental entities would be entitled to pursue their claims against the Company and other defendants. Private plaintiff litigation will also continue.

The Company has been informed that 45 states, the District of Columbia, and all eligible United States territories have elected to join the settlement. Three states were the subject of earlier settlements. The Company has elected to proceed with the settlement process based on that level of participation. The settlement process will progress to the period during which subdivisions may elect to join.

In December 2022, the Company also agreed to a formal settlement agreement with a leadership group representing tribes throughout the United States. The agreement would resolve substantially all opioid claims against Company entities by such tribes. The maximum amount payable by the Company under the settlement would be $113 million in opioid remediation and $18 million in attorneys' fees and costs. The amounts would be payable over 10 years, beginning in 2023. The agreement is contingent upon sufficient participation by tribes.

The Company has concluded that settlement of opioid claims by governmental entities and tribes is probable, and the loss related thereto could be reasonably estimated. As a result of that conclusion, and its assessment of certain other opioid-related claims including those for which the Company reached agreement in August and September 2022, the Company recorded pre-tax charges of $5.2 billion and $99 million during the three months ended September 30, 2022 and the three months ended December 31, 2022, respectively, of which $4.8 billion was recorded in other long-term liabilities on the consolidated balance sheet. In addition, the Company expects the cash impact in 2023 and 2024 to be less than $500 million in each year. Because loss contingencies are inherently unpredictable and unfavorable developments or resolutions can occur, the assessment requires judgments about future events. Moreover, the settlement is in its early phases, and there is no assurance that contingencies will be satisfied. The amount of ultimate loss may differ materially from this accrual.

Because of the many uncertainties associated with any settlement arrangement or other resolution of all opioid-related litigation matters, including the uncertain scope of participation by governmental entities, and given that the Company continues to actively defend ongoing litigation for which it believes it has defenses and assertions that have merit, the Company is not able to reasonably estimate the range of ultimate possible loss for all opioid-related litigation matters at this time. The outcome of these legal matters could have a material effect on the Company's business, financial condition, operating results and/or cash flows.

In January 2020, the DOJ served the Company with a DEA administrative subpoena. The subpoena seeks documents relating to practices with respect to prescription opioids and other controlled substances at CVS pharmacy locations concerning potential violations of the federal Controlled Substances Act and the federal False Claims Act. In January 2022, the DOJ served the Company with a CID regarding similar subjects, and the Company is providing documents and information in response to these matters.

Prescription Processing Litigation and Investigations

The Company is named as a defendant in a number of lawsuits and is subject to a number of investigations concerning its prescription processing practices, including the following:

U.S. ex rel. *Bassan* et al. *v. Omnicare, Inc. and CVS Health Corp.* (U.S. District Court for the Southern District of New York). In December 2019, the U.S. Attorney's Office for the Southern District of New York (the "SDNY") filed a complaint-in-intervention in this previously sealed *qui tam* case. The complaint alleges that for certain non-skilled nursing facilities, Omnicare improperly filled prescriptions beyond one year where a valid prescription did not exist and that these dispensing events violated the federal False Claims Act. The Company is defending itself against these claims.

U.S. ex rel. Gill et al. v. CVS Health Corp. et al. (U.S. District Court for the Northern District of Illinois). In July 2022, the Delaware Attorney General's Office moved for partial intervention as to allegations under the Delaware false claims act related to not escheating alleged overpayments in this previously sealed *qui tam* case. The federal government and the remaining states declined to intervene on other additional theories in the relator's complaint. The Company is defending itself against all of the claims.

In July 2017, the Company also received a subpoena from the California Department of Insurance requesting documents concerning the Company's Omnicare pharmacies' cycle fill process for assisted living facilities. The Company has been cooperating with the California Department of Insurance and providing documents and information in response to this subpoena.

In December 2016, the Company received a CID from the U.S. Attorney's Office for the Northern District of New York requesting documents and information in connection with a federal False Claims Act investigation concerning whether the Company's retail pharmacies improperly submitted certain insulin claims to Part D of the Medicare program rather than Part B of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to this CID.

Provider Proceedings

The Company is named as a defendant in purported class actions and individual lawsuits arising out of its practices related to the payment of claims for services rendered to its members by providers with whom the Company has a contract and with whom the Company does not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that the Company paid too little to its health plan members and/or providers for out-of-network services (including COVID-19 testing) and/or otherwise allege that the Company failed to timely or appropriately pay or administer claims and benefits (including the

Company's post payment audit and collection practices). Other major health insurers are the subject of similar litigation or have settled similar litigation.

The Company also has received subpoenas and/or requests for documents and other information from, and been investigated by, state Attorneys General and other state and/or federal regulators, legislators and agencies relating to, and the Company is involved in other litigation regarding, its out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against the Company with respect to its out-of-network benefit payment and/or administration practices.

CMS Actions

CMS regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to the Company's and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by providers. The Company collects claim and encounter data from providers and generally relies on providers to appropriately code their submissions to the Company and document their medical records, including the diagnosis data submitted to the Company with claims. CMS pays increased premiums to Medicare Advantage plans and Medicare PDP plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to the Company. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by providers and the resulting risk-adjusted premium payments to the plans. CMS may require the Company to refund premium payments if the Company's risk-adjusted premiums are not properly supported by medical record data. The Office of the Inspector General of the HHS (the "OIG") also is auditing the Company's risk adjustment-related data and that of other companies. The Company expects CMS and the OIG to continue these types of audits.

In 2012, in the "Notice of Final Payment Error Calculation for Part C Medicare Advantage Risk Adjustment Validation Data (RADV) Contract-Level Audits," CMS revised its audit methodology for RADV contract-level audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS announced extrapolation of the error rate identified in the audit sample along with the application of a process to account for errors in the government's traditional fee-for-service Medicare program ("FFS Adjuster"). For contract years prior to 2011, CMS did not extrapolate sample error rates to the entire contract, nor did CMS propose to apply a FFS adjuster. By applying the FFS Adjuster, Medicare Advantage organizations would have been liable for repayments only to the extent that their extrapolated payment errors exceeded the error rate in Original Medicare, which could have impacted the extrapolated repayments to which Medicare Advantage organizations are subject. This revised contract-level audit methodology increased the Company's exposure to premium refunds to CMS based on incomplete medical records maintained by providers. In the RADV audit methodology CMS used from 2011-2013, CMS selected only a few of the Company's Medicare Advantage contracts for various contract years for contract-level RADV audits. In October 2018, CMS in the proposed rule ("Proposed Rule") announced a new methodology for RADV audits targeting certain health conditions and members with many diagnostic conditions along with extrapolation for the error rates identified without use of a FFS Adjuster. While the rule was under proposal, CMS initiated contract-level RADV audits for the years 2014 and 2015 with this new RADV methodology without a final rule.

On January 30, 2023, CMS released the final rule ("RADV Audit Rule"), announcing it may use extrapolation for payment years 2018 forward, for both RADV audits and OIG audits and eliminated the application of a FFS Adjuster in Part C contract-level RADV audits of Medicare Advantage organizations. In the RADV Audit Rule, CMS indicated that it will use more than one audit methodology going forward and indicated CMS will audit contracts it believes are at the highest risk for overpayments based on its statistical modeling, citing a 2016 Governmental Accountability Office report that recommended selection of contract-level RADV audits with a focus on contracts likely to have high rates of improper payment, the highest coding intensity scores, and contracts with high levels of unsupported diagnoses from prior RADV audits.

The Company is currently unable to predict which of its Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds for years prior to 2018 or prospective adjustments to Medicare Advantage premium payments made to the Company, the effect of any such refunds or adjustments on the actuarial soundness of the Company's Medicare Advantage bids, or whether any RADV audit findings would require the Company to change its method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in the Company's bids

for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG or otherwise, including audits of the Company's MLR rebates, methodology and/or reports, could be material and could adversely affect the Company's operating results, cash flows and/or financial condition.

The RADV Audit Rule does not apply to the CMS Part C Improper Payment Measures audits nor the HHS-RADV programs.

Medicare and Medicaid CIDs

The Company has received CIDs from the Civil Division of the DOJ in connection with a current investigation of the Company's patient chart review processes related to risk adjustment data submissions under Parts C and D of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to these CIDs.

In May 2017, the Company received a CID from the SDNY requesting documents and information concerning possible false claims submitted to Medicare in connection with reimbursements for prescription drugs under the Medicare Part D program. The Company has been cooperating with the government and providing documents and information in response to this CID.

Stockholder Matters

Beginning in February 2019, multiple class action complaints, as well as a derivative complaint, were filed by putative plaintiffs against the Company and certain current and former officers and directors. The plaintiffs in these cases assert a variety of causes of action under federal securities laws that are premised on allegations that the defendants made certain omissions and misrepresentations relating to the performance of the Company's LTC business unit. The Company and its current and former officers and directors are defending themselves against these claims. Since filing, several of the cases have been consolidated, and the first-filed federal case, *City of Miami Fire Fighters' and Police Officers' Retirement Trust,* et al. (formerly known as *Anarkat*), was dismissed with prejudice in February 2021. Plaintiffs appealed that decision to the First Circuit after their motion for reconsideration was denied, and in August 2022 the First Circuit affirmed the dismissal. *In re CVS Health Corp. Securities Act Litigation* (formerly known as *Waterford*) and *In re CVS Health Corp. Securities Litigation* (formerly known as *City of Warren* and *Freundlich*) have been stayed pending the outcome of the First Circuit appeal. Plaintiffs in both cases have since filed amended complaints, which the Company has moved to dismiss.

In August and September 2020, two class actions under the Employee Retirement Income Security Act of 1974 ("ERISA") were filed in the U.S. District Court for the District of Connecticut against CVS Health, Aetna, and several current and former executives, directors and/or members of Aetna's Compensation and Talent Management Committee: *Radcliffe v. Aetna Inc.,* et al. and *Flaim v. Aetna Inc.,* et al. The plaintiffs in these cases assert a variety of causes of action premised on allegations that the defendants breached fiduciary duties and engaged in prohibited transactions relating to participants in the Aetna 401(k) Plan's investment in company stock between December 3, 2017 and February 20, 2019, claiming losses related to the performance of the Company's LTC business unit. The district court consolidated the actions, and in October 2021, dismissed the consolidated action without prejudice. Plaintiffs filed an amended consolidated complaint, which the Company moved to dismiss. In October 2022, the court granted the Company's motion to dismiss with prejudice. Plaintiffs have appealed this decision to the Second Circuit. The Company also received a related document request pursuant to ERISA § 104(b), to which the Company has responded. The Company and its current and former officers and directors are defending themselves against these claims.

In December 2021, the Company received a demand for inspection of books and records pursuant to Delaware Corporation Law Section 220 (the "Demand"). The Demand purports to be related to potential breaches of fiduciary duties by the Board in relation to certain matters concerning opioids.

Other Legal and Regulatory Proceedings

The Company is also a party to other legal proceedings and is subject to government investigations, inquiries and audits and has received and is cooperating with the government in response to CIDs, subpoenas, or similar process from various governmental agencies requesting information. These other legal proceedings and government actions include claims of or relating to bad faith, medical or professional malpractice, breach of fiduciary duty, claims processing, dispensing of medications, non-compliance with state and federal regulatory regimes, marketing misconduct, denial of or failure to timely or appropriately pay or administer claims and benefits, provider network structure (including the use of performance-based networks and termination of provider contracts), rescission of insurance coverage, improper disclosure or use of personal information, anticompetitive practices, general contractual matters, product liability, intellectual property litigation, and employment litigation. Some of

these other legal proceedings are or are purported to be class actions or derivative claims. The Company is defending itself against the claims brought in these matters.

Awards to the Company and others of certain government contracts, particularly Medicaid contracts and other contracts with government customers in the Company's Health Care Benefits segment, frequently are subject to protests by unsuccessful bidders. These protests may result in awards to the Company being reversed, delayed, or modified. The loss or delay in implementation of any government contract could adversely affect the Company's operating results. The Company will continue to defend contract awards it receives.

There also continues to be a heightened level of review and/or audit by regulatory authorities and legislators of, and increased litigation regarding, the Company's and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including manufacturers' rebates, pricing, the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight, and claim payment practices (including payments to out-of-network providers).

As a leading national health solutions company, the Company regularly is the subject of government actions of the types described above. These government actions may prevent or delay the Company from implementing planned premium rate increases and may result, and have resulted, in restrictions on the Company's businesses, changes to or clarifications of the Company's business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to the Company by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

The Company can give no assurance that its businesses, financial condition, operating results and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iii) pending or future federal or state government investigations of one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting one or more of the industries in which the Company competes and/or the health care industry generally.

17. Segment Reporting

The Company has three operating segments, Health Care Benefits, Pharmacy Services and Retail/LTC, as well as a Corporate/ Other segment. The Company's segments maintain separate financial information, and the Company's chief operating decision maker (the "CODM") evaluates the segments' operating results on a regular basis in deciding how to allocate resources among the segments and in assessing segment performance. The CODM evaluates the performance of the Company's segments based on adjusted operating income, which is defined as operating income (GAAP measure) excluding the impact of amortization of intangible assets and other items, if any, that neither relate to the ordinary course of the Company's business nor reflect the Company's underlying business performance. See the reconciliation of consolidated operating income (GAAP measure) to consolidated adjusted operating income below for further context regarding the items excluded from operating income in determining adjusted operating income. The Company uses adjusted operating income as its principal measure of segment performance as it enhances the Company's ability to compare past financial performance with current performance and analyze underlying business performance and trends. Non-GAAP financial measures the Company discloses, such as consolidated adjusted operating income, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

In 2022, 2021 and 2020, revenues from the federal government accounted for 18%, 17% and 16%, respectively, of the Company's consolidated total revenues, primarily related to contracts with CMS for coverage of Medicare-eligible individuals within the Health Care Benefits segment.

The following is a reconciliation of financial measures of the Company's segments to the consolidated totals:

In millions	Health Care Benefits	Pharmacy Services [1]	Retail/ LTC	Corporate/ Other	Intersegment Eliminations [2]	Consolidated Totals
2022:						
Revenues from external customers	$ 90,844	$ 157,787	$ 72,874	$ 124	$ —	$ 321,629
Intersegment revenues	89	11,449	33,764	—	(45,302)	—
Net investment income (loss)	476	—	(44)	406	—	838
Total revenues	91,409	169,236	106,594	530	(45,302)	322,467
Adjusted operating income (loss)	5,984	7,356	6,705	(1,785)	(728)	17,532
Depreciation and amortization	1,629	567	1,813	238	—	4,247
2021:						
Revenues from external customers	81,515	143,194	66,078	125	—	290,912
Intersegment revenues	85	9,828	34,010	—	(43,923)	—
Net investment income	586	—	17	596	—	1,199
Total revenues	82,186	153,022	100,105	721	(43,923)	292,111
Adjusted operating income (loss)	5,012	6,859	7,623	(1,471)	(711)	17,312
Depreciation and amortization	1,837	576	1,884	215	—	4,512
2020:						
Revenues from external customers	74,926	132,663	60,208	111	—	267,908
Intersegment revenues	58	9,275	30,990	—	(40,323)	—
Net investment income	483	—	—	315	—	798
Total revenues	75,467	141,938	91,198	426	(40,323)	268,706
Adjusted operating income (loss)	6,188	5,688	6,146	(1,306)	(708)	16,008
Depreciation and amortization	1,832	612	1,801	196	—	4,441

(1) Total revenues of the Pharmacy Services segment include approximately $12.6 billion, $11.6 billion and $10.9 billion of retail co-payments for 2022, 2021 and 2020, respectively. See Note 1 ''Significant Accounting Policies'' for additional information about retail co-payments.

(2) Intersegment revenue eliminations relate to intersegment revenue generating activities that occur between the Health Care Benefits segment, the Pharmacy Services segment, and/or the Retail/LTC segment. Intersegment adjusted operating income eliminations occur when members of Pharmacy Services segment clients enrolled in Maintenance Choice® elect to pick up maintenance prescriptions at one of the Company's retail pharmacies instead of receiving them through the mail. When this occurs, both the Pharmacy Services and Retail/LTC segments record the adjusted operating income on a stand-alone basis.

The following is a reconciliation of consolidated operating income to adjusted operating income for the years ended December 31, 2022, 2021 and 2020:

In millions	**2022**	**2021**	**2020**
Operating income (GAAP measure)	$ 7,746	$ 13,193	$ 13,911
Amortization of intangible assets [(1)]	1,808	2,259	2,341
Office real estate optimization charges [(2)]	117	—	—
Gain on divestiture of subsidiaries [(3)]	(475)	—	(269)
Opioid litigation charges [(4)]	5,803	—	—
Loss on assets held for sale [(5)]	2,533	—	—
Acquisition-related integration costs [(6)]	—	132	332
Store impairments [(7)]	—	1,358	—
Goodwill impairment [(8)]	—	431	—
Acquisition purchase price adjustment outside of measurement period [(9)]	—	(61)	—
Receipt of fully reserved ACA risk corridor receivable [(10)]	—	—	(307)
Adjusted operating income	$ 17,532	$ 17,312	$ 16,008

(1) The Company's acquisition activities have resulted in the recognition of intangible assets as required under the acquisition method of accounting which consist primarily of trademarks, customer contracts/relationships, covenants not to compete, technology, provider networks and value of business acquired. Definite-lived intangible assets are amortized over their estimated useful lives and are tested for impairment when events indicate that the carrying value may not be recoverable. The amortization of intangible assets is reflected in the Company's GAAP consolidated statements of operations in operating expenses within each segment. Although intangible assets contribute to the Company's revenue generation, the amortization of intangible assets does not directly relate to the underwriting of the Company's insurance products, the services performed for the Company's customers or the sale of the Company's products or services. Additionally, intangible asset amortization expense typically fluctuates based on the size and timing of the Company's acquisition activity. Accordingly, the Company believes excluding the amortization of intangible assets enhances the Company's and investors' ability to compare the Company's past financial performance with its current performance and to analyze underlying business performance and trends. Intangible asset amortization excluded from the related non-GAAP financial measure represents the entire amount recorded within the Company's GAAP financial statements, and the revenue generated by the associated intangible assets has not been excluded from the related non-GAAP financial measure. Intangible asset amortization is excluded from the related non-GAAP financial measure because the amortization, unlike the related revenue, is not affected by operations of any particular period unless an intangible asset becomes impaired or the estimated useful life of an intangible asset is revised.

(2) In 2022, the office real estate optimization charges primarily relate to the abandonment of leased real estate and the related right-of-use assets and property and equipment in connection with the planned reduction of corporate office real estate space in response to the Company's new flexible work arrangement. The office real estate optimization charges are reflected in the Company's GAAP consolidated statement of operations in operating expenses within the Health Care Benefits, Corporate/Other and Pharmacy Services segments.

(3) In 2022, the gain on divestiture of subsidiaries represents the pre-tax gain on the sale of bswift, which the Company sold in November 2022, and the pre-tax gain on the sale of PayFlex, which the Company sold in June 2022. In 2020, the gain on divestiture of subsidiary represents the pre-tax gain on the sale of the Workers' Compensation business, which the Company sold in July 2020. The gains on divestitures are reflected as a reduction of operating expenses in the Company's GAAP consolidated statements of operations within the Health Care Benefits segment.

(4) In 2022, the opioid litigation charges relate to agreements to resolve substantially all opioid claims against the Company by certain states and governmental entities. The opioid litigation charges are reflected within the Corporate/Other segment.

(5) In 2022, the loss on assets held for sale relates to the LTC reporting unit within the Retail/LTC segment. The Company continually evaluates its portfolio for non-strategic assets. The Company determined that its LTC business was no longer a strategic asset and during the third quarter of 2022 committed to a plan to sell the LTC business. As of September 30, 2022, the LTC business met the criteria for held-for-sale accounting and its net assets were accounted for as assets held for sale. The carrying value of the LTC business was determined to be greater than its estimated fair value less costs to sell and a loss on assets held for sale was recorded during the third quarter of 2022. As of December 31, 2022, the net assets of the LTC business continued to meet the criteria for held-for-sale accounting and during the fourth quarter of 2022, an incremental loss on assets held for sale was recorded to write down the carrying value of the LTC business to its estimated fair value less costs to sell. During 2022, the loss on assets held for sale also relates to the Commercial Business reporting unit within the Health Care Benefits segment. In March 2022, the Company reached an agreement to sell its Thailand business, which was included in the Commercial Business reporting unit. At that time, a portion of the Commercial Business goodwill was specifically allocated to the Thailand business. The net assets of the Thailand business were accounted for as assets held for sale at March 31, 2022. The carrying value of the Thailand business was determined to be greater than its estimated fair value less costs to sell and a loss on assets held for sale was recorded during the first quarter of 2022. The sale of the Thailand business closed in the second quarter of 2022, and the ultimate loss on the sale was not material.

(6) In 2021 and 2020, acquisition-related integration costs relate to the acquisition of Aetna. The acquisition-related integration costs are reflected in the Company's GAAP consolidated statements of operations in operating expenses within the Corporate/Other segment.

(7) In 2021, the store impairment charge relates to the write down of operating lease right-of-use assets and property and equipment in connection with the planned closure of approximately 900 retail stores between 2022 and 2024. The store impairment charge is reflected within the Retail/LTC segment.

(8) In 2021, the goodwill impairment charge relates to an impairment of the remaining goodwill of the LTC reporting unit within the Retail/LTC segment.

(9) In 2021, the Company received $61 million related to a purchase price working capital adjustment for an acquisition completed during the first quarter of 2020. The resolution of this matter occurred subsequent to the acquisition accounting measurement period and is reflected in the Company's GAAP consolidated statement of operations as a reduction of operating expenses within the Health Care Benefits segment.

(10) In 2020, the Company received $313 million owed to it under the ACA's risk corridor program that was previously fully reserved for as payment was uncertain. After considering offsetting items such as the ACA's minimum MLR rebate requirements and premium taxes, the Company recognized pre-tax income of $307 million in the Company's GAAP consolidated statement of operations within the Health Care Benefits segment.

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of CVS Health Corporation

Opinion on Internal Control over Financial Reporting

We have audited CVS Health Corporation'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, CVS Health Corporation (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 2022 consolidated financial statements of the Company and our report dated February 8, 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

Boston, Massachusetts
February 8, 2023

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of CVS Health Corporation

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of CVS Health Corporation (the Company) as of December 31, 2022 and 2021, the related consolidated statements of operations, comprehensive income, shareholders' equity and cash flows for each of the three years in the period ended December 31, 2022, and the related notes (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 8, 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 Matters

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 separate opinions on the critical audit matter or on the accounts or disclosures to which it relates.

Valuation of health care costs payable

Description of the Matter

At December 31, 2022, the incurred but not reported ("IBNR") liabilities represented $7.8 billion of $10.4 billion of health care costs payable. As discussed in Note 1 to the consolidated financial statements, the Company's liability for health care costs payable includes estimated payments for (1) services rendered to members but not yet reported and (2) claims that have been reported but not yet paid, each as of the financial statement date (collectively, "IBNR"). The estimated IBNR liability is developed utilizing actuarial principles and assumptions that include historical and projected claim submission and processing patterns, historical and assumed medical cost trends, historical utilization of medical services, claim inventory levels, changes in membership and product mix, seasonality and other relevant factors to record the actuarial best estimate of health care costs payable. There is significant uncertainty inherent in determining management's actuarial best estimate of health care costs payable. In particular, the estimate is sensitive to the assumed completion factors and the assumed health care cost trend rates.

Auditing management's actuarial best estimate of IBNR reserves for health care costs payable for its products and services involved a high degree of subjectivity in evaluating management's assumptions used in the valuation process.

How We Addressed the Matter in Our Audit

We obtained an understanding, evaluated the design and tested the operating effectiveness of controls over the process for estimating IBNR reserves. This included, among others, controls over the completeness and accuracy of data used in the actuarial projections, the transfer of data between underlying source systems, and the review and approval processes that management has in place for the actuarial principles and assumptions used in estimating the health care costs payable.

To test IBNR reserves, our audit procedures included, among others, testing the completeness and accuracy of the underlying claim and membership data used in the calculation of IBNR reserves. We involved actuarial specialists to assist with our audit procedures, which included, among others, evaluating the methodologies applied by the Company in determining the actuarially determined liability, evaluating management's actuarial principles and assumptions used in their analysis based on historical claim experience, and independently calculating a range of reserve estimates for comparison to management's actuarial best estimate of the liability for health care costs payable. 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 2007.

Boston, Massachusetts
February 8, 2023

Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure.

None.

Item 9A. Controls and Procedures.

Evaluation of disclosure controls and procedures

The Company's Chief Executive Officer and Chief Financial Officer, after evaluating the effectiveness of the design and operation of the Company's disclosure controls and procedures (as defined in Rules 13a-15 (f) and 15d-15(f) under the Securities Exchange Act of 1934) as of December 31, 2022, have concluded that as of such date the Company's disclosure controls and procedures were adequate and effective at a reasonable assurance level and designed to ensure that material information relating to the Company and its consolidated subsidiaries would be made known to such officers on a timely basis.

Management's report on internal control over financial reporting

Management is responsible for establishing and maintaining adequate internal control over financial reporting. The 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 the Company's consolidated 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 Company's consolidated financial statements. In order to ensure the Company's internal control over financial reporting is effective, management regularly assesses such control and did so most recently for its financial reporting as of December 31, 2022.

Management conducted an assessment of the effectiveness of the Company's internal control over financial reporting based on the criteria established in *Internal Control-Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 Framework). This evaluation included review of the documentation, evaluation of the design effectiveness and testing of the operating effectiveness of controls. The Company's system of internal control over financial reporting is enhanced by periodic reviews by the Company's internal auditors, written policies and procedures and a written Code of Conduct adopted by CVS Health Corporation's Board of Directors, applicable to all employees of the Company. In addition, the Company has an internal Disclosure Committee, comprised of management from each functional area within the Company, which performs a separate review of disclosure controls and procedures. There are inherent limitations in the effectiveness of any system of internal control over financial reporting.

Based on management's assessment, management concluded that the Company's internal control over financial reporting is effective and provides reasonable assurance that assets are safeguarded and that the financial records are reliable for preparing financial statements as of December 31, 2022.

Ernst & Young LLP, the Company's independent registered public accounting firm, is appointed by CVS Health Corporation's Board of Directors and ratified by CVS Health Corporation's stockholders. They were engaged to render an opinion regarding the fair presentation of the Company's consolidated financial statements as well as conducting an audit of internal control over financial reporting. Their reports included in Item 8 of this Form 10-K are based upon audits conducted in accordance with the standards of the Public Company Accounting Oversight Board (United States).

Changes in internal control over financial reporting

There has been no change in the Company's internal control over financial reporting identified in connection with the evaluation required by paragraph (d) of Rule 13a-15 or Rule 15d-15 that occurred during the fourth quarter ended December 31, 2022 that has materially affected, or is reasonably likely to materially affect, the Company's internal control over financial reporting.

Item 9B. Other Information.

No events have occurred during the fourth quarter ended December 31, 2022 that would require disclosure under this item.

Item 9C. Disclosure Regarding Foreign Jurisdictions that Prevent Inspections.

None.

PART III

Item 10. Directors, Executive Officers and Corporate Governance.

Information concerning the Executive Officers of CVS Health Corporation is included in Part I of this 10-K pursuant to General Instruction G to Form 10-K.

The sections of the Proxy Statement under the captions "Committees of the Board as of the Annual Meeting," "Code of Conduct," "Audit Committee Report," and "Biographies of our Incumbent Board Nominees" are incorporated herein by reference.

Item 11. Executive Compensation.

The sections of the Proxy Statement under the captions "Non-Employee Director Compensation" and "Executive Compensation and Related Matters," including "Letter from the Management Planning and Development Committee," "Compensation Committee Report," "Compensation Discussion and Analysis" and "Compensation of Named Executive Officers" are incorporated herein by reference.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.

The sections of the Proxy Statement under the captions "Share Ownership of Directors and Certain Executive Officers" and "Share Ownership of Principal Stockholders" are incorporated herein by reference. Those sections contain information concerning security ownership of certain beneficial owners and management and related stockholder matters.

The following table summarizes information about the registrant's common stock that may be issued upon the exercise of options, warrants and rights under all of the Company's equity compensation plans as of December 31, 2022:

	Number of securities to be issued upon exercise of outstanding options, warrants and rights [1] [2] (a)	Weighted average exercise price of outstanding options, warrants and rights (b)	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in first column) [1] (c)
Equity compensation plans approved by stockholders [3]	26,544	$ 75.70	21,341
Equity compensation plans not approved by stockholders [4]	1,800	43.60	—
Total	28,344	74.28	21,341

(1) Shares in thousands.
(2) Consists of: (i) 13,834 shares of common stock underlying outstanding options, (ii) 639 shares of common stock issuable upon the exercise of outstanding stock appreciation rights ("SARs") and (iii) 13,871 shares of common stock issuable on the vesting of outstanding restricted stock units, deferred stock units and performance stock units, assuming target level performance in the case of performance stock units. The number of shares included with respect to outstanding SARs is the number of shares of CVS Health Corporation common stock that would have been issued had the SARs been exercised based on the closing price per share of CVS Health Corporation common stock on December 31, 2022, as reported on the NYSE, which was $93.19.
(3) Consists of the CVS Health 2017 Incentive Compensation Plan.
(4) Consists of the Amended Aetna Inc. 2010 Stock Incentive Plan (the "Aetna Stock Plan"). The Aetna Stock Plan expired on May 21, 2020, therefore there are no securities available for future grants under this plan.

The Aetna Stock Plan was last approved by Aetna's shareholders at Aetna's 2017 Annual Meeting on May 19, 2017. The Company elected to continue to grant awards under the Aetna Stock Plan to employees of Aetna and its subsidiaries following the completion of the Company's acquisition of Aetna. The Aetna Stock Plan was designed to promote the Company's interests and those of its stockholders and to further align the interests of stockholders and employees by tying awards to total return to stockholders, enabling plan participants to acquire additional equity interests in the Company and providing compensation opportunities dependent upon the Company's performance. The Aetna Stock Plan was not submitted to the Company's stockholders and expired on May 21, 2020. Under the Aetna Stock Plan, eligible participants could be granted stock options to

purchase shares of CVS Health Corporation common stock, SARs, time-vesting and/or performance-vesting incentive stock or incentive units and other stock-based awards.

Item 13. Certain Relationships and Related Transactions, and Director Independence.

The sections of the Proxy Statement under the captions “Independence Determinations for Directors” and “Related Person Transaction Policy” are incorporated herein by reference.

Item 14. Principal Accountant Fees and Services.

The section of the Proxy Statement under the caption “Item 2: Ratification of Appointment of Independent Registered Public Accounting Firm for 2022” is incorporated herein by reference.

PART IV

Item 15. Exhibits, Financial Statement Schedules.

The following documents are filed as part of this 10-K:

1. Financial Statements. See "Index to Consolidated Financial Statements" in Item 8 of this 10-K.

2. Financial Statement Schedules. All financial statement schedules are omitted because they are not applicable, not required under the instructions, or the information is included in the consolidated financial statements or related notes.

3. Exhibits. The exhibits listed in the "Index to Exhibits" in this Item 15 are filed or incorporated by reference as part of this 10-K. Exhibits marked with an asterisk (*) are management contracts or compensatory plans or arrangements. Exhibits other than those listed are omitted because they are not required to be listed or are not applicable. Pursuant to Item 601(b)(4)(iii) of Regulation S-K, the Registrant hereby agrees to furnish to the Securities and Exchange Commission a copy of any omitted instrument that is not required to be listed.

INDEX TO EXHIBITS

Exhibit	Description
2	**Plan of acquisition, reorganization, arrangement, liquidation or succession**
2.1	Agreement and Plan of Merger, dated as of September 2, 2022, by and among CVS Pharmacy, Inc., Noah Merger Sub, Inc. and Signify Health, Inc. (incorporated by reference to Exhibit 2.1 of the Registrant's Current Report on Form 8-K filed September 6, 2022).
2.2	Voting Agreement, dated as of September 2, 2022, by and among CVS Pharmacy, Inc. and certain stockholders of Signify Health, Inc. party thereto (incorporated by reference to Exhibit 99.1 of the Registrant's Current Report on Form 8-K filed September 6, 2022).
3	**Articles of Incorporation and Bylaws**
3.1	Restated Certificate of Incorporation of the Registrant dated June 4, 2018 (incorporated by reference to Exhibit 3.1C of Registrant's Current Report on Form 8-K filed June 5, 2018).
3.2	By-Laws of the Registrant, as amended and restated November 17, 2022 (incorporated by reference to Exhibit 3.1 to the Registrant's Current Report on Form 8-K filed November 21, 2022).
4	**Instruments defining the rights of security holders, including indentures**
4.1	Specimen common stock certificate (incorporated by reference to Exhibit 4.1 to the Registration Statement of the Registrant ((then known as CVS Corporation) as successor to Melville Corporation) on Form 8-B filed November 4, 1996).
4.2	Senior Indenture dated August 15, 2006, between the Registrant and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed August 15, 2006).
4.3	Form of the Registrant's 2023 Note (incorporated by reference to Exhibit 4.5 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.4	Form of the Registrant's 2025 Note (incorporated by reference to Exhibit 4.6 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.5	Form of the Registrant's 2028 Note (incorporated by reference to Exhibit 4.7 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.6	Form of the Registrant's 2038 Note (incorporated by reference to Exhibit 4.8 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.7	Form of the Registrant's 2048 Note (incorporated by reference to Exhibit 4.9 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.8	Form of the Registrant's 2024 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed August 15, 2019).
4.9	Form of the Registrant's 2026 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed August 15, 2019).
4.10	Form of the Registrant's 2029 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed August 15, 2019).
4.11	Form of the Registrant's 2027 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed on March 31, 2020).

4.12	Form of the Registrant's 2030 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed on March 31, 2020).
4.13	Form of the Registrant's 2040 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed on March 31, 2020).
4.14	Form of the Registrant's 2050 Note (incorporated by reference to Exhibit 4.4 to the Registrant's Current Report on Form 8-K filed on March 31, 2020).
4.15	Form of the Registrant's 2027 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed on August 21, 2020).
4.16	Form of the Registrant's 2030 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed on August 21, 2020).
4.17	Form of the Registrant's 2040 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed on August 21, 2020).
4.18	Form of the Registrant's 2027 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed on December 16, 2020).
4.19	Form of the Registrant's 2031 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed on December 16, 2020).
4.20	Form of the 2031 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed on August 18, 2021).
4.21	Material terms of outstanding securities that are registered under Section 12 of the 1934 Act as required by Item 202(a)-(d) and (f) of Regulation S-K.
10	**Material Contracts**
10.1*	Five Year Credit Agreement dated as of May 16, 2022, by and among the Registrant, the lenders party thereto, and Bank of America, N.A., as Administrative Agent (incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2022).
10.2*	First Amendment to Five Year Credit Agreement dated as of May 16, 2022, to the Five Year Credit Agreement dated as of May 11, 2021, by and among the Registrant, the lenders party thereto and Bank of America, N.A., as Administrative Agent (incorporated by reference to Exhibit 10.2 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2022).
10.3*	First Amendment to Five Year Credit Agreement dated as of May 16, 2022, to the Five Year Credit Agreement dated as of May 16, 2019, by and among the Registrant, the lenders party thereto and Bank of America, N.A., as Administrative Agent (incorporated by reference to Exhibit 10.3 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2022).
10.4*	Five Year Credit Agreement dated as of May 11, 2021, by and among the Registrant, the lenders party thereto, and Bank of America, N.A., as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2021).
10.5*	Five Year Credit Agreement, dated as of May 16, 2019, by and among the Registrant, the lenders party thereto and Bank of America N.A., as Administrative Agent (incorporated by reference to Exhibit 10.2 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).
10.6*	The Registrant's Supplemental Retirement Plan I for Select Senior Management, as amended and restated as of December 31, 2008 (incorporated by reference to Exhibit 10.6 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2009).
10.7*	Form of Enterprise Non-Competition, Non-Disclosure and Developments Agreement between the Registrant and certain of the Registrant's executive officers (incorporated by reference to Exhibit 10.25 of the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2013).
10.8*	The Registrant's Deferred Stock Compensation Plan, as amended and restated (incorporated by reference to Exhibit 10.11 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2019).
10.9*	The Registrant's 2007 Employee Stock Purchase Plan, as amended (incorporated by reference to Exhibit 99.2 to the Registrant's Registration Statement on Form S-8 filed May 19, 2020).
10.10*	Universal 409A Definition Document, as amended (incorporated by reference to Exhibit 10.28 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
10.11*	The Registrant's Amended and Restated Deferred Compensation Plan (incorporated by reference to Exhibit 10.10 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2021).
10.12*	The Registrant's Partnership Equity Program, as amended (incorporated by reference to Exhibit 10.25 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.13*	The Registrant's Performance-Based Restricted Stock Unit Plan, as amended (incorporated by reference to Exhibit 10.27 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.14*	The Registrant's 2017 Incentive Compensation Plan, as amended (incorporated by reference to Exhibit 99.1 to the Registrant's Registration Statement on Form S-8 filed May 19, 2020).
10.15*	The Registrant's Executive Incentive Plan, as amended (incorporated by reference to Exhibit 10.4 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017).

10.16*	The Registrant's Long-Term Incentive Plan, as amended (incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017).
10.17*	Form of Non-Qualified Stock Option Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.29 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.18*	Form of Restricted Stock Unit Agreement - Annual Grant - between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.30 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.19*	Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.20*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Pre-Tax) (incorporated by reference to Exhibit 10.32 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.21*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Post-Tax) (incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.22*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2018).
10.23*	Form of Performance Stock Unit Agreement (LTIP) - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2018).
10.24*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended September 30, 2020).
10.25*	The Registrant's Management Incentive Plan (incorporated by reference to Exhibit 10.27 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2019).
10.26*	The Registrant's Amended and Restated Severance Plan for Non-Store Employees dated October 11, 2021(incorporated by reference to Exhibit 10.25 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2021).
10.27*	The Registrant's Performance-Based Restricted Stock Unit Program, as amended (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.28*	Form of Non-Qualified Stock Option Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.39 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.29*	Form of Restricted Stock Unit Agreement - Annual Grant - between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.40 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.30*	Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.41 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.31*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Pre-Tax) (incorporated by reference to Exhibit 10.42 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.32*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Post-Tax) (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2013).
10.33*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.5 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).
10.34*	Amended and Restated Employment Agreement between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2008).
10.35*	Amendment dated as of December 21, 2012 to the Amended and Restated Employment Agreement between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012).
10.36*	Form of Non-Qualified Stock Option Agreement - Annual Grant between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.37 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).

10.37*	Form of Restricted Stock Unit Agreement - Annual Grant between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.38*	Amendment dated January 22, 2015 to Nonqualified Stock Option Agreements between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K filed January 23, 2015).
10.39*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).
10.40*	Change in Control Agreement effective as of July 19, 2010 between the Registrant and Eva Boratto (incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2019).
10.41*	Restrictive Covenant Agreement dated June 21, 2019 between the Registrant and Eva Boratto (incorporated by reference to Exhibit 10.48 to the registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2019).
10.42*	Separation Agreement dated June 9, 2021 between CVS Pharmacy, Inc. and Eva C. Boratto (incorporated by reference to Exhibit 10.3 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2021).
10.43*	Change in Control Agreement dated December 22, 2008 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012).
10.44*	Amendment dated as of December 31, 2012 to the Change in Control Agreement dated December 22, 2008 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.34 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012).
10.45*	Restricted Stock Unit Agreement - Annual Grant dated April 1, 2016 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.44 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.46*	Restrictive Covenant Agreement dated May 20, 2016 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.45 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.47*	Change in Control Agreement dated October 1, 2012 between the Registrant and Thomas Moriarty (incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2015).
10.48*	Restrictive Covenant Agreement dated July 8, 2019 between the Registrant and Thomas Moriarty (incorporated by reference to Exhibit 10.56 of the Registrant's Annual Report on form 10-K for the fiscal year ended December 31, 2019).
10.49*	Amended and Restated Employment Agreement dated November 5, 2020 between the Registrant and Karen S. Lynch (incorporated by reference to Exhibit 10.51 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2020).
10.50*	Restrictive Covenant Agreement dated November 6, 2020 between the Registrant and Karen S. Lynch (incorporated by reference to Exhibit 10.52 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2020).
10.51*	Restrictive Covenant Agreement dated September 29, 2020 between the Registrant and Alan Lotvin (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2021).
10.52*	Change in Control Agreement dated October 15, 2012 between the Registrant and Alan Lotvin (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2021).
10.53*	Letter Agreement dated May 16, 2021 between the Registrant and Shawn Guertin (incorporated by reference to Exhibit 10.4 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2021).
10.54*	Restrictive Covenant Agreement dated May 16, 2021 between CVS Pharmacy, Inc. and Shawn Guertin (incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2021).
10.55*	Change in Control Agreement dated May 16, 2021 between the Registrant and Shawn Guertin (incorporated by reference to Exhibit 10.6 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2021).
10.56*	Form of Nonqualified Stock Option Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.55 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2021).
10.57*	Descriptions of certain arrangements not embodied in formal documents as described under the heading "Non-Employee Director Compensation" are incorporated herein by reference to the Proxy Statement (when filed).

10.58*	Form of Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant. (incorporated by reference to Exhibit 10.1 of Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ending March 31, 2022).
10.59*	Form of Performance Stock Unit Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.2 of Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ending March 31, 2022).
10.60*	Form of Nonqualified Stock Option Agreement between the Registrant and selected executives of the Registrant (incorporated by reference to Exhibit 10.3 of Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ending March 31, 2022).
10.61*	Form of Nonqualified Stock Option Agreement between the Registrant and selected executives of the Registrant (incorporated by reference to Exhibit 10.4 of Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ending March 31, 2022).
21	**Subsidiaries of the registrant**
21.1	Subsidiaries of CVS Health Corporation.
23	**Consents of experts and counsel**
23.1	Consent of Ernst & Young LLP.
31	**Rule 13a-14(a)/15d-14(a) Certifications**
31.1	Certification by the Chief Executive Officer.
31.2	Certification by the Chief Financial Officer.
32	**Section 1350 Certifications**
32.1	Certification by the Chief Executive Officer.
32.2	Certification by the Chief Financial Officer.
101	**Interactive Data File**
101	The following materials from the CVS Health Corporation Annual Report on Form 10-K for the fiscal year ended December 31, 2022 formatted in Inline XBRL: (i) the Consolidated Statements of Operations, (ii) the Consolidated Statements of Comprehensive Income, (iii) the Consolidated Balance Sheets, (iv) the Consolidated Statements of Cash Flows, (v) the Consolidated Statements of Shareholders' Equity and (vi) the related Notes to Consolidated Financial Statements. The instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
104	
104	Cover Page Interactive Data File - The cover page from the Company's Annual Report on Form 10-K for the year ended December 31, 2022, formatted in Inline XBRL (included as Exhibit 101).

Item 16. Form 10-K Summary.

None.

SIGNATURES

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

CVS HEALTH CORPORATION

Date: February 8, 2023

By: /s/ SHAWN M. GUERTIN

Shawn M. Guertin
Executive Vice President and Chief Financial Officer

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

Signature	Title(s)	Date
/s/ FERNANDO AGUIRRE **Fernando Aguirre**	Director	February 8, 2023
/s/ JEFFREY R. BALSER, M.D., Ph.D. **Jeffrey R. Balser, M.D., Ph.D.**	Director	February 8, 2023
/s/ C. DAVID BROWN II **C. David Brown II**	Director	February 8, 2023
/s/ JAMES D. CLARK **James D. Clark**	Senior Vice President - Controller and Chief Accounting Officer (Principal Accounting Officer)	February 8, 2023
/s/ ALECIA A. DECOUDREAUX **Alecia A. DeCoudreaux**	Director	February 8, 2023
/s/ NANCY-ANN M. DEPARLE **Nancy-Ann M. DeParle**	Director	February 8, 2023
/s/ ROGER N. FARAH **Roger N. Farah**	Chair of the Board and Director	February 8, 2023
/s/ ANNE M. FINUCANE **Anne M. Finucane**	Director	February 8, 2023
/s/ SHAWN M. GUERTIN **Shawn M. Guertin**	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 8, 2023
/s/ EDWARD J. LUDWIG **Edward J. Ludwig**	Director	February 8, 2023
/s/ KAREN S. LYNCH **Karen S. Lynch**	President and Chief Executive Officer (Principal Executive Officer) and Director	February 8, 2023
/s/ JEAN-PIERRE MILLON **Jean-Pierre Millon**	Director	February 8, 2023
/s/ MARY L. SCHAPIRO **Mary L. Schapiro**	Director	February 8, 2023
/s/ WILLIAM C. WELDON **William C. Weldon**	Director	February 8, 2023

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

(Mark One)

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2021

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: 001-01011

CVS HEALTH CORPORATION
(Exact name of registrant as specified in its charter)

Delaware	**05-0494040**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: **(401) 765-1500**

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

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, par value $0.01 per share	CVS	New York Stock Exchange

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

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act.	☒	Yes	☐	No
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.	☐	Yes	☒	No
Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days.	☒	Yes	☐	No
Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files).	☒	Yes	☐	No

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

Large accelerated filer	☒	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 has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C 7262(b)) by the registered public accounting firm that prepared or issued its audit report.				☒
Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act).	☐	Yes	☒	No

The aggregate market value of the registrant's common stock held by non-affiliates was approximately $109,651,334,285 as of June 30, 2021, based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be affiliates of the registrant.

As of February 2, 2022, the registrant had 1,312,510,426 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The following materials are incorporated by reference into this Form 10-K:

Information contained in the definitive proxy statement for CVS Health Corporation's 2022 Annual Meeting of Stockholders, to be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year ended December 31, 2021 (the "Proxy Statement"), is incorporated by reference in Parts III and IV to the extent described therein.

TABLE OF CONTENTS

Unless the context otherwise requires, references to the terms "we," "our" or "us" used throughout this Annual Report on Form 10-K (this "10-K") refer to CVS Health Corporation (a Delaware corporation), together with its subsidiaries (collectively, "CVS Health" or the "Company"). References to competitors and other companies throughout this 10-K, including the information incorporated herein by reference, are for illustrative or comparison purposes only and are not identifying that these companies are the only competitors or closest competitors of the Company or any of the Company's businesses, products, or services.

CAUTIONARY STATEMENT CONCERNING FORWARD-LOOKING STATEMENTS

The Private Securities Litigation Reform Act of 1995 (the "Reform Act") provides a "safe harbor" for forward-looking statements, so long as (1) those statements are identified as forward-looking, and (2) the statements are accompanied by meaningful cautionary statements that identify important factors that could cause actual results to differ materially from those discussed in the statement. We are taking advantage of these safe harbor provisions.

Certain information contained in this 10-K is forward-looking within the meaning of the Reform Act or SEC rules. This information includes, but is not limited to: "Outlook for 2022" of Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A") included in Item 7, "Quantitative and Qualitative Disclosures About Market Risk" included in Item 7A, "Government Regulation" included in Item 1, and "Risk Factors" included in Item 1A. In addition, throughout this 10-K and our other reports and communications, we use the following words or variations or negatives of these words and similar expressions when we intend to identify forward-looking statements:

· *Anticipates*	· *Believes*	· *Can*	· *Continue*	· *Could*
· *Estimates*	· *Evaluate*	· *Expects*	· *Explore*	· *Forecast*
· *Guidance*	· *Intends*	· *Likely*	· *May*	· *Might*
· *Outlook*	· *Plans*	· *Potential*	· *Predict*	· *Probable*
· *Projects*	· *Seeks*	· *Should*	· *View*	· *Will*

All statements addressing the future operating performance of CVS Health or any segment or any subsidiary and/or future events or developments, including statements relating to the projected impact of coronavirus disease 2019 ("COVID-19") and its emerging new variants on the Company's businesses, investment portfolio, operating results, cash flows and/or financial condition, statements relating to corporate strategy, statements relating to future revenue, operating income or adjusted operating income, earnings per share or adjusted earnings per share, Health Care Benefits segment business, sales results and/or trends, medical cost trends, medical membership, Medicare Part D membership, medical benefit ratios and/or operations, Pharmacy Services segment business, sales results and/or trends and/or operations, Retail/LTC segment business, sales results and/or trends and/or operations, incremental investment spending, interest expense, effective tax rate, weighted-average share count, cash flow from operations, net capital expenditures, cash available for debt repayment, integration synergies, net synergies, integration costs, enterprise modernization, transformation, leverage ratio, cash available for enhancing shareholder value, inventory reduction, turn rate and/or loss rate, debt ratings, the Company's ability to attract or retain customers and clients, store development and/or relocations, new product development, and the impact of industry and regulatory developments, as well as statements expressing optimism or pessimism about future operating results or events, are forward-looking statements within the meaning of the Reform Act.

Forward-looking statements rely on a number of estimates, assumptions and projections concerning future events, and are subject to a number of significant risks and uncertainties and other factors that could cause actual results to differ materially from those statements. Many of these risks and uncertainties and other factors are outside our control. Certain of these risks and uncertainties and other factors are described under "Risk Factors" included in Item 1A of this 10-K; these are not the only risks and uncertainties we face. There can be no assurance that the Company has identified all the risks that may affect it. Additional risks and uncertainties not presently known to the Company or that the Company currently believes to be immaterial also may adversely affect the Company's businesses. If any of those risks or uncertainties develops into actual events, those events or circumstances could have a material adverse effect on the Company's businesses, operating results, cash flows, financial condition and/or stock price, among other effects.

You should not put undue reliance on forward-looking statements. Any forward-looking statement speaks only as of the date of this 10-K, and we disclaim any intention or obligation to update or revise forward-looking statements, whether as a result of new information, future events, uncertainties or otherwise.

PART I

Item 1. Business.

Overview

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health," the "Company," "we," "our" or "us"), is a leading diversified health solutions company, making healthier happen now. In an increasingly connected and digital world, we are meeting people wherever they are and changing health care to meet their needs. The Company has more than 9,900 retail locations, nearly 1,200 walk-in medical clinics, a leading pharmacy benefits manager with approximately 110 million plan members with expanding specialty pharmacy solutions and a dedicated senior pharmacy care business serving more than one million patients per year. The Company also serves an estimated 35 million people through traditional, voluntary and consumer-directed health insurance products and related services, including expanding Medicare Advantage offerings and a leading standalone Medicare Part D prescription drug plan ("PDP"). The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

The Company has four reportable segments: Health Care Benefits, Pharmacy Services, Retail/LTC and Corporate/Other.

Business Strategy

The Company seeks to improve access, lower costs and enhance health outcomes by engaging with consumers when, where and how they desire. This means delivering solutions that are personalized, seamless, connected and increasingly digital. CVS Health is also shifting from transaction-based primary care to addressing holistic health – physical, emotional, social, economic – which will lead to higher quality of care and lower medical costs. The Company is a leader in key segments of health care today through foundational businesses and is seeking to create new sources of value by expanding into next generation primary care delivery and health services, with a goal of improving satisfaction levels for both providers and consumers. The Company believes its consumer-centric strategy will drive sustainable long-term growth and deliver value for all stakeholders.

COVID-19

The COVID-19 pandemic and its emerging new variants continue to impact the U.S. and other countries around the world. Our strong local presence and scale in communities across the country has enabled us to play an indispensable role in the national response to COVID-19, as well as provide seamless support for our customers wherever they need us: in our CVS locations, in their homes, and virtually.

The Company offered COVID-19 diagnostic testing at more than 4,800 CVS Pharmacy® locations, at community-based testing sites in underserved areas and through its Return Ready℠ solution as of December 31, 2021. During 2021, the Company also began selling over-the-counter ("OTC") test kits in its retail locations and online. The Company began administering COVID-19 vaccinations in long-term care facilities and in certain of its retail pharmacies during December 2020 and February 2021, respectively, and began the administration of COVID-19 boosters and pediatric vaccines during the fourth quarter of 2021. The Company offered COVID-19 vaccinations at more than 9,800 CVS Pharmacy locations as of December 31, 2021. During the year ended December 31, 2021, the Company administered more than 32 million COVID-19 tests and more than 59 million COVID-19 vaccines. The Company expects to continue to play a significant role in COVID-19 testing and vaccine administration in the future, while maintaining a strong commitment to testing and vaccine equity by optimizing site locations and targeting outreach initiatives to reach vulnerable populations.

The impact of COVID-19 on the Company's businesses, operating results, cash flows and financial condition in the years ended December 31, 2021 and 2020, as well as information regarding certain expected impacts of COVID-19 on the Company, is discussed throughout this 10-K.

Health Care Benefits Segment

The Health Care Benefits segment operates as one of the nation's leading diversified health care benefits providers, serving an estimated 35 million people as of December 31, 2021. The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make more informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental and behavioral health plans, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services and health information

technology ("HIT") products and services. The Health Care Benefits segment also provided workers' compensation administrative services through its Coventry Health Care Workers' Compensation business ("Workers' Compensation business") prior to the sale of this business on July 31, 2020. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates.

Health Care Benefits Products and Services

The Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk of medical and dental care costs) as "ASC." Health Care Benefits products and services consist of the following:

- *Commercial Medical*: The Health Care Benefits segment offers point-of-service ("POS"), preferred provider organization ("PPO"), health maintenance organization ("HMO") and indemnity benefit ("Indemnity") plans. Commercial medical products also include health savings accounts ("HSAs") and consumer-directed health plans that combine traditional POS or PPO and/or dental coverage, subject to a deductible, with an accumulating benefit account (which may be funded by the plan sponsor and/or the member in the case of HSAs). With the launch of Aetna Virtual Primary Care™ in 2021, eligible members now have access to health services remotely, paired with access to in-person visits with providers in the Company's network, including at MinuteClinic® and CVS HealthHUB® locations. Principal products and services are targeted specifically to large multi-site national, mid-sized and small employers, individual insureds and expatriates. The Company offers medical stop loss insurance coverage for certain employers who elect to self-insure their health benefits. Under medical stop loss insurance products, the Company assumes risk for costs associated with large individual claims and/or aggregate loss experience within an employer's plan above a pre-set annual threshold. The segment also has a portfolio of additional health products and services that complement its medical products such as dental plans, behavioral health and employee assistance products, provider network access and vision products.
- *Government Medical*: In select geographies, the Health Care Benefits segment offers Medicare Advantage plans, Medicare Supplement plans and prescription drug coverage for Medicare beneficiaries; participates in Medicaid and subsidized Children's Health Insurance Programs ("CHIP"); and participates in demonstration projects for members who are eligible for both Medicare and Medicaid ("Duals"). These Government Medical products are further described below:
    - *Medicare Advantage:* Through annual contracts with the U.S. Centers for Medicare & Medicaid Services ("CMS"), the Company offers HMO and PPO products for eligible individuals in certain geographic areas through the Medicare Advantage program. Members typically receive enhanced benefits over traditional fee-for-service Medicare coverage ("Original Medicare"), including reduced cost-sharing for preventive care, vision and other services. The Company offered network-based HMO and/or PPO plans in 46 states and Washington, D.C. in 2021. For certain qualifying employer groups, the Company offers Medicare PPO products nationally. When combined with the Company's PDP product, these national PPO plans form an integrated national Insured Medicare product for employers that provides medical and pharmacy benefits.
    - *Medicare PDP:* The Company is a national provider of drug benefits under the Medicare Part D prescription drug program. All Medicare eligible individuals are eligible to participate in this voluntary prescription drug plan. Members typically receive coverage for certain prescription drugs, usually subject to a deductible, co-insurance and/or co-payment. The Company offered PDP plans in all 50 states and Washington, D.C. in 2021. On November 30, 2018, the Company completed the sale of the standalone PDPs of Aetna, Inc. ("Aetna") to WellCare Health Plans, Inc. effective December 31, 2018. The Company provided administrative services to, and retained the financial results of, the divested plans through 2019. Subsequent to 2019, the Company no longer retains the financial results of the divested plans.
    - *Medicare Supplement:* For certain Medicare eligible members, the Company offers supplemental coverage for certain health care costs not covered by Original Medicare. The products included in the Medicare Supplement portfolio help to cover some of the gaps in Original Medicare, and include coverage for Medicare deductibles and coinsurance amounts. The Company offered a wide selection of Medicare Supplement products in 49 states and Washington, D.C. in 2021.
    - *Medicaid and CHIP:* The Company offers health care management services to individuals eligible for Medicaid and CHIP under multi-year contracts with government agencies in various states that are subject to annual appropriations. CHIP are state-subsidized insurance programs that provide benefits for families with uninsured children. The Company offered these services on an Insured or ASC basis in 16 states in 2021.
    - *Duals:* The Company provides health coverage to beneficiaries who are dually eligible for both Medicare and Medicaid coverage. These members must meet certain income and resource requirements in order to qualify for

this coverage. The Company coordinates 100% of the care for these members and may provide them with additional services in order to manage their health care costs.

The Company also has a portfolio of transformative products and services aimed at creating a holistic and integrated approach to individual health and wellness. These products and services complement the Commercial Medical and Government Medical products and aim to provide innovative solutions, create integrated experience offerings and enable enhanced care delivery to customers.

Health Care Benefits Provider Networks

The Company contracts with physicians, hospitals and other providers for services they provide to the Company's members. The Company uses a variety of techniques designed to help encourage appropriate utilization of medical services ("utilization") and maintain affordability of quality coverage. In addition to contracts with providers for negotiated rates of reimbursement, these techniques include creating risk sharing arrangements that align economic incentives with providers, the development and implementation of guidelines for the appropriate utilization and the provision of data to providers to enable them to improve health care quality. At December 31, 2021, the Company's underlying nationwide provider network had approximately 1.5 million participating providers. Other providers in the Company's provider networks also include laboratory, imaging, urgent care and other freestanding health facilities.

Health Care Benefits Quality Assessment

CMS uses a 5-star rating system to monitor Medicare health care and drug plans and ensure that they meet CMS's quality standards. CMS uses this rating system to provide Medicare beneficiaries with a tool that they can use to compare the overall quality of care and level of customer service of companies that provide Medicare health care and drug plans. The rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management and overall customer satisfaction. See "Health Care Benefits Pricing" below in this Item 1 for further discussion of star ratings. The Company seeks Health Plan accreditation for Aetna HMO plans from the National Committee for Quality Assurance ("NCQA"), a private, not-for-profit organization that evaluates, accredits and certifies a wide range of health care organizations. Health care plans seeking accreditation must pass a rigorous, comprehensive review and must annually report on their performance.

Aetna Life Insurance Company ("ALIC"), a wholly-owned subsidiary of the Company, has received nationwide NCQA PPO Health Plan accreditation. As of December 31, 2021, all of the Company's Commercial HMO and all of ALIC's PPO members who were eligible participated in HMOs or PPOs that are accredited by the NCQA.

The Company's provider selection and credentialing/re-credentialing policies and procedures are consistent with NCQA and URAC, a health care accrediting organization that establishes quality standards for the health care industry, as well as state and federal, requirements. In addition, the Company is certified under the NCQA Credentials Verification Organization ("CVO") certification program for all certification options and has URAC CVO accreditation.

Quality assessment programs for contracted providers who participate in the Company's networks begin with the initial review of health care practitioners. Practitioners' licenses and education are verified, and their work history is collected by the Company or in some cases by the practitioner's affiliated group or organization. The Company generally requires participating hospitals to be certified by CMS or accredited by The Joint Commission, the American Osteopathic Association, or Det Norske Veritas Healthcare.

The Company also offers quality and outcome measurement programs, quality improvement programs, and health care data analysis systems to providers and purchasers of health care services.

Health Care Benefits Information Systems

The Health Care Benefits segment currently operates and supports an end-to-end suite of information technology platforms to support member engagement, enrollment, health benefit administration, care management, service operations, financial reporting and analytics. The multiple platforms are supported by an integration layer to facilitate the transfer of real-time data. There is continued focus and investment in enterprise data platforms, cloud capabilities, digital products to offer innovative solutions and a seamless experience to the Company's members through mobile and web channels. The Company is making concerted investments in emerging technology capabilities such as voice, artificial intelligence and robotics to further automate, reduce cost and improve the experience for all of its constituents. The Health Care Benefits segment is utilizing the

full breadth of the Company's assets to build enterprise technology that will help guide our members through their health care journey, provide them a high level of service, enable healthier outcomes and encourage them to take next best actions to lead healthier lives.

Health Care Benefits Customers

Medical membership is dispersed throughout the United States, and the Company also serves medical members in certain countries outside the United States. The Company offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, many of which are available nationwide. Depending on the product, the Company markets to a range of customers including employer groups, individuals, college students, part-time and hourly workers, health plans, providers, governmental units, government-sponsored plans, labor groups and expatriates. For additional information on medical membership, see "Health Care Benefits Segment" in the Management's Discussion and Analysis of Financial Condition and Results of Operations (the "MD&A") included in Item 7 of this 10-K.

The Company markets both Commercial Insured and ASC products and services primarily to employers that sponsor the Company's products for the benefit of their employees and their employees' dependents. Frequently, larger employers offer employees a choice among coverage options, from which the employee makes his or her selection during a designated annual open enrollment period. Typically, employers pay all of the monthly premiums to the Company and, through payroll deductions, obtain reimbursement from employees for a percentage of the premiums that is determined by each employer. Some Health Care Benefits products are sold directly to employees of employer groups on a fully employee-funded basis. In some cases, the Company bills the covered individual directly. In addition, effective January 2022, the Company entered the individual public health insurance exchanges ("Public Exchanges") in eight states through which it sells Insured plans directly to individual consumers.

The Company offers Insured Medicare coverage on an individual basis as well as through employer groups to their retirees. Medicaid and CHIP members are enrolled on an individual basis. The Company also offers Insured health care coverage to members who are dually-eligible for both Medicare and Medicaid.

Health Care Benefits products are sold through: the Company's sales personnel; independent brokers, agents and consultants who assist in the production and servicing of business; as well as private health insurance exchanges ("Private Exchanges") and Public Exchanges (together with Private Exchanges, "Insurance Exchanges"). For large employers or other entities that sponsor the Company's products ("plan sponsors"), independent consultants and brokers are frequently involved in employer health plan selection decisions and sales. In some instances, the Company may pay commissions, fees and other amounts to brokers, agents, consultants and sales representatives who place business with the Company. In certain cases, the customer pays the broker for services rendered, and the Company may facilitate that arrangement by collecting the funds from the customer and transmitting them to the broker. The Company supports marketing and sales efforts with an advertising program that may include television, radio, billboards, print media and social media, supplemented by market research and direct marketing efforts.

The U.S. federal government is a significant customer of the Health Care Benefits segment through contracts with CMS for coverage of Medicare-eligible individuals and federal employee-related benefit programs. Other than the contracts with CMS, the Health Care Benefits segment is not dependent upon a single customer or a few customers the loss of which would have a significant effect on the earnings of the segment. The loss of business from any one, or a few, independent brokers or agents would not have a material adverse effect on the earnings of the Health Care Benefits segment. In 2021, 2020 and 2019, Health Care Benefits segment revenues from the federal government accounted for 14%, 13% and 13%, respectively, of the Company's consolidated total revenues. Contracts with CMS for coverage of Medicare-eligible individuals in the Health Care Benefits segment accounted for approximately 79%, 78% and 76%, respectively, of the Company's consolidated revenues from the federal government in 2021, 2020 and 2019.

Health Care Benefits Pricing

For Commercial Insured plans, contracts containing the pricing and other terms of the relationship are generally established in advance of the policy period and typically have a duration of one year. Fees under ASC plans are generally fixed for a period of one year.

Generally, a fixed premium rate is determined at the beginning of the policy period for Commercial Insured plans. The Company typically cannot recover unanticipated increases in health care and other benefit costs in the current policy period; however, it may consider prior experience for a product in the aggregate or for a specific customer, among other factors, in

determining premium rates for future policy periods. Where required by state laws, premium rates are filed and approved by state regulators prior to contract inception. Future operating results could be adversely affected if the premium rates requested are not approved or are adjusted downward or their approval is delayed by state or federal regulators.

The Company has Medicare Advantage and PDP contracts with CMS to provide HMO, PPO and prescription drug coverage to Medicare beneficiaries in certain geographic areas. Under these annual contracts, CMS pays the Company a fixed per member (or "capitation") payment and/or a portion of the premium, both of which are based on membership and adjusted for demographic and health risk factors. CMS also considers inflation, changes in utilization patterns and average per capita fee-for-service Medicare costs in the calculation of the fixed capitation payment or premium. PDP contracts also provide a risk-sharing arrangement with CMS to limit the Company's exposure to unfavorable expenses or benefit from favorable expenses. Amounts payable to the Company under the Medicare arrangements are subject to annual revision by CMS, and the Company elects to participate in each Medicare service area or region on an annual basis. Premiums paid to the Company for Medicare products are subject to federal government reviews and audits, which can result, and have resulted, in retroactive and prospective premium adjustments and refunds to the government and/or members. In addition to payments received from CMS, some Medicare Advantage products and all PDP products require a supplemental premium to be paid by the member or sponsoring employer. In some cases these supplemental premiums are adjusted based on the member's income and asset levels. Compared to Commercial Medical products, Medicare contracts generate higher per member per month revenues and higher health care and other benefit costs.

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA") ties a portion of each Medicare Advantage plan's reimbursement to the plan's "star ratings." Plans must have a star rating of four or higher (out of five) to qualify for bonus payments. CMS released the Company's 2022 star ratings in October 2021. The Company's 2022 star ratings will be used to determine which of the Company's Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2023. Based on the Company's membership at December 31, 2021, 87% of the Company's Medicare Advantage members were in plans with 2022 star ratings of at least 4.0 stars, compared to 83% of the Company's Medicare Advantage members being in plans with 2021 star ratings of at least 4.0 stars based on the Company's membership at December 31, 2020.

Rates for Medicare Supplement products are regulated at the state level and vary by state and plan.

Under Insured Medicaid contracts, state government agencies pay the Company fixed monthly rates per member that vary by state, line of business and demographics; and the Company arranges, pays for and manages the health care services provided to Medicaid beneficiaries. These rates are subject to change by each state, and, in some instances, provide for adjustment for health risk factors. CMS requires these rates to be actuarially sound. The Company also receives fees from customers where it provides services under ASC Medicaid contracts. ASC Medicaid contracts generally are for periods of more than one year, and certain of them contain performance incentives and limited financial risk sharing with respect to certain medical, financial and operational metrics. Under these arrangements, performance is evaluated annually, with associated financial incentive opportunities, and financial risk share obligations are typically limited to a percentage of the fees otherwise payable to the Company. Payments to the Company under Medicaid contracts are subject to the annual appropriation process in the applicable state.

Under Duals contracts, the rate setting process is generally established by CMS in partnership with the state government agency participating in the demonstration project. Both CMS and the state government agency may seek premium and other refunds under certain circumstances, including if the Company fails to comply with CMS regulations or other contractual requirements.

The Company offers HMO and consumer-directed medical and dental plans to federal employees under the Federal Employees Health Benefits ("FEHB") Program and the Federal Employees Dental and Vision Insurance Program. Premium rates and fees for those plans are subject to federal government review and audit, which can result, and have resulted, in retroactive and prospective premium and fee adjustments and refunds to the government and/or members.

Beginning in 2014, the ACA imposed significant new industry-wide fees, assessments and taxes, including an annual levy known as the health insurer fee (the "HIF"). The HIF applied for 2020 and was temporarily suspended for 2019. In December 2019, the HIF was repealed for calendar years after 2020. For additional information on the ACA fees, assessments and taxes, see Note 1 ''Significant Accounting Policies'' included in Item 8 of this 10-K. The Company's goal is to collect premiums and fees where possible, or solve for, all of the ACA-related fees, assessments and taxes.

Health Care Benefits Seasonality

The Health Care Benefits segment's quarterly operating income progression is also impacted by (i) the seasonality of benefit costs which generally increase during the year as Insured members progress through their annual deductibles and out-of-pocket expense limits and (ii) the seasonality of operating expenses, which are generally the highest during the fourth quarter due primarily to spending to support readiness for the start of the upcoming plan year and marketing associated with Medicare annual enrollment.

During the year ended December 31, 2021, the customary quarterly operating income progression was impacted by COVID-19. While overall medical costs in the first quarter were generally consistent with historical baseline levels in the aggregate, the segment experienced increased COVID-19 testing and treatment costs and lower Medicare risk-adjusted revenue. During the second quarter, COVID-19 testing and treatment costs persisted, however at levels significantly lower than those observed during the first quarter. Beginning in the third quarter, medical costs once again increased primarily driven by the spread of the emerging new variants of COVID-19, which resulted in increased testing and treatment costs that continued throughout the fourth quarter.

During the year ended December 31, 2020, the customary quarterly operating income progression was also impacted by COVID-19. Beginning in mid-March, the health care system experienced a significant reduction in utilization that is discretionary and the cancellation of elective medical procedures. Utilization remained below historical levels through April, began to recover in May and June and reached more normal levels in the third and fourth quarters, with select geographies impacted by COVID-19 waves. The impact of the deferral of non-essential care was partially offset by COVID-19 testing and treatment costs, as well as planned COVID-19 related investments.

Health Care Benefits Competition

The health care benefits industry is highly competitive, primarily due to a large number of for-profit and not-for-profit competitors, competitors' marketing and pricing and a proliferation of competing products, including new products that are continually being introduced into the marketplace. New entrants into the marketplace, as well as consolidation within the industry, have contributed to and are expected to intensify the competitive environment. In addition, the rapid pace of change as the industry evolves towards a consumer-focused retail marketplace, including Insurance Exchanges, and the increased use of technology to interact with members, providers and customers, increase the risks the Company currently faces from new entrants and disruptive actions by existing competitors compared to prior periods.

The Company believes that the significant factors that distinguish competing health plans include the perceived overall quality (including accreditation status), quality of service, comprehensiveness of coverage, cost (including premium rates, provider discounts and member out-of-pocket costs), product design, financial stability and ratings, breadth and quality of provider networks, ability to offer different provider network options, providers available in such networks, and quality of member support and care management programs. The Company believes that it is competitive on each of these factors. The Company's ability to increase the number of persons covered by its health plans or to increase Health Care Benefits segment revenues is affected by its ability to differentiate itself from its competitors on these factors. Competition may also affect the availability of services from providers, including primary care physicians, specialists and hospitals.

Insured products compete with local and regional health care benefits plans, health care benefits and other plans sponsored by other large commercial health care benefit insurance companies, health system owned health plans, new entrants into the marketplace and numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association. The largest competitor in Medicare products is Original Medicare. Additional Health Care Benefits segment competitors include other types of medical and dental provider organizations, various specialty service providers (including pharmacy benefit management ("PBM") services providers), health care consultants, financial services companies, integrated health care delivery organizations (networks of providers who also coordinate administrative services for and assume insurance risk of their members), third party administrators ("TPAs"), HIT companies and, for certain plans, programs sponsored by the federal or state governments. Emerging competitors include start up health care benefits plans, technology companies, provider-owned health plans, new joint ventures (including not-for-profit joint ventures among firms from multiple industries), technology firms, financial services firms that are distributing competing products on their proprietary Private Exchanges, and consulting firms that are distributing competing products on their proprietary Private Exchanges, as well as non-traditional distributors such as retail companies. The Company's ability to increase the number of persons enrolled in Insured Commercial Medical products also is affected by the desire and ability of employers to self-fund their health coverage.

The Health Care Benefits segment's ASC plans compete primarily with other large commercial health care benefit companies, numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association and TPAs.

The Health Care Benefits segment's international products compete with local, global and U.S.-based health plans and commercial health care benefit insurance companies, many of whom are licensed in more geographies and have a longer operating history, better brand recognition and greater marketplace presence in one or more geographies.

The provider solutions and HIT marketplaces and products are evolving rapidly. The Company competes for provider solutions and HIT business with other large health plans and commercial health care benefit insurance companies as well as information technology companies and companies that specialize in provider solutions and HIT. Many information technology product competitors have longer operating histories, better brand recognition, greater marketplace presence and more experience in developing innovative products.

In addition to competitive pressures affecting the Company's ability to obtain new customers or retain existing customers, the Health Care Benefits segment's medical membership has been and may continue to be adversely affected by adverse and/or uncertain economic conditions and reductions in workforce by existing customers due to adverse and/or uncertain general economic conditions, especially in the United States and industries where such membership is concentrated.

Health Care Benefits Reinsurance

The Company currently has several reinsurance agreements with non-affiliated insurers that relate to Health Care Benefits insurance policies. The Company entered into these contracts to reduce the risk of catastrophic losses which in turn reduces capital and surplus requirements. The Company frequently evaluates reinsurance opportunities and refines its reinsurance and risk management strategies on a regular basis.

Pharmacy Services Segment

The Pharmacy Services segment provides a full range of PBM solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services and mail order pharmacy. In addition, through the Pharmacy Services segment, the Company provides specialty pharmacy and infusion services, clinical services, disease management services, medical spend management and pharmacy and/or other administrative services for providers and federal 340B drug pricing program covered entities ("Covered Entities"). The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, PDPs, Medicaid managed care ("Managed Medicaid") plans, plans offered on Insurance Exchanges and other sponsors of health benefit plans throughout the United States and Covered Entities. The Pharmacy Services segment includes retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services. During the year ended December 31, 2021, the Company's PBM filled or managed 2.2 billion prescriptions on a 30-day equivalent basis.

PBM Services

The Company dispenses prescription drugs directly through its mail order dispensing and specialty mail order pharmacies and through pharmacies in its retail network. All prescriptions processed by the Company are analyzed, processed and documented by the Company's proprietary prescription management systems. These systems provide essential features and functionality to allow plan members to utilize their prescription drug benefits. These systems also streamline the process by which prescriptions are processed by staff and network pharmacists by enhancing review of various items through automation, including plan eligibility, early refills, duplicate dispensing, appropriateness of dosage, drug interactions or allergies, over-utilization and potential fraud.

Plan Design Offerings and Administration
The Company assists its PBM clients in designing pharmacy benefit plans that help improve health outcomes while minimizing the costs to the client. The Company also assists PBM clients in monitoring the effectiveness of their plans through frequent, informal communications, the use of proprietary software, as well as through formal annual, quarterly and sometimes monthly performance reviews. The Company administers pharmacy benefit plans for clients who contract with it to facilitate prescription drug coverage and claims processing for their eligible plan members. The Company also provides administrative services for Covered Entities.

The Company makes recommendations to help PBM clients design benefit plans that promote the use of lower cost, clinically appropriate drugs and helps its PBM clients control costs by recommending plan designs that encourage the use of generic equivalents of brand name drugs when such equivalents are available. Clients also have the option, through plan design, to further lower their pharmacy benefit plan costs by setting different member payment levels for different products on their drug lists or "formularies," which helps guide members to choose lower cost alternatives through appropriate financial incentives.

Formulary Management
The Company utilizes an independent panel of doctors, pharmacists and other medical experts, referred to as the CVS Caremark National Pharmacy and Therapeutics Committee, to review and approve the selection of drugs that meet the Company's standards of safety and efficacy for inclusion on one of the Company's template formularies. The Company's formularies provide recommended products in numerous drug classes to help ensure member access to clinically appropriate drugs with alternatives within a class under the client's pharmacy benefit plan, while helping to drive the lowest net cost for clients that select one of the Company's formularies. To help improve clinical outcomes for members and clients, the Company conducts ongoing, independent reviews of all drugs, including those appearing on the formularies and generic equivalent products. Many of the Company's clients choose to adopt a template formulary offering as part of their plan design. PBM clients are given capabilities to offer real time benefits information for a member's specific plan design, provided digitally at the point of prescribing, at the CVS pharmacy and directly to members.

Retail Pharmacy Network Management Services
The Company maintains a national network of approximately 66,000 retail pharmacies, consisting of approximately 40,000 chain pharmacies (which includes CVS Pharmacy locations) and approximately 26,000 independent pharmacies, in the United States, including Puerto Rico, the District of Columbia, Guam and the U.S. Virgin Islands. When a customer fills a prescription in a retail pharmacy, the pharmacy sends prescription data electronically to the Company from the point-of-sale. This data interfaces with the Company's proprietary prescription management systems, which verify relevant plan member data and eligibility, while also performing a drug utilization review to help evaluate clinical appropriateness and safety and confirming that the pharmacy will receive payment for the prescription. The Company also offers a performance program for non-Medicare customers, which can be implemented with either the Company's broad, national network or with any managed network (as allowed by applicable laws and regulations). Under the program, high performing pharmacies are eligible to receive an incremental positive performance payment. The program aligns with key Healthcare Effectiveness Data Information Set measures utilized by CMS and is funded by client fees.

Mail Order Pharmacy Services
The Pharmacy Services segment operates mail order dispensing pharmacies in the United States. Plan members or their prescribers submit prescriptions or refill requests, primarily for maintenance medications, to these pharmacies, and staff pharmacists review these prescriptions and refill requests with the assistance of the Company's prescription management systems. This review may involve communications with the prescriber and, with the prescriber's approval when required, can result in generic substitution, therapeutic interchange or other actions designed to help reduce cost and/or improve quality of treatment. The Company's mail order dispensing pharmacies have been awarded Mail Service Pharmacy accreditation from URAC.

Specialty Pharmacy and Infusion Services
The Pharmacy Services segment operates specialty mail order pharmacies, retail specialty pharmacy stores and branches for infusion and enteral nutrition services in the United States. The specialty mail order pharmacies are used for delivery of advanced medications to individuals with chronic or genetic diseases and disorders. The Company's specialty mail order pharmacies have been awarded Specialty Pharmacy accreditation from URAC. Substantially all of the Company's specialty mail order pharmacies also have been accredited by The Joint Commission and the Accreditation Commission for Health Care ("ACHC"), which are independent, not-for-profit organizations that accredit and certify health care programs and organizations in the United States. The ACHC accreditation includes an additional accreditation by the Pharmacy Compounding Accreditation Board, which certifies compliance with the highest level of pharmacy compounding standards.

Clinical Services
The Company offers multiple clinical programs and services to help clients manage overall pharmacy and health care costs in a clinically appropriate manner. These programs are primarily designed to promote better health outcomes and to help target inappropriate medication utilization and non-adherence to medication, each of which may result in adverse medical events that negatively affect member health and client pharmacy and medical spend. These programs include utilization management ("UM"), medication management, quality assurance, adherence and counseling programs to complement the client's plan design and clinical strategies. To help address prescription opioid abuse and misuse, the Company introduced an industry-leading UM approach that limits to seven days the supply of opioids dispensed for certain acute prescriptions for patients who

are new to therapy, limits the daily dosage of opioids dispensed based on the strength of the opioid and requires the use of immediate-release formulations of opioids before extended-release opioids are dispensed. The Company's Pharmacy Advisor® program facilitates pharmacist counseling, both face-to-face and over the telephone, to help participating plan members with certain chronic diseases, such as diabetes and cardiovascular conditions, to identify gaps in care, adhere to their prescribed medications and manage their health conditions. The Company also has digital connectivity that helps to lower drug costs for patients by providing expanded visibility to lower cost alternatives through enhanced analytics and data sharing.

Disease Management Programs
The Company's clinical programs and services utilize advanced protocols and offer clients convenience in working with providers and other third parties. The Company's care management program covers diseases such as rheumatoid arthritis, Parkinson's disease, epilepsy and multiple sclerosis and is accredited by the NCQA. The Company's UM program covers similar diseases and is accredited by the NCQA and URAC.

Medical Benefit Management
The Company's NovoLogix® online preauthorization tool helps identify and capture cost savings opportunities for specialty drugs billed under the medical benefit by identifying outliers to appropriate dosages and costs, and helps to ensure clinically appropriate use of specialty drugs.

Group Purchasing Organization Services
The Company operates a group purchasing organization that negotiates pricing for the purchase of pharmaceuticals and rebates with pharmaceutical manufacturers on behalf of its participants. The Company also provides various administrative, management and reporting services to pharmaceutical manufacturers.

Pharmacy Services Information Systems

The Pharmacy Services segment's claim adjudication platform incorporates architecture that centralizes the data generated from filling mail order prescriptions, adjudicating retail pharmacy claims and delivering other solutions to PBM clients. The Health Engagement Engine® technology and proprietary clinical algorithms help connect the various parts of the enterprise and serve an essential role in cost management and health improvement, leveraging cloud-native technologies and practices. This capability transforms pharmacy data into actionable interventions at key points of care, including in retail, mail and specialty pharmacies as well as in customer care call center operations, leveraging our enterprise data platform to improve the quality of care. The technology leverages assisted artificial intelligence to deliver insights to the business and bring automation to otherwise manual tasks. Specialty services also connects with our claim adjudication platform and various health plan adjudication platforms with a centralized architecture servicing many clients and members. Operating services, such as Specialty Expedite®, provide an interconnected onboarding solution for specialty medications and branding solutions ranging from fulfillment to total patient management. These services are managed through our new innovative specialty workflow and web platform.

Pharmacy Services Clients

The Company's Pharmacy Services clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D plans, Managed Medicaid plans and plans offered on Insurance Exchanges and other sponsors of health benefit plans throughout the United States and Covered Entities. Pharmaceuticals are provided to eligible members in benefit plans maintained by clients and utilize the Company's information systems, among other things, to help perform safety checks, drug interaction screening and identify opportunities for generic substitution. Substantially all of the Pharmacy Services segment's revenues are generated from dispensing and managing prescription drugs to eligible members in benefit plans maintained by clients.

Pharmacy Services Seasonality

The majority of Pharmacy Services segment revenues are not seasonal in nature.

Pharmacy Services Competition

The Company believes the primary competitive factors in the pharmacy services industry include: (i) the ability to negotiate favorable discounts from drug manufacturers as well as to negotiate favorable discounts from, and access to, retail pharmacy networks; (ii) the ability to identify and apply effective cost management programs utilizing clinical strategies, including the development and utilization of preferred formularies; (iii) the ability to market PBM products and services; (iv) the commitment

to provide flexible, clinically-oriented services to clients and be responsive to clients' needs; (v) the quality, scope and costs of products and services offered to clients and their members; and (vi) operational excellence in delivering services. The Pharmacy Services segment has a significant number of competitors offering PBM services, including large, national PBM companies (e.g., Prime Therapeutics and MedImpact), PBMs owned by large national health plans (e.g., the Express Scripts business of Cigna Corporation and the OptumRx business of UnitedHealth) and smaller standalone PBMs.

Retail/LTC Segment

The Retail/LTC segment sells prescription drugs and a wide assortment of health and wellness products and general merchandise, provides health care services through its MinuteClinic walk-in medical clinics, provides medical diagnostic testing, administers vaccinations for illnesses such as influenza, COVID-19 and shingles and conducts long-term care pharmacy ("LTC") operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to long-term care facilities and other care settings. As of December 31, 2021, the Retail/LTC segment operated more than 9,900 retail locations, nearly 1,200 MinuteClinic locations as well as online retail pharmacy websites, LTC pharmacies and on-site pharmacies. During the year ended December 31, 2021, the Retail/LTC segment filled 1.6 billion prescriptions on a 30-day equivalent basis. For the year ended December 31, 2021, the Company dispensed approximately 26.4% of the total retail pharmacy prescriptions in the United States.

Retail/LTC Products and Services

A typical retail store sells prescription drugs and a wide assortment of high-quality, nationally advertised brand name and proprietary brand merchandise. Pharmacy locations may also contract with Covered Entities under the federal 340B drug pricing program. Front store categories include over-the-counter drugs, consumer health products, beauty products and personal care products. LTC operations include distribution of prescription drugs and related consulting and ancillary services. The Company purchases merchandise from numerous manufacturers and distributors. The Company believes that competitive sources are readily available for substantially all of the products carried in its retail stores and the loss of any one supplier would not likely have a material effect on the Retail/LTC segment. The Company's MinuteClinic locations offer a variety of health care services.

Retail/LTC revenues by major product group are as follows:

	Percentage of Revenues		
	2021	2020	2019
Pharmacy [1]	76.0 %	76.9 %	76.7 %
Front store and other [2]	24.0 %	23.1 %	23.3 %
	100.0 %	100.0 %	100.0 %

(1) Pharmacy includes LTC sales and sales in pharmacies within Target Corporation ("Target") and other retail stores.
(2) "Other" represents less than 12% of the "Front store and other" revenue category in all periods presented.

Pharmacy
Pharmacy revenues represented approximately three-fourths of Retail/LTC segment revenues in each of 2021, 2020 and 2019. The Company believes that retail pharmacy operations will continue to represent a critical part of the Company's business due to industry demographics, e.g., an aging American population consuming a greater number of prescription drugs, prescription drugs being used more often as the first line of defense for managing illness, the introduction of new pharmaceutical products, the need for vaccinations, including the COVID-19 vaccination, and Medicare Part D growth. The Company believes the retail pharmacy business benefits from investment in both people and technology, as well as innovative collaborations with health plans, PBMs and providers. Given the nature of prescriptions, consumers want their prescriptions filled accurately by professional pharmacists using the latest tools and technology, and ready when promised. Consumers also need medication management programs and better information to help them get the most out of their health care dollars. To assist consumers with these needs, the Company has introduced integrated pharmacy health care services that provide an earlier, easier and more effective approach to engaging consumers in behaviors that can help lower costs, improve health and save lives.

Front Store
Front store revenues reflect the Company's strategy of innovating with new and unique products and services, using innovative personalized marketing and adjusting the mix of merchandise to match customers' needs and preferences. A key component of the front store strategy is the ExtraCare® card program, which is one of the largest and most successful retail loyalty programs in the United States. The ExtraCare program allows the Company to balance marketing efforts so it can reward its best

customers by providing them with automatic sale prices, customized coupons, ExtraBucks® rewards and other benefits. The Company also offers a subscription-based membership program, CarePass®, under which members are entitled to a suite of benefits delivered over the course of the subscription period, as well as a promotional reward that can be redeemed for future goods and services. The Company continues to launch and enhance new and exclusive brands to create unmatched offerings in beauty products and deliver other unique product offerings, including a full range of high-quality CVS Health® and other proprietary brand products that are only available through CVS stores. The Company currently carries approximately 6,000 CVS Health and proprietary items, which accounted for approximately 22% of front store revenues during 2021.

MinuteClinic
As of December 31, 2021, the Company operated nearly 1,200 MinuteClinic locations in the United States. The clinics are staffed by nurse practitioners and physician assistants who utilize nationally established guidelines to deliver a variety of health care services. Payors value these clinics because they provide convenient, high-quality, cost-effective care, in many cases offering an attractive alternative to more expensive sites of care. MinuteClinic is collaborating with the Health Care Benefits and Pharmacy Services segments to help meet the needs of the Company's health plan members and CVS Caremark's client plan members by offering programs that can improve member health and lower costs. MinuteClinic also maintains relationships with leading hospitals, clinics and physicians in the communities we serve to support and enhance quality, access and continuity of care.

On-site Pharmacies
The Company also operates a limited number of pharmacies located at client sites, which provide certain health plan members and customers with a convenient alternative for filling their prescriptions and receiving vaccinations, including the COVID-19 vaccination.

Medical Diagnostic Testing
The Company offers medical diagnostic testing primarily through its COVID-19 testing sites located at CVS Pharmacy locations, in its MinuteClinic locations, at community-based testing sites in underserved areas and through its Return Ready solution.

Long-term Care Pharmacy Operations
The Retail/LTC segment provides LTC pharmacy services through the Omnicare® business. Omnicare's customers consist of skilled nursing facilities, assisted living facilities, independent living communities, hospitals, correctional facilities, and other health care service providers. The Company provides pharmacy consulting, including monthly patient drug therapy evaluations, to assist in compliance with state and federal regulations and provide proprietary clinical and health management programs. It also provides pharmaceutical case management services for retirees, employees and dependents who have drug benefits under corporate-sponsored health care programs.

Community Location Development

CVS Health's community health destinations are an integral part of its ability to meet the needs of consumers and maintain its leadership position in the changing health care landscape. When paired with its rapidly expanding digital presence, the Company's physical presence in thousands of communities across the country represents a competitive advantage by allowing it to develop deep and trusted relationships through everyday engagement in consumer health. The Company's community health destinations have played, and will continue to play, a key role in the Company's continued growth and success. During 2021, the Company opened approximately 55 new community locations, relocated approximately 15 locations, converted approximately 300 locations into CVS HealthHUB locations and closed approximately 80 locations.

The Company's continuous assessment of its national footprint is an essential component of competing effectively in the current health care environment. On an ongoing basis, the Company evaluates changes in population, consumer buying patterns and future health needs to assess the ability of its existing stores and locations to meet the needs of its consumers and the business. During the fourth quarter of 2021, the Company completed a strategic review of its retail business and announced its plans to reduce store density in certain locations through the closure of approximately 900 stores between 2022 and 2024.

As part of the Company's strategic review of its retail business, CVS Health will also create new store formats to drive higher engagement with consumers. Three distinct models will serve as community health destinations: (a) sites dedicated to offering primary care services; (b) an enhanced version of CVS HealthHUB locations with products and services designed for everyday health and wellness needs; and (c) traditional CVS Pharmacy stores that provide prescription services and health, wellness, personal care and other convenient retail offerings.

Retail/LTC Information Systems

The Company has continued to invest in information systems to enable it to deliver exceptional customer service, enhance safety and quality, and expand patient care services while lowering operating costs. The proprietary WeCARE Workflow tool supports pharmacy teams by prioritizing work to meet customer expectations, facilitating prescriber outreach, and seamlessly integrating clinical programs. This solution delivers improved efficiency and enhances customer experience, as well as provides a framework to accommodate the evolution of pharmacy practice and the expansion of clinical programs. Our Health Engagement Engine technology and data science clinical algorithms enable the Company to help identify opportunities for pharmacists to deliver face-to-face counseling regarding patient health and safety matters, including medication adherence issues, gaps in care and management of certain chronic health conditions. The Company's digital strategy is to empower the consumer to navigate their pharmacy experience and manage their condition through integrated online and mobile solutions that offer utility and convenience. The Company's LTC digital technology suite, Omniview®, improves the efficiency of customers' operations with tools that include executive dashboards, pre-admission pricing, electronic ordering of prescription refills, proof-of-delivery tracking, access to patient profiles, receipt and management of facility bills, and real-time validation of Medicare Part D coverage, among other capabilities.

Through the collaboration of its digital and technical teams, the Company has established critical tools which enable patients to schedule COVID-19 diagnostic testing and vaccination appointments through CVS.com and MinuteClinic.com. Key elements of the offerings include landing pages which highlight services and answer common questions, screening capabilities to determine patient eligibility, service location locator and appointment selection tools to efficiently identify the requested service on a specified date, time, and location and registration pages to collect required patient information, accelerating the administration of the test or vaccine once at the store. Once scheduled, the tools provide the user with instructions and notifications including SMS text message and email reminders, and, following administration, also provide digital results for tests and records for vaccinations, enabling patients to view and save their medical records for convenient access at a later point.

Retail/LTC Customers

The success of the Retail/LTC segment's businesses is dependent upon the Company's ability to establish and maintain contractual relationships with pharmacy benefit managers and other payors on acceptable terms. Substantially all of the Retail/LTC segment's pharmacy revenues are derived from pharmacy benefit managers, managed care organizations ("MCOs"), government funded health care programs, commercial employers and other third-party payors. No single Retail/LTC payor accounted for 10% or more of the Company's consolidated total revenues in 2021, 2020 or 2019.

Retail/LTC Seasonality

The majority of Retail/LTC segment revenues, particularly pharmacy revenues, generally are not seasonal in nature. However, front store revenues tend to be higher during the December holiday season. In addition, both pharmacy and front store revenues are affected by the timing and severity of the cough, cold and flu season. Uncharacteristic or extreme weather conditions also can adversely affect consumer shopping patterns and Retail/LTC revenues, expenses and operating results.

During the year ended December 31, 2021, the customary quarterly operating income progression continued to be impacted by COVID-19. During the first quarter, the Company experienced reduced customer traffic in its retail pharmacies, which reflected the impact of a weak cough, cold and flu season, while it administered the highest quarterly volume of COVID-19 diagnostic tests. During the second quarter, the segment generated earnings from COVID-19 vaccinations and saw improved customer traffic as vaccinated customers began more actively shopping in CVS locations. During the third and fourth quarters, emerging new variants drove the continued administration of COVID-19 vaccinations (including booster shots), which reached their highest levels of the year during the fourth quarter, and diagnostic testing. During the third and fourth quarters, the segment also generated earnings from the sale of OTC test kits in the front store.

During the year ended December 31, 2020, the customary quarterly operating income progression was also impacted by COVID-19. During March 2020, the Company experienced greater use of 90-day prescriptions, early refills of maintenance medications and increased front store volume as consumers prepared for the COVID-19 pandemic. Subsequent to March 2020, the Company experienced reduced customer traffic in its retail pharmacies and MinuteClinic locations due to shelter-in-place orders as well as reduced new therapy prescriptions as a result of the COVID-19 pandemic. Beginning in the third quarter, the Company saw an increase in diagnostic testing related to the COVID-19 pandemic and in December 2020, the Company began administering COVID-19 vaccinations in long-term care facilities.

Retail/LTC Competition

The retail pharmacy business is highly competitive. The Company believes that it competes principally on the basis of: (i) store location and convenience, (ii) customer service and satisfaction, (iii) product selection and variety, and (iv) price. In the areas it serves, the Company competes with other drugstore chains (e.g., Walgreens and Rite Aid), supermarkets, discount retailers (e.g., Walmart), independent pharmacies, restrictive pharmacy networks, internet companies (e.g., Amazon), membership clubs, retail health clinics, urgent care and primary care offices, as well as mail order dispensing pharmacies.

LTC pharmacy services are highly regional or local in nature, and within a given geographic area of operation, highly competitive. The Company's largest LTC pharmacy competitor nationally is PharMerica. The Company also competes with numerous local and regional institutional pharmacies, pharmacies owned by long-term care facilities and local retail pharmacies. Some states have enacted "freedom of choice" or "any willing provider" requirements as part of their state Medicaid programs or in separate legislation, which may increase the competition that the Company faces in providing services to long-term care facility residents in these states.

Corporate/Other Segment

The Company presents the remainder of its financial results in the Corporate/Other segment, which primarily consists of:

- Management and administrative expenses to support the Company's overall operations, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments, expenses associated with the Company's investments in its transformation and enterprise modernization programs and acquisition-related integration costs; and
- Products for which the Company no longer solicits or accepts new customers such as large case pensions and long-term care insurance products.

Generic Sourcing Venture

The Company and Cardinal Health, Inc. ("Cardinal") each have a 50% ownership in Red Oak Sourcing, LLC ("Red Oak"), a generic pharmaceutical sourcing entity. Under this arrangement, the Company and Cardinal contributed their sourcing and supply chain expertise to Red Oak and agreed to source and negotiate generic pharmaceutical supply contracts for both companies through Red Oak. Red Oak does not own or hold inventory on behalf of either company.

Working Capital Practices

The Company funds the growth of its businesses through a combination of cash flow from operations, commercial paper and other short-term borrowings, proceeds from sale-leaseback transactions and long-term borrowings. For additional information on the Company's working capital practices, see "Liquidity and Capital Resources" in the MD&A included in Item 7 of this 10-K. Employer groups, individuals, college students, part-time and hourly workers, health plans, providers, governmental units, government-sponsored plans (with the exception of Medicare Part D services, which are described below), labor groups and expatriates, which represent the vast majority of Health Care Benefits segment revenues, typically settle in less than 30 days. As a provider of Medicare Part D services, the Company contracts annually with CMS. Utilization of services each plan year results in the accumulation of either a receivable from or a payable to CMS. The timing of settlement of the receivable or payable with CMS takes several quarters, which impacts working capital from year to year. The majority of the Retail/LTC segment non-pharmacy revenues are paid in cash, or with debit or credit cards. Managed care organizations, pharmacy benefit managers, government funded health care programs, commercial employers and other third party insurance programs, which represent the vast majority of the Company's consolidated pharmacy revenues, typically settle in less than 30 days. The remainder of the Company's consolidated pharmacy revenues are paid in cash, or with debit or credit cards.

Human Capital

Overview

At CVS Health, we share a single, clear purpose: bringing our heart to every moment of your health. We devote significant time and attention to the attraction, development and retention of talent to deliver high levels of service to our customers. Our commitment to them includes a competitive rewards package and programs that support our diverse range of colleagues in rewarding and fulfilling careers. As of December 31, 2021, we employed approximately 300,000 colleagues primarily in the United States including in all 50 states, the District of Columbia and Puerto Rico, approximately 72% of whom were full-time.

We believe engaged colleagues produce stronger business results and are more likely to build a career with the Company. Each year we conduct an internal engagement survey that provides colleagues with an opportunity to share their opinions and experiences with respect to their role, their team and the enterprise to help our Board and our management identify areas where we can improve colleague experience. The survey covers a broad range of topics including development and opportunities, diversity management, recognition, performance, well-being, compliance and continuous improvement. In 2021, greater than 80% of our colleagues participated in the engagement survey, of which greater than 75% responded that they were actively engaged.

The Board and our chief executive officer ("CEO") provide oversight of our human capital strategy, which consists of the following categories: total rewards; diversity, equity and inclusion; colleague development; and health and safety.

Total Rewards

We recognize how vital our colleagues are to our success and strive to offer comprehensive and competitive wages and benefits to meet the varying needs of our colleagues and their families. The benefits and programs include annual bonuses, 401(k) plans, stock awards, an employee stock purchase plan, health care and insurance benefits, paid time off, flexible work schedules, family leave, dependent care resources, colleague assistance programs and tuition assistance, among many others, depending on eligibility.

In recognition of the critical role that the attraction and retention of talent plays in the success of our business, during 2021, we also announced a significant investment in our employees through an increase in the Company's minimum hourly wage to $15.00 an hour effective July 2022, with incremental increases to the Company's competitive hourly rates beginning in August 2021. The new wage structure also incorporates additional increases beyond the $15.00 minimum, with higher starting hourly rates for roles such as pharmacy technicians and call center representatives. In addition, during 2021 we awarded incremental

bonuses to select colleague groups in recognition of their ongoing contributions throughout the COVID-19 pandemic, the most significant of which included bonuses to our pharmacist and distribution center colleagues.

Diversity, Equity & Inclusion

We believe that a diverse workforce creates a healthier, stronger and more sustainable company. We aim to attract, develop, retain and support a diverse workforce that reflects the many customers, patients, members and communities we serve. Our Diversity Management Leadership Council, a cross-functional group of senior leaders appointed by our CEO, works with our Strategic Diversity Management leadership team to intentionally embed diversity across all facets of our business. For our efforts, we have been recognized as a DiversityInc Top 50 Company, a LatinaStyle Top 50 Company for Latinas and earned a 100 percent score on both the Human Rights Campaign Corporate Equality Index as well as the Disability Equality Index, meaning the company is recognized as a "Best Place to Work for Disability Inclusion." The Company discloses information on our diversity, equity and inclusion strategy and programs in our annual Corporate Social Responsibility ("CSR") Report.

As a foundation of diversity and inclusion, we continuously focus on increasing underrepresented populations across our business. In 2021, 71% of our total colleague population and 55% of our colleagues at the manager level and above self-reported as female. In addition, in 2021 our colleagues reported their race/ethnicity as: White (49%), Black/African American (17%), Hispanic/Latino (15%), Asian (11%) and Other (8%). The appendix to our CSR Report, our Strategic Diversity Management Report and our EEO-1 Employer Information Report include additional information on the diversity of our workforce.

Our diversity management strategy emphasizes workplace representation, inclusion and belonging, talent acquisition and management and a diverse marketplace. We incorporated a diversity metric into our 2021 annual cash incentive program for our most senior leaders who have the greatest ability to influence the overall hiring, development and promotion of our colleagues. We also continued the deployment of conscious inclusion training for colleagues designed to enhance awareness of biases and support inclusive behaviors. Our CSR Report includes additional information with respect to our conscious inclusion training. We support 16 Colleague Resource Groups ("CRGs") that include more than 26,000 colleagues across the enterprise. These groups represent a wide range of professional, cultural, ethical and personal affinities and interests, as well as formal mentoring programs. Our CRGs provide our colleagues with an opportunity to connect and network with one another through a particular affinity, culture or interest. Each of our CRGs is sponsored by a senior leader.

Colleague Development

The Company offers a number of resources and programs that attract, engage, develop, advance and retain colleagues. Training and development provides colleagues the support they need to perform well in their current role while planning and preparing for future roles. We offer an online orientation program that pairs new hires with seasoned colleagues and the training continues throughout a colleague's career through in-person, virtual and self-paced learning at all levels. We also provide mentoring, tools and workshops for colleagues to manage their career development. We offer a variety of management and leadership programs that develop incumbent diverse and other high potential colleagues. Our broad training practices include updated, tech-enabled tools and keep our colleagues informed of new developments in our industry that are relevant to their roles. During the year ended December 31, 2021, our colleagues invested more than 13 million hours in learning and development courses.

Our colleague development program also promotes the importance of compliance across our business. Our colleagues demonstrate this commitment through our annual Code of Conduct training, which 100% of active colleagues completed in 2021. In 2021, we launched more than 70 different training courses as part of our annual Enterprise Compliance Training Program.

Health & Safety

We have a strong commitment to providing a safe working environment. We have implemented an environmental health and safety management system to support adherence and monitoring of programs designed to make our various business operations compliant with applicable occupational safety and health regulations and requirements. Our Environmental Health and Safety Department oversees the implementation and adherence to programs like Powered Industrial Truck training, materials handling and storage, selection of personal protective equipment and workplace violence prevention.

We utilize Safety Service Plans to analyze data and concentrate on key areas of risk to reduce the chance of workplace incidents. We focus on identifying causes and improving performance when workplace incidents occur. We also engage leaders

in promoting a culture of safety. With safety task forces in place at each distribution center, we empower leaders and safety business partners to identify policies, procedures and processes that could improve their own operations.

From the outset of the COVID-19 pandemic, we took a comprehensive approach to managing occupational health and safety challenges presented by the pandemic, including implementing facial covering requirements for our workplaces and providing face masks to colleagues, providing sick leave, implementing symptom screening measures and implementing additional protocols in accordance with applicable Occupational Safety and Health Administration ("OSHA") requirements and guidance and Centers for Disease Control and Prevention ("CDC") guidelines for workplaces. We have emphasized the importance of taking immediate steps toward full vaccination.

Environmental, Social and Governance ("ESG") Strategy

Overview

CVS Health believes the health of our people, communities and planet are linked to the health of our business. Our ESG strategy is designed to use our assets to transform the health care experience and invest in community health at the local level, while working to reduce the environmental impact of our operations. Our ESG strategy includes a set of goals we hope to achieve in 2030 or earlier. We believe these goals are achievable without materially adversely affecting our businesses, operating results, cash flows and/or prospects. Our ESG strategy consists of four pillars: *Healthy People*, *Healthy Business*, *Healthy Community* and *Healthy Planet*.

Healthy People

Through physical and virtual interactions, we provide convenient, personalized and integrated access to health care support and services. We continue to implement and expand initiatives that build on our innovative health care model, with the ultimate aim to transform the health care experience for every person we reach to improve health outcomes. These include helping to improve chronic disease prevention and management, helping to reduce and prevent prescription drug misuse, and improving the social determinants of health, which include education, transportation and behavioral health. Through our ESG strategy we are focused on our interaction with individuals across all our touchpoints to increase the likelihood that these initiatives will succeed.

Healthy Business

As we work to transform health care, we are committed to operating a healthy business for all our stakeholders, including our patients, customers, stockholders, clients, partners, communities and colleagues. Throughout our large operational footprint and including our supply chain, we are committed to acting responsibly with respect for human rights, privacy, information security, public policy, marketing and advertising. We focus on diversity, equity and inclusion as well as colleague development, health and safety. Through our ESG strategy we will be investing in colleague mentoring, sponsorship, development and advancement; workforce initiatives that provide employment services and training to the underserved; and providing access to health care while addressing health disparities.

Healthy Community

By working with community-focused organizations and through innovative programs that can be tailored to and executed across different communities, we are driving positive health outcomes and reducing overall health care costs. Through our recently announced Health Zones initiative, CVS Health and our nonprofit partners are working together to create a model that reduces health disparities, promotes and enhances equity and ensures at-risk communities can thrive. Through our ESG strategy we are building healthier communities through social impact investments, such as supporting health care professionals, reducing food insecurity, engaging our customers in community health, and coordinating care for the underserved.

Healthy Planet

Our work to improve the planet is aligned with our commitment to the communities we serve and to help protect our businesses from the negative impacts of climate change. All of our businesses, including our community locations, corporate offices and operation centers, distribution centers, and specialty pharmacy and PBM mail pharmacy locations, can be impacted by climate change-related extreme weather events and we are doing our part to reduce our environmental impacts. We are focused on identifying resource efficiencies across our operations and supply chain. We are proud to be recognized as a leader in addressing climate-related issues and are working closely with key stakeholders to make and deliver meaningful progress. Key

priorities include the advancement of our greenhouse gas ("GHG") emissions-reduction targets, reduction in our energy consumption, the advancement of sustainability in transportation, logistics and our physical locations, which includes retrofitting community and corporate locations with LED lighting, exploring investments in renewable energy, reducing water use, focusing on smarter consumption through a "digital first" approach and the reduction of our use of paper and plastic. In October 2021, CVS Health's science-based net zero GHG emissions targets were validated by the Science Based Targets initiatives ("SBTi"). We continue to make meaningful progress to reduce our environmental impact.

Intellectual Property

The Company has registered and/or applied to register a variety of trademarks and service marks used throughout its businesses, as well as domain names, and relies on a combination of copyright, patent, trademark and trade secret laws, in addition to contractual restrictions, to establish and protect the Company's proprietary rights. The Company regards its intellectual property as having significant value in the Health Care Benefits, Pharmacy Services and Retail/LTC segments. The Company is not aware of any facts that could materially impact the continuing use of any of its intellectual property.

Government Regulation

Overview

The Company's operations are subject to comprehensive federal, state and local laws and regulations and comparable multiple levels of international regulation in the jurisdictions in which it does business. There also continues to be a heightened level of review and/or audit by federal, state and international regulators of the health and related benefits industry's business and reporting practices. In addition, many of the Company's PBM clients and the Company's payors in the Retail/LTC segment, including insurers, Medicare plans, Managed Medicaid plans and MCOs, are themselves subject to extensive regulations that affect the design and implementation of prescription drug benefit plans that they sponsor. Similarly, the Company's LTC clients, such as skilled nursing facilities, are subject to government regulations, including many of the same government regulations to which the Company is subject.

The laws and rules governing the Company's businesses and interpretations of those laws and rules continue to expand and become more restrictive each year and are subject to frequent change. The application of these complex legal and regulatory requirements to the detailed operation of the Company's businesses creates areas of uncertainty. Further, there are numerous proposed health care, financial services and other laws and regulations at the federal, state and international levels, some of which could adversely affect the Company's businesses if they are enacted. The Company cannot predict whether pending or future federal or state legislation or court proceedings will change aspects of how it operates in the specific markets in which it competes or the health care industry generally, but if changes occur, the impact of any such changes could have a material adverse impact on the Company's businesses, operating results, cash flows and/or stock price. Possible regulatory or legislative changes include the federal or one or more state governments fundamentally restructuring the Commercial, Medicare or Medicaid marketplace; reducing payments to the Company in connection with Medicare, Medicaid, dual eligible or special needs programs; increasing its involvement in drug reimbursement, pricing, purchasing, and/or importation; or changing the laws governing PBMs.

The Company has internal control policies and procedures and conducts training and compliance programs for its employees to help prevent, detect and correct prohibited practices. However, if the Company's employees or agents fail to comply with applicable laws governing its international or other operations, it may face investigations, prosecutions and other legal proceedings and actions which could result in civil penalties, administrative remedies and criminal sanctions. Any failure or alleged failure to comply with applicable laws and regulations summarized below, or any adverse applications or interpretations of, or changes in, the laws and regulations affecting the Company and/or its businesses, could have a material adverse effect on the Company's operating results, financial condition, cash flows and/or stock price. See Item 3 of this 10-K, "Legal Proceedings," for further information.

The Company can give no assurance that its businesses, financial condition, operating results and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations, including the laws and regulations described in this Government Regulation section, as they may relate to one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iii) pending or future federal or state governmental investigations of one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; or (v) adverse developments

in pending or future legal proceedings against or affecting the Company, including *qui tam* lawsuits, or affecting one or more of the industries in which the Company competes and/or the health care industry generally.

Laws and Regulations Related to COVID-19

The Families First Coronavirus Response Act (the "Families First Act") and the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") were enacted in March 2020. Each of the Families First Act and the CARES Act requires the Company to provide coverage for COVID-19 related medical services, in many cases without member cost-sharing, in its Insured Health Care Benefits products.

The CARES Act also provides relief funding to providers to reimburse them for health care related expenses incurred in preventing, preparing for and/or responding to COVID-19 (provided no other source is obligated to reimburse those expenses) or lost health care related revenues that are attributable to COVID-19. Under the CARES Act, the Company receives reimbursement for uninsured patients in connection with COVID-19 testing and vaccination as well as monoclonal antibody treatment. Aside from such reimbursement, the Company has not requested any funding under the CARES Act. However, in the second quarter of 2020, the Company received $43 million from the CARES Act provider relief fund, all of which was returned to the U.S. Department of Health and Human Services ("HHS") during the second quarter of 2020.

The CARES Act also allows for the deferral of the payment of the employer share of Social Security taxes effective March 27, 2020 by permitting them to remit the associated payments in two equal installments on or about December 31, 2021 and December 31, 2022. The Company elected to defer approximately $670 million of its Social Security tax payments during the year ended December 31, 2020. The Company paid the first of two equal installments in December 2021 and will remit the second installment on or about December 31, 2022, as required under the CARES Act.

Congress enacted the American Rescue Plan Act in March 2021. Among other changes, as a result of this legislation, Public Exchange plan premium subsidies increased for low-income individuals and became available to people with incomes higher than 400% of the federal poverty limit. These changes are currently in effect through the remainder of 2022, and Congress may extend, or potentially make permanent, these policies in subsequent legislation, which could cause continued shifts in enrollment into Public Exchange plans.

In addition to the Families First Act, the CARES Act, and the American Rescue Plan Act, the Company continues to experience new legislation, regulation, directives, orders and other requirements from federal, state, county and municipal authorities related to the COVID-19 pandemic. These governmental actions have included, but are not limited to, requirements to waive member cost-sharing associated with COVID-19 testing and treatment, provide coverage for additional COVID-19-related services, expand the use of telemedicine, extend grace periods for payments of premiums or limit coverage termination based on non-payment of premiums or fees, modify health benefits coverage eligibility rules to help maintain employee eligibility, and facilitate, accelerate or advance payments to providers, and other requirements related to the public health emergency. These requirements may impact different areas of our business differently and for different lengths of time, and present financial implications with respect to implementing and unwinding our compliance with these new requirements.

The Company has operations that fall within the scope of COVID-19 vaccine requirements for federal contractors, certain health care workers, and the requirements of certain jurisdictions such as New York City. Several of these are subject to judicial challenges. We are continuing to closely monitor and update our practices in response to developments or changes in the COVID-19 vaccination policies established by various federal agencies as well as the several state- and municipal-specific COVID-19 vaccine mandates that provide expanded exemptions, modifications, requirements or restrictions regarding employee vaccinations. We have a process for employees to request a reasonable accommodation if they are unable to get vaccinated due to a medical condition, sincerely held religious belief, or any other legally recognized exemption. Employees must apply and be approved for a reasonable accommodation in order to be exempt from the vaccination requirement.

Additionally, in December 2021, the Biden administration reiterated CARES Act guidance noting commercial health insurers are not required to cover workplace or surveillance testing and announced several new directives and actions to combat COVID-19, including the expansion of free at-home testing to be covered by commercial health insurers for the remainder of the public health emergency. On January 10, 2022, the HHS announced that commercial health insurers must cover the costs of up to eight rapid OTC COVID-19 test kits per individual per 30-day period. This requirement will likely impact multiple business operations, including increasing benefit costs in our commercial health insurance business and increasing revenues in our retail business. The requirement may also result in a decrease in more expensive tests and treatments, which could partially mitigate the increase in benefit costs in our commercial health insurance business. These impacts will be highly dependent on the overall supply of testing products.

The impact of this governmental activity on the U.S. economy, consumer, customer and health care provider behavior and health care utilization patterns is beyond our knowledge and control. As a result, the financial and/or operational impact these COVID-19 related governmental actions and inactions will have on our businesses, operating results, cash flows and/or financial condition is uncertain, but the collective impact could be material and adverse.

Laws and Regulations Related to Multiple Segments of the Company's Business

Laws Related to Reimbursement by Government Programs - The Company is subject to various federal and state laws concerning its submission of claims and other information to Medicare, Medicaid and other federal and state government-sponsored health care programs. Potential sanctions for violating these laws include recoupment or reduction of government reimbursement amounts, civil penalties, treble damages, and exclusion from participation in government health care programs. Such laws include the federal False Claims Act (the "False Claims Act"), the federal anti-kickback statute (the "AKS"), state false claims acts and anti-kickback statutes in most states, the federal "Stark Law" and related state laws. In particular, the False Claims Act prohibits intentionally submitting, conspiring to submit, or causing to be submitted, false claims, records, or statements to the federal government, or intentionally failing to return overpayments, in connection with reimbursement by federal government programs. In addition, any claim for government reimbursement also violates the False Claims Act where it results from a violation of the AKS.

Both federal and state false claims laws permit private individuals to file *qui tam* or "whistleblower" lawsuits on behalf of the federal or state government. Participants in the health and related benefits industry, including the Company, frequently are subject to actions under the False Claims Act or similar state laws. The federal Stark Law generally prohibits physicians from referring Medicare or Medicaid beneficiaries for certain services, including outpatient prescription drugs, to any entity with which the physician, or an immediate family member of the physician, has a financial relationship. The Stark Law further prohibits the entity receiving a prohibited referral from presenting a claim for reimbursement by Medicare or Medicaid for services furnished pursuant to the prohibited referral. Various states have enacted similar laws.

The ACA - The ACA significantly increased federal and state oversight of health plans. Among other requirements, it specifies minimum medical loss ratios ("MLRs") for Commercial and Medicare Insured products, specifies features required to be included in commercial benefit designs, limits commercial individual and small group rating and pricing practices, encourages additional competition (including potential incentives for new participants to enter the marketplace), and includes regulations and processes that could delay or limit the Company's ability to appropriately increase its health plan premium rates. This in turn could adversely affect the Company's ability to continue to participate in certain product lines and/or geographies that it serves today.

In June 2021, the United States Supreme Court dismissed a challenge on procedural grounds that argued the ACA is unconstitutional in its entirety and issued an opinion preserving the ACA and its consumer protections in its current form. Even though the ACA was deemed constitutional, there may nevertheless be continued efforts to invalidate, modify, repeal or replace portions of it. In addition to litigation, parts of the ACA continue to evolve through the promulgation of executive orders, legislation, regulations and guidance at the federal or state level. The Company expects the ACA, including potential changes thereto, to continue to significantly impact its business operations and operating results, including pricing, medical benefit ratios ("MBRs") and the geographies in which the Company's products are available.

Medicare Regulation - The Company's Medicare Advantage products compete directly with Original Medicare and Medicare Advantage products offered by other Medicare Advantage organizations and Medicare Supplement products offered by other insurers. The Company's Medicare PDP and Medicare Supplement products are products that Medicare beneficiaries who are enrolled in Original Medicare purchase to enhance their Original Medicare coverage.

The Company continues to expand the number of counties in which it offers Medicare products. The Company has expanded its Medicare service area and products in 2022 and is seeking to substantially grow its Medicare membership, revenue and operating results over the next several years, including through growth in Medicare Supplement products. The anticipated organic expansion of the Medicare service area and Medicare products offered and the Medicare-related provisions of the ACA significantly increase the Company's exposure to funding and regulation of, and changes in government policy with respect to and/or funding or regulation of, the various Medicare programs in which the Company participates, including changes in the amounts payable to us under those programs and/or new reforms or surcharges on existing programs. For example, the ACA requires minimum MLRs for Medicare Advantage and Medicare Part D plans of 85%. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS.

Due to potential lower utilization of medical services by Medicare beneficiaries during the COVID-19 pandemic, it is possible certain Medicare Advantage contracts may not meet the 85% MLR for consecutive years.

The Company's Medicare Advantage and PDP products are heavily regulated by CMS. The regulations and contractual requirements applicable to the Company and other private participants in Medicare programs are complex, expensive to comply with and subject to change. For example, the Medicare Advantage Overpayment Rule, issued in 2014, implemented the ACA requirements that Medicare Advantage and PDP plans report and refund to CMS overpayments that those plans receive from CMS. Failure to notify overpayments to CMS could result in liability under the False Claims Act. The precise interpretation, impact and legality of this rule are subject to pending litigation. Payments the Company receives from CMS for its Medicare Advantage and Part D businesses also are subject to risk adjustment based on the health status of the individuals enrolled. Elements of that risk adjustment mechanism continue to be challenged by the U.S. Department of Justice (the "DOJ"), the Office of the Inspector General of the HHS (the "OIG") and CMS itself. Substantial changes in the risk adjustment mechanism, including changes that result from enforcement or audit actions, could materially affect the amount of the Company's Medicare reimbursement, require the Company to raise prices or reduce the benefits offered to Medicare beneficiaries, and potentially limit the Company's (and the industry's) participation in the Medicare program.

The Company has invested significant resources to comply with Medicare standards, and its Medicare compliance efforts will continue to require significant resources. CMS may seek premium and other refunds, prohibit the Company from continuing to market and/or enroll members in or refuse to passively enroll members in one or more of the Company's Medicare or Medicare-Medicaid demonstration (historically known as "dual eligible") plans, exclude us from participating in one or more Medicare, dual eligible or dual eligible special needs plan programs and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with CMS regulations or its Medicare contractual requirements. The Company's Medicare Supplement products are regulated at the state level and subject to similar significant compliance requirements and risks.

In addition, in November 2020, the HHS released the final Rebate Rule (the "Rebate Rule"), which eliminates the regulatory safe harbor from prosecution under the AKS for rebates from pharmaceutical companies to PBMs in Medicare Part D, replacing it with two far narrower safe harbors designed to directly benefit patients with high out-of-pocket costs and to change the way PBMs are compensated. The new safe harbors are (i) for rebates which are passed on to the patient at the point of sale and (ii) for flat service fee payments made to PBMs which cannot be tied to the list prices of drugs. It is unclear whether the Rebate Rule will be enforceable, whether pharmaceutical companies will respond by reducing list prices, whether list prices in the private market may also be reduced, and what the resulting impact will be to PBMs or the Company. The Pharmaceutical Care Management Association (the "PCMA"), which represents PBMs, has filed a suit in an effort to block the Rebate Rule, claiming that the Rebate Rule would lead to higher premiums in Medicare Part D and was adopted in an unlawful manner. The Bipartisan Infrastructure Act of 2021 delays the effective date of the rebate rule to January 2026, and pending Reconciliation legislation would fully repeal the Rebate Rule.

In December 2021, President Biden signed the Protecting Medicare and American Farmers from Sequester Cuts Act. The legislation extends the suspension of the 2% Medicare sequester cuts until March 2022. Starting in April 2022, the Medicare sequester cuts will be phased back in with a 1% cut that will continue through June. Absent any further changes by Congress, the 2% Medicare sequester would be fully implemented again effective July 1, 2022. Congress suspended the Medicare sequester cuts due to the COVID-19 pandemic, providing a continued increase in Medicare Advantage and Part D plan payments, as well as Medicare fee-for-service provider payments. The legislation also includes a 3% increase in the Medicare Physician Fee Schedule payments for 2022. Congress enacted a similar increase of 3.75% for 2021 which was set to expire. As a result of this increase, Medicare Advantage plans who have contracts with providers based on the Medicare Physician Fee Schedule will need to increase their payment rates by 3%. This increase became effective in January 2022 and does not include any allowance for the increased Medicare Advantage costs that result from the provision. Taken together, the two provisions represent a modest increase in Medicare Advantage costs relative to our expectations for 2022.

Currently, Congress is considering legislation to add additional benefits to Medicare Part B, such as dental, hearing and vision benefits. The Congressional Budget Office has not yet scored any of the proposals.

Going forward, the Company expects CMS, the OIG, the DOJ, other federal agencies and the U.S. Congress to continue to scrutinize closely each component of the Medicare program (including Medicare Advantage, PDPs, demonstration projects such as Medicare-Medicaid plans and provider network access and adequacy), modify the terms and requirements of the program and possibly seek to recast or limit private insurers' roles. It is also possible that Congress may reform the structure of the Medicare Part D program and may consider changes to Medicare Advantage payment policies due to recent recommendations by the Medicare Payment Advisory Commission and to reduce the potential added cost burden of costly new

benefits, or policies that impact drug pricing such as price controls and inflationary rebates applied to pharmaceutical manufacturers.

It is not possible to predict the outcome of such regulatory or Congressional activity, any of which could materially and adversely affect the Company.

Medicare Audits - CMS regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare Advantage and PDP beneficiaries. For example, CMS conducts risk adjustment data validation ("RADV") audits of a subset of Medicare Advantage contracts for each contract year. Since 2011, CMS has selected certain of the Company's Medicare Advantage contracts for various years for RADV audit, and the number of RADV audits continues to increase. The OIG also is auditing the Company's risk adjustment data and that of other companies, and the Company expects CMS and the OIG to continue auditing risk adjustment data. The Company also has received Civil Investigative Demands ("CIDs") from, and provided documents and information to, the Civil Division of the DOJ in connection with a current investigation of its patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

In October 2018, CMS issued proposed rules related to, among other things, changes to the RADV audit methodology established by CMS in 2012. CMS projects that the changes to the RADV audit methodology would increase its recoveries from Medicare Advantage plans as a result of RADV audits. CMS has requested comments on the proposed rules, including whether the proposed RADV rule change should apply retroactively to audits of Medicare Advantage plans for contract year 2011 and forward, and gave notice that it has extended the timeline for publication of the final rules until November 2022. While the Company submitted timely comments to the proposed rules, if they are adopted as proposed there may be potential adverse effects, which could be material, on the Company's operating results, financial condition, and cash flows. CMS also has announced that its goal is to subject all Medicare Advantage contracts to either a comprehensive or a targeted RADV audit for each contract year.

Medicare Star Ratings - A portion of each Medicare Advantage plan's reimbursement is tied to the plan's "star ratings." The star rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management, compliance and overall customer satisfaction. Only Medicare Advantage plans with an overall star rating of four or more stars (out of five stars) are eligible for a quality bonus in their basic premium rates. As a result, the Company's Medicare Advantage plans' operating results in 2022 and going forward will be significantly affected by their star ratings. The Company's star ratings and past performance scores are adversely affected by the compliance issues that arise each year in its Medicare operations. CMS released the Company's 2022 star ratings in October 2021. The Company's 2022 star ratings will be used to determine which of its Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2023. Based on the Company's membership at December 31, 2021, 87% of the Company's Medicare Advantage members were in plans with 2022 star ratings of at least 4.0 stars. CMS also gives PDPs star ratings which affect each PDP's enrollment. Medicare Advantage and PDP plans that are rated less than three stars for three consecutive years are subject to contract termination by CMS. CMS continues to revise its star ratings system to make it harder to achieve four stars or more. Despite the Company's success in achieving high 2022 star ratings and other quality measures and the continuation of its improvement efforts, there can be no assurances that it will be successful in maintaining or improving its star ratings in future years. Accordingly, the Company's Medicare Advantage plans may not be eligible for full level quality bonuses, which could adversely affect the benefits such plans can offer, reduce membership and/or reduce profit margins.

Medicare Benchmark Rates - In January 2021, CMS issued its final notice detailing final 2022 Medicare Advantage benchmark payment rates. Final 2022 Medicare Advantage rates resulted in an increase in industry benchmark rates of approximately 4.1%. This rate increase only partially offsets the challenge the Company faces from the impact of the increasing cost of medical care (including prescription medications) and CMS local and national coverage decisions that require the Company to pay for services and supplies that are not factored into the Company's bids. The federal government may seek to impose restrictions on the configuration of pharmacy or other provider networks for Medicare Advantage and/or PDP plans, or otherwise restrict the ability of these plans to alter benefits, negotiate prices or establish other terms to improve affordability or maintain viability of products. The Company currently believes that the payments it has received and will receive in the near term are adequate to justify the Company's continued participation in the Medicare Advantage and PDP programs, although there are economic and political pressures to continue to reduce spending on the program, and this outlook could change.

340B Drug Pricing Program – The 340B Drug Pricing Program allows eligible Covered Entities to purchase prescription drugs from manufacturers at a steep discount, and is overseen by the HHS and the Health Resources and Services Administration ("HRSA"). In 2020, a number of pharmaceutical manufacturers began programs that limited Covered Entities' participation in the program through contract pharmacies arrangements. In May 2021, HRSA sent enforcement letters to

multiple manufacturers to curb these practices. In September 2021, HRSA forwarded the enforcement actions to the OIG for potential imposition of civil monetary penalties. Those enforcement actions are currently subject to ongoing litigation. A reduction in Covered Entities' participation in contract pharmacy arrangements, as a result of the pending enforcement actions or otherwise, a reduction in the use of the Company's administrative services by Covered Entities, or a reduction in drug manufacturers' participation in the program could materially and adversely affect the Company.

Anti-Remuneration Laws - Federal law prohibits, among other things, an entity from knowingly and willfully offering, paying, soliciting or receiving, subject to certain exceptions and "safe harbors," any remuneration to induce the referral of individuals or the purchase, lease or order of items or services for which payment may be made under Medicare, Medicaid or certain other federal and state health care programs. A number of states have similar laws, some of which are not limited to services paid for with government funds. Sanctions for violating these federal and state anti-remuneration laws may include imprisonment, criminal and civil fines, and exclusion from participation in Medicare, Medicaid and other federal and state government-sponsored health care programs. Companies involved in public health care programs such as Medicare and/or Medicaid are required to maintain compliance programs to detect and deter fraud, waste and abuse, and are often the subject of fraud, waste and abuse investigations and audits. The Company has invested significant resources to comply with Medicare and Medicaid program standards. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that the Company's compliance efforts in this area will continue to require significant resources.

Antitrust and Unfair Competition - The U.S. Federal Trade Commission ("FTC") investigates and prosecutes practices that are "unfair trade practices" or "unfair methods of competition." Numerous lawsuits have been filed throughout the United States against pharmaceutical manufacturers, retail pharmacies and/or PBMs under various federal and state antitrust and unfair competition laws challenging, among other things: (i) brand name drug pricing and rebate practices of pharmaceutical manufacturers, (ii) the maintenance of retail or specialty pharmacy networks by PBMs, and (iii) various other business practices of PBMs and retail pharmacies. In July 2021, the FTC approved several resolutions that direct agency staff to use compulsory process, such as subpoenas, to investigate seven specific enforcement priorities. Priority targets include, among other businesses, health care businesses, such as pharmaceutical companies, pharmacy benefits managers and hospitals. To the extent that the Company appears to have actual or potential market power in a relevant market or CVS Pharmacy, CVS Specialty or MinuteClinic plays a unique or expanded role in a Health Care Benefits or Pharmacy Services segment product offering, the Company's business arrangements and uses of confidential information may be subject to heightened scrutiny from an anti-competitive perspective and possible challenge by state and/or federal regulators and/or private parties.

Privacy and Confidentiality Requirements - Many of the Company's activities involve the receipt, use and disclosure by the Company of personally identifiable information ("PII") as permitted in accordance with applicable federal and state privacy and data security laws, which require organizations to provide appropriate privacy and security safeguards for such information. In addition to PII, the Company uses and discloses de-identified data for analytical and other purposes when permitted. Additionally, there are industry standards for handling credit card data known as the Payment Card Industry Data Security Standard, which are a set of requirements designed to help ensure that entities that process, store or transmit credit card information maintain a secure environment. Certain states have incorporated these requirements into state laws or enacted other requirements relating to the use and/or disclosure of PII.

The federal Health Insurance Portability and Accountability Act of 1996 and the regulations issued thereunder (collectively, "HIPAA"), as further modified by the American Recovery and Reinvestment Act of 2009 ("ARRA") impose extensive requirements on the way in which health plans, providers, health care clearinghouses (known as "covered entities") and their business associates use, disclose and safeguard protected health information ("PHI"). Further, ARRA requires the Company and other covered entities to report any breaches of PHI to impacted individuals and to the HHS and to notify the media in any states where 500 or more people are impacted by the unauthorized release or use of or access to PHI. Criminal penalties and civil sanctions may be imposed for failing to comply with HIPAA standards. The Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), enacted as part of ARRA, amended HIPAA to impose additional restrictions on third-party funded communications using PHI and the receipt of remuneration in exchange for PHI. The HITECH Act also extended HIPAA privacy and security requirements and penalties directly to business associates. HHS has begun to audit health plans, providers and other parties to enforce HIPAA compliance, including with respect to data security.

In addition to HIPAA, state health privacy laws apply to the extent they are more protective of individual privacy than is HIPAA, including laws that place stricter controls on the release of information relating to specific diseases or conditions and requirements to notify members of unauthorized release or use of or access to PHI. States also have adopted regulations to implement provisions of the Financial Modernization Act of 1999 (also known as the Gramm-Leach-Bliley Act ("GLBA")) which generally require insurers, including health insurers, to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer

shares such information with a non-affiliated third party. Like HIPAA, GLBA sets a "floor" standard, allowing states to adopt more stringent requirements governing privacy protection. Complying with additional state requirements requires us to make additional investments beyond those the Company has made to comply with HIPAA and GLBA.

The Cybersecurity Information Sharing Act of 2015 encourages organizations to share cyber threat indicators with the federal government and, among other things, directs HHS to develop a set of voluntary cybersecurity best practices for organizations in the health care industry. In addition, states have begun to enact more comprehensive privacy laws and regulations addressing consumer rights to data access, deletion, protection or transparency, such as the California Consumer Privacy Act ("CCPA"). States also are starting to issue regulations and proposed regulations specifically related to cybersecurity, such as the regulations issued by the New York Department of Financial Services. Complying with conflicting cybersecurity regulations, which may differ from state to state, requires significant resources. In addition, differing approaches to state privacy and/or cyber-security regulation and varying enforcement philosophies may materially and adversely affect the Company's ability to standardize its products and services across state lines. Widely-reported large scale commercial data breaches in the United States and abroad increase the likelihood that additional data security legislation will be considered by additional states. These legislative and regulatory developments will impact the design and operation of the Company's businesses, its privacy and security strategy and its web-based and mobile assets.

Finally, each Public Exchange is required to adhere to privacy and security standards with respect to PII, and to impose privacy and security standards that are at least as protective of PII as those the Public Exchange has implemented for itself or non-Public Exchange entities, which include insurers offering plans through the Public Exchange and their designated downstream entities, including PBMs and other business associates. These standards may differ from, and be more stringent than, HIPAA.

Consumer Protection Laws - The federal government has many consumer protection laws, such as the Federal Trade Commission Act, the Federal Postal Service Act and the Consumer Product Safety Act. Most states also have similar consumer protection laws and a growing number of states regulate subscription programs. In addition, the federal government and most states have adopted laws and/or regulations requiring places of public accommodation, health care services and other goods and services to be accessible to people with disabilities. These consumer protection and accessibility laws and regulations have been the basis for investigations, lawsuits and multistate settlements relating to, among other matters, the marketing of loyalty programs, and health care products and services, pricing accuracy, expired front store products, financial incentives provided by drug manufacturers to pharmacies in connection with therapeutic interchange programs, disclosures related to how personal data is used and protected and the accessibility of goods and services to people with disabilities. As a result of the Company's direct-to-consumer activities, including mobile and web-based solutions offered to members and to other consumers, the Company also is subject to federal and state regulations applicable to electronic communications and to other general consumer protection laws and regulations. For example, the CCPA became effective in 2020, and additional federal and state regulation of consumer privacy protection may be proposed or enacted in 2020. The Company expects these new laws and regulations to impact the design of its products and services and the management and operation of its businesses and to increase its compliance costs.

Transparency in Coverage Rule - In October 2020, the HHS, the U.S. Department of Labor ("DOL") and the U.S. Internal Revenue Service ("IRS," and together with the HHS and DOL, the "Tri-Departments") released a final rule requiring health insurers to disclose negotiated prices of drugs, medical services, supplies and other covered items. The rule requires group health plans and health insurance issuers in the individual and group markets to disclose cost-sharing information upon request, to a participant, beneficiary, or enrollee and require plans and issuers to publicly disclose in-network provider rates, historical out-of-network allowed amounts and the associated billed charges, and negotiated rates and historical net prices for prescription drugs. Disclosure of data in a machine readable file is required beginning in January 2022, and insurers are required to have a consumer tool in place by January 2023. In August 2021, the federal government delayed enforcement of the requirement to publish machine-readable files for in-network rates, out-of-network allowed amounts and billed charges until July 2022. It also delayed enforcement of machine-readable files related to prescription drug pricing until further rulemaking occurs. The public disclosure of insurer- or PBM-negotiated price concessions may result in drug manufacturers lowering discounts or rebates, resulting in higher drug costs for patients and impacting the ability of the Company to negotiate drug prices and provide competitive products and services to consumers.

Additionally, the Consolidated Appropriations Act of 2021 was signed into law in December 2020 and contains further transparency provisions requiring group health plans and health insurance issuers to report certain prescription drug costs, overall spending on health services and prescription drugs, and information about premiums and the impact of rebates and other remuneration on premiums and out-of-pocket costs to the Tri-Departments. No later than 18 months after the first submission and bi-annually thereafter, the Tri-Departments will release a public report on drug pricing trends, drug reimbursement, and the

impact of drug prices on premiums. In August, the Tri-Departments deferred enforcement of both the December 2021 deadline for reporting 2020 plan year data and the June 2022 deadline for reporting 2021 plan year data to December 2022.

Telemarketing and Other Outbound Contacts - Certain federal and state laws, such as the Telephone Consumer Protection Act and the Telemarketing Sales Rule, give the FTC, the Federal Communications Commission and state attorneys general the ability to regulate, and bring enforcement actions relating to, telemarketing practices and certain automated outbound contacts such as phone calls, texts or emails. Under certain circumstances, these laws provide consumers with a private right of action. Violations of these laws could result in substantial statutory penalties and other sanctions.

Pharmacy and Professional Licensure and Regulation - The Company is subject to a variety of intersecting federal and state statutes and regulations that govern the wholesale distribution of drugs; operation of retail, specialty, infusion, LTC and mail order pharmacies; licensure of facilities and professionals, including pharmacists, technicians, nurses and other health care professionals; registration of facilities with the U.S. Drug Enforcement Administration (the "DEA") and analogous state agencies that regulate controlled substances; packaging, storing, shipping and tracking of pharmaceuticals; repackaging of drug products; labeling, medication guides and other consumer disclosures; interactions with prescribers and health care professionals; compounding of prescription medications; dispensing of controlled and non-controlled substances; counseling of patients; transfers of prescriptions; advertisement of prescription products and pharmacy services; security; inventory control; recordkeeping; reporting to Boards of Pharmacy, the U.S. Food and Drug Administration (the "FDA"), the U.S. Consumer Product Safety Commission, the DEA and related state agencies; and other elements of pharmacy practice. Pharmacies are highly regulated and have contact with a wide variety of federal, state and local agencies with various powers to investigate, inspect, audit or solicit information, including Boards of Pharmacy and Nursing, the DEA, the FDA, the DOJ, HHS and others. Many of these agencies have broad enforcement powers, conduct audits on a regular basis, can impose substantial fines and penalties, and may revoke the license, registration or program enrollment of a facility or professional.

State Insurance, HMO and Insurance Holding Company Regulation - A number of states regulate affiliated groups of insurers and HMOs such as the Company under holding company statutes. These laws may, among other things, require prior regulatory approval of dividends and material intercompany transfers of assets and transactions between the regulated companies and their affiliates, including their parent holding companies. The Company expects the states in which its insurance and HMO subsidiaries are licensed to continue to expand their regulation of the corporate governance and internal control activities of its insurance companies and HMOs. Changes to state insurance, HMO and/or insurance holding company laws or regulations or changes to the interpretation of those laws or regulations, including due to regulators' increasing concerns regarding insurance company and/or HMO solvency due, among other things, to past and expected payor insolvencies, could negatively affect the Company's businesses in various ways, including through increases in solvency fund assessments, requirements that the Company hold greater levels of capital and/or delays in approving dividends from regulated subsidiaries.

PBM offerings of prescription drug coverage under certain risk arrangements may be subject to laws and regulations in various states. Such laws may require that the party at risk become licensed as an insurer, establish reserves or otherwise demonstrate financial viability. Laws that may apply in such cases include insurance laws and laws governing MCOs and limited prepaid health service plans. In addition, several states require that PBMs become directly registered or licensed with the department of insurance or similar government oversight agency regardless of any arrangements they have with clients. PBM licensure laws may include oversight of certain PBM activities and operations and may include auditing of those activities.

The states of domicile of the Company's regulated subsidiaries have statutory risk-based capital ("RBC") requirements for health and other insurance companies and HMOs based on the National Association of Insurance Commissioners' (the "NAIC") Risk-Based Capital for Insurers Model Act (the "RBC 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. The RBC Model Act sets forth the formula for calculating 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 company's business. 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. At December 31, 2021, the RBC level of each of the Company's insurance and HMO subsidiaries was above the level that would require regulatory action.

For information regarding restrictions on certain payments of dividends or other distributions by the Company's HMO and insurance company subsidiaries, see Note 12 ''Shareholders' Equity'' included in Item 8 of this 10-K.

The holding company laws for the states of domicile of certain of the Company's subsidiaries also restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes, without such approval (or an exemption), no person may acquire any voting security of an insurance holding company (such as the

Company's ultimate parent company, CVS Health Corporation) that controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would control the insurance holding company. 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.

Certain states have laws that prohibit submitting a false claim or making a false record or statement in order to secure reimbursement from an insurance company. These state laws vary, and violation of them may lead to the imposition of civil or criminal penalties.

Government Agreements and Mandates - From time to time, the Company and/or its various affiliates are subject to certain consent decrees, settlement and other agreements, corrective action plans and corporate integrity agreements with various federal, state and local authorities relating to such matters as privacy practices, controlled substances, PDPs, expired products, environmental and safety matters, marketing and advertising practices, PBM, LTC and other pharmacy operations and various other business practices. Certain of these agreements contain ongoing reporting, monitoring and/or other compliance requirements for the Company. Failure to meet the Company's obligations under these agreements could result in civil or criminal remedies, financial penalties, administrative remedies, and/or exclusion from participation in federal health care programs.

Environmental and Safety Regulation - The Company's businesses are subject to various federal, state and local laws, regulations and other requirements pertaining to protection of the environment, public health and employee safety, including, for example, regulations governing the management of hazardous substances, the cleaning up of contaminated sites, and the maintenance of safe working conditions in the Company's retail locations, distribution centers and other facilities. Governmental agencies at the federal, state and local levels continue to focus on the retail and health care sectors' compliance with such laws and regulations, and have at times pursued enforcement activities. Any failure to comply with these regulations could result in fines or other sanctions by government authorities.

ERISA Regulation - The Employee Retirement Income Security Act of 1974 ("ERISA"), provides for comprehensive federal regulation of certain employee pension and benefit plans, including private employer and union sponsored health plans and certain other plans that contract with us to provide PBM services. In general, the Company assists plan sponsors in the administration of their health benefit plans, including the prescription drug benefit portion of those plans, in accordance with the plan designs adopted by the plan sponsors. In addition, the Company may have fiduciary duties where it has specifically contracted with a plan sponsor to accept limited fiduciary responsibility, such as for the adjudication of initial prescription drug benefit claims and/or the appeals of denied claims under a plan. In addition to its fiduciary provisions, ERISA imposes civil and criminal liability on service providers to health plans and certain other persons if certain forms of illegal remuneration are made or received. These provisions of ERISA are broadly written and their application to specific business practices is often uncertain.

Some of the Company's health and related benefits and large case pensions products and services and related fees also are subject to potential issues raised by judicial interpretations relating to ERISA. Under those interpretations, together with DOL regulations, the Company may have ERISA fiduciary duties with respect to PBM members and/or certain general account assets held under contracts that are not guaranteed benefit policies. As a result, certain transactions related to those general account assets are subject to conflict of interest and other restrictions, and the Company must provide certain disclosures to policyholders annually. The Company must comply with these restrictions or face substantial penalties.

In addition, ERISA generally preempts all state and local laws that relate to employee benefit plans, but the extent of the pre-emption continues to be reviewed by courts, including the U.S. Supreme Court. For example, in December 2020, the U.S. Supreme Court upheld an Arkansas law that, among other things, mandates a particular pricing methodology, establishes an appeals process for a pharmacy when the reimbursement is below the pharmacy's acquisition cost, permits a pharmacy to reverse and rebill if they cannot procure the drug from its wholesaler at a price equal to or less than the reimbursement rate, prohibits a PBM from reimbursing a pharmacy less than the amount it reimburses an affiliate on a per unit basis, and permits a pharmacy to decline to dispense if the reimbursement is lower than the pharmacy's acquisition cost. Also, in November 2021, the U.S. Court of Appeals for the Eighth Circuit upheld a North Dakota law that regulates employer-sponsored ERISA health plans and certain PBM practices within Medicare.

Other Legislative Initiatives and Regulatory Initiatives - The U.S. federal and state governments, as well as governments in other countries where the Company does business, continue to enact and seriously consider many broad-based legislative and regulatory proposals that have had a material impact on or could materially impact various aspects of the health care and related benefits system and the Company's businesses, operating results and/or cash flows. For example:

- Under the Budget Control Act of 2011 and the American Taxpayer Relief Act of 2012 significant, automatic across-the-board budget cuts (known as sequestration) began in March 2013, including Medicare spending cuts of not more than 2% of total program costs per year through 2024. Since then, Congress has extended and modified sequestration a number of times. The CARES Act temporarily suspended Medicare sequestration from May 2020 to the end of December 2020 and extended mandatory sequestration to 2030. Several subsequent acts have extended the temporary suspension of Medicare sequestration through the end of March 2022, at which point a 1% sequestration will take effect April 2022 through June 2022, with the full 2% sequestration due to resume in July 2022. Significant uncertainty remains as to whether and how the U.S. Congress will proceed with actions that create additional federal revenue and/or with entitlement reform. The Company cannot predict future federal Medicare or federal or state Medicaid funding levels or the impact that future federal or state budget actions or entitlement program reform, if it occurs, will have on the Company's businesses, operations or operating results, but the effects could be materially adverse, particularly on the Company's Medicare and/or Medicaid revenues, MBRs and operating results.
- The European Union's ("EU's") General Data Protection Regulation ("GDPR") began to apply across the EU during 2018.
- Other significant legislative and/or regulatory measures which are or recently have been under consideration include the following:
    - Increasing the corporate tax rate.
    - Eliminating payment of manufacturer's rebates on prescription drugs to PBMs, PDPs and Managed Medicaid organizations in connection with federally funded health care programs.
    - Imposing requirements and restrictions on the design and/or administration of pharmacy benefit plans offered by the Company's and its clients' health plans and/or its PBM clients and/or the services the Company provides to those clients, including prohibiting "differential" or "spread" pricing in PBM contracts; restricting or eliminating the use of formularies for prescription drugs; restricting the Company's ability to require members to obtain drugs through a home delivery or specialty pharmacy; restricting the Company's ability to place certain specialty or other drugs in the higher cost tiers of its pharmacy formularies; restricting the Company's ability to make changes to drug formularies and/or clinical programs; limiting or eliminating rebates on pharmaceuticals; requiring the use of up front purchase price discounts on pharmaceuticals in lieu of rebates; restricting the Company's ability to configure and reimburse its health plan and retail pharmacy provider networks, including use of CVS Pharmacy locations; and restricting or eliminating the use of certain drug pricing methodologies.
    - Increasing federal or state government regulation of, or involvement in, the pricing and/or purchasing of drugs.
    - Restricting the Company's ability to limit providers' participation in its networks and/or remove providers from its networks by imposing network adequacy requirements or otherwise (including in its Medicare and Commercial Health Care Benefits products).
    - Imposing assessments on (or to be collected by) health plans or health carriers that may or may not be passed through to their customers. These assessments may include assessments for insolvency, the uninsured, uncompensated care, Medicaid funding or defraying health care provider medical malpractice insurance costs.
    - Mandating coverage by the Company's and its clients' health plans for additional conditions and/or specified procedures, drugs or devices (e.g., high cost pharmaceuticals, experimental pharmaceuticals and oral chemotherapy regimens).
    - Regulating electronic connectivity.
    - Mandating or regulating the disclosure of provider fee schedules, manufacturer's rebates and other data about the Company's payments to providers and/or payments the Company receives from pharmaceutical manufacturers.
    - Mandating or regulating disclosure of provider outcome and/or efficiency information.
    - Prescribing or limiting members' financial responsibility for health care or other covered services they utilize, including restricting "surprise" bills by providers and by specifying procedures for resolving "surprise" bills.
    - Prescribing payment levels for health care and other covered services rendered to the Company's members by providers who do not have contracts with the Company.
    - Assessing the medical device status of home infusion therapy products and/or solutions, mobile consumer wellness tools and clinical decision support tools, which may require compliance with FDA requirements in relation to some of these products, solutions and/or tools.
    - Restricting the ability of employers and/or health plans to establish or impose member financial responsibility.
    - Proposals to expand benefits under Original Medicare.
    - Amending or supplementing ERISA to impose greater requirements on PBMs or the administration of employer-funded benefit plans or limit the scope of current ERISA pre-emption, which would among other things expose

the Company and other health plans to expanded liability for punitive and other extra-contractual damages and additional state regulation.

It is uncertain whether the Company can counter the potential adverse effects of such potential legislation or regulation on its operating results or cash flows, including whether it can recoup, through higher premium rates, expanded membership or other measures, the increased costs of mandated coverage or benefits, assessments, fees, taxes or other increased costs, including the cost of modifying its systems to implement any enacted legislation or regulations.

The Company's businesses also may be affected by other legislation and regulations. The Dodd-Frank Wall Street Reform and Consumer Protection Act creates incentives for whistleblowers to speak directly to the government rather than utilizing internal compliance programs and reduces the burden of proof under the Foreign Corrupt Practices Act of 1977 (the "FCPA"). There also are laws and regulations that set standards for the escheatment of funds to states.

Health savings accounts, health reimbursement arrangements and flexible spending accounts and certain of the tax, fee and subsidy provisions of the ACA also are regulated by the U.S. Department of the Treasury and the Internal Revenue Service.

The Company also may be adversely affected by court and regulatory decisions that expand or revise the interpretations of existing statutes and regulations or impose medical malpractice or bad faith liability. Federal and state courts, including the U.S. Supreme Court, continue to consider cases, and federal and state regulators continue to issue regulations and interpretations, addressing bad faith liability for denial of medical claims, the scope of ERISA's fiduciary duty requirements, the scope of the False Claims Act and the pre-emptive effect of ERISA and Medicare Part D on state laws.

Contract Audits - The Company is subject to audits of many of its contracts, including its PBM client contracts, its PBM rebate contracts, its PBM network contracts, its contracts relating to Medicare Advantage and/or Medicare Part D, the agreements the Company's pharmacies enter into with other payors, its Medicaid contracts and its customer contracts. Because some of the Company's contracts are with state or federal governments or with entities contracted with state or federal agencies, audits of these contracts are often regulated by the federal or state agencies responsible for administering federal or state benefits programs, including those which operate Medicaid fee for service plans, Managed Medicaid plans, Medicare Part D plans or Medicare Advantage organizations.

Federal Employee Health Benefits Program - The Company's subsidiaries contract with the Office of Personnel Management (the "OPM") to provide managed health care services under the FEHB program in their service areas. These contracts with the OPM and applicable government regulations establish premium rating arrangements for this program. In addition to other requirements, such as the Transparency in Coverage Rule note above, OPM regulations require that community-rated FEHB plans meet a FEHB program-specific minimum MLR by plan code and market. Managing to these rules is complicated by the simultaneous application of the minimum MLR standards and associated premium rebate requirements of the ACA. The Company also has a contractual arrangement with carriers for the FEHB program, such as the BlueCross BlueShield Association, to provide pharmacy services to federal employees, postal workers, annuitants, and their dependents under the Government-wide Service Benefit Plan, as authorized by the FEHB Act and as part of the FEHB program. Additionally, the Company manages certain FEHB plans on a "cost-plus" basis. These arrangements subject the Company to certain aspects of the FEHB Act, and other federal regulations, such as the FEHB Acquisition Regulation, that otherwise would not be applicable to the Company. The OPM also is auditing the Company and its other contractors to, among other things, verify that plans meet their applicable FEHB program-specific MLR and the premiums established under the OPM's Insured contracts and costs allocated pursuant to the OPM's cost-based contracts are in compliance with the requirements of the applicable FEHB program. The OPM may seek premium refunds or institute other sanctions against the Company if it fails to comply with the FEHB program requirements.

Clinical Services Regulation - The Company provides clinical services to health plans, PBMs and providers for a variety of complex and common medical conditions, including arranging for certain members to participate in disease management programs. State laws regulate the practice of medicine, the practice of pharmacy, the practice of nursing and certain other clinical activities. Clinicians engaged in a professional practice in connection with the provision of clinical services must satisfy applicable state licensing requirements and must act within their scope of practice.

Third Party Administration and Other State Licensure Laws - Many states have licensure or registration laws governing certain types of administrative organizations, such as PPOs, TPAs and companies that provide utilization review services. Several states also have licensure or registration laws governing the organizations that provide or administer consumer card programs (also known as cash card or discount card programs).

International Regulation - The Company has insurance licenses in several foreign jurisdictions and does business directly or through local affiliations in numerous countries around the world. The Company has taken steps to be able to continue to serve customers in the European Economic Area following the United Kingdom's exit from the EU ("Brexit").

The Company's international operations are subject to different, and sometimes more stringent, legal and regulatory requirements, which vary widely by jurisdiction, including anti-corruption laws; economic sanctions laws; various privacy, insurance, tax, tariff and trade laws and regulations; corporate governance, privacy, data protection (including the EU's General Data Protection Regulation which began to apply across the EU during 2018), data mining, data transfer, labor and employment, intellectual property, consumer protection and investment laws and regulations; discriminatory licensing procedures; compulsory cessions of reinsurance; required localization of records and funds; higher premium and income taxes; limitations on dividends and repatriation of capital; and requirements for local participation in an insurer's ownership. In addition, the expansion of the Company's operations into foreign countries increases the Company's exposure to the anti-bribery, anti-corruption and anti-money laundering provisions of U.S. law, including the FCPA, and corresponding foreign laws, including the U.K. Bribery Act 2010 (the "UK Bribery Act").

Anti-Corruption Laws - The FCPA prohibits offering, promising or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage. The Company also is subject to applicable anti-corruption laws of the jurisdictions in which it operates. In many countries outside the United States, health care professionals are employed by the government. Therefore, the Company's dealings with them are subject to regulation under the FCPA. Violations of the FCPA and other anti-corruption laws may result in severe criminal and civil sanctions as well as other penalties, and there continues to be a heightened level of FCPA enforcement activity by the U.S. Securities and Exchange Commission (the "SEC") and the DOJ. The UK Bribery Act is an anti-corruption law that is broader in scope than the FCPA and applies to all companies with a nexus to the United Kingdom. Disclosures of FCPA violations may be shared with the UK authorities, thus potentially exposing companies to liability and potential penalties in multiple jurisdictions.

Anti-Money Laundering Regulations - Certain lines of the Company's businesses are subject to Treasury anti-money laundering regulations. Those lines of business have implemented anti-money laundering policies designed to ensure their compliance with the regulations. The Company also is subject to anti-money laundering laws in non-U.S. jurisdictions where it operates.

Office of Foreign Assets Control - The Company also is subject to regulation by the Office of Foreign Assets Control of the U.S. Department of Treasury ("OFAC"). OFAC administers and enforces economic and trade sanctions based on U.S. foreign policy and national security goals against targeted foreign countries and regimes, terrorists, international narcotics traffickers, those engaged in activities related to the proliferation of weapons of mass destruction, and other threats to the national security, foreign policy or economy of the United States. In addition, the Company is subject to similar regulations in the non-U.S. jurisdictions in which it operates.

FDA Regulation - The FDA regulates the Company's compounding pharmacy and clinical research operations. The FDA also generally has authority to, among other things, regulate the manufacture, distribution, sale and labeling of medical devices (including hemodialysis devices such as the device the Company is developing and mobile medical devices) and many products sold through retail pharmacies, including prescription drugs, over-the-counter medications, cosmetics, dietary supplements and certain food items. In addition, the FDA regulates the Company's activities as a distributor of store brand products.

Laws and Regulations Related to the Health Care Benefits Segment

In addition to the laws and regulations discussed above that may affect multiple segments of the Company's business, the Company is subject to federal, state, local and international statutes and regulations governing its Health Care Benefits segment specifically.

Overview - Differing approaches to state insurance regulation and varying enforcement philosophies may materially and adversely affect the Company's ability to standardize its Health Care Benefits products and services across state lines. These laws and regulations, including the ACA, restrict how the Company conducts its business and result in additional burdens and costs to the Company. Significant areas of governmental regulation include premium rates and rating methodologies, underwriting rules and procedures, required benefits, sales and marketing activities, provider rates of payment, restrictions on health plans' ability to limit providers' participation in their networks and/or remove providers from their networks and financial condition (including reserves and minimum capital or risk based capital requirements). These laws and regulations are different in each jurisdiction and vary from product to product.

Each health insurer and HMO must file periodic financial and operating reports with the states in which it does business. In addition, health insurers and HMOs are subject to state examination and periodic license renewal. Applicable laws also restrict the ability of the Company's regulated subsidiaries to pay dividends, and certain dividends require prior regulatory approval. In addition, some of the Company's businesses and related activities may be subject to PPO, MCO, utilization review or TPA-related licensure requirements and regulations. These licensure requirements and regulations differ from state to state, but may contain provider network, contracting, product and rate, financial and reporting requirements. There also are laws and regulations that set specific standards for the Company's delivery of services, payment of claims, fraud prevention, protection of consumer health information, and payment for covered benefits and services.

Required Regulatory Approvals - The Company must obtain and maintain regulatory approvals to price, market and administer many of its Health Care Benefits products. Supervisory agencies, including CMS, the Center for Consumer Information and Insurance Oversight and the DOL, as well as state health, insurance, managed care and Medicaid agencies, have broad authority to take one or more of the following actions:

- Grant, suspend and revoke the Company's licenses to transact business;
- Suspend or exclude the Company from participation in government programs;
- Suspend or limit the Company's authority to market products;
- Regulate many aspects of the products and services the Company offers, including the pricing and underwriting of many of its products and services;
- Assess damages, fines and/or penalties;
- Terminate the Company's contract with the government agency and/or withhold payments from the government agency to the Company;
- Impose retroactive adjustments to premiums and require the Company to pay refunds to the government, customers and/or members;
- Restrict the Company's ability to conduct acquisitions or dispositions;
- Require the Company to maintain minimum capital levels in its subsidiaries and monitor its solvency and reserve adequacy;
- Regulate the Company's investment activities on the basis of quality, diversification and other quantitative criteria; and/or
- Exclude the Company's plans from participating in Public Exchanges if they are deemed to have a history of "unreasonable" premium rate increases or fail to meet other criteria set by HHS or the applicable state.

The Company's operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time the Company receives subpoenas and other requests for information from, federal, state and international supervisory and enforcement agencies, attorneys general and other state, federal and international governmental authorities and legislators.

Commercial Product Pricing and Underwriting Restrictions - Pricing and underwriting regulation by states limits the Company's underwriting and rating practices and those of other health insurers, particularly for small employer groups, and varies by state. In general, these limitations apply to certain customer segments and limit the Company's ability to set prices for new or renewing groups, or both, based on specific characteristics of the group or the group's prior claim experience. In some states, these laws and regulations restrict the Company's ability to price for the risk it assumes and/or reflect reasonable costs in the Company's pricing.

The ACA expanded the premium rate review process by, among other things, requiring the Company's Commercial Insured rates to be reviewed for "reasonableness" at either the state or the federal level. HHS established a federal premium rate review process that generally applies to proposed premium rate increases equal to or exceeding a federally (or lower state) specified threshold. HHS's rate review process imposes additional public disclosure requirements as well as additional review on filings requesting premium rate increases equal to or exceeding this "reasonableness" threshold. These combined state and federal review requirements may prevent, further delay or otherwise affect the Company's ability to price for the risk it assumes, which could adversely affect its MBRs and operating results, particularly during periods of increased utilization of medical services and/or medical cost trend or when such utilization and/or trend exceeds the Company's projections.

The ACA also specifies minimum MLRs of 85% for large group Commercial products and 80% for individual and small group Commercial products. Because the ACA minimum MLRs are structured as "floors" for many of their requirements, states have the latitude to enact more stringent rules governing these restrictions. For Commercial products, states have and may adopt higher minimum MLR requirements, use more stringent definitions of "medical loss ratio," incorporate minimum MLR

requirements into prospective premium rate filings, require prior approval of premium rates or impose other requirements related to minimum MLR. Minimum MLR requirements and similar actions further limit the level of margin the Company can earn in its Insured Commercial products while leaving the Company exposed to medical costs that are higher than those reflected in its pricing. The Company also may be subject to significant fines, penalties, premium refunds and litigation if it fails to comply with minimum MLR laws and regulations.

In addition, the Company requested increases in its premium rates in its Commercial Health Care Benefits business for 2022 and expects to continue to request increases in those rates for 2023 and beyond in order to adequately price for projected medical cost trends, required expansions of coverage and rating limits, and significant assessments, fees and taxes imposed by the federal and state governments, including as a result of the ACA. The Company's rates also must be adequate to reflect adverse selection in its products, particularly in small group Commercial products. These rate increases may be significant and thus heighten the risks of adverse publicity, adverse regulatory action and adverse selection and the likelihood that the Company's requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.

Many of the laws and regulations governing the Company's pricing and underwriting practices also limit the differentials in premium rates insurers and other carriers may charge between new and renewal business, and/or between groups based on differing characteristics. They may also require that carriers disclose to customers the basis on which the carrier establishes new business and renewal premium rates and limit the ability of a carrier to terminate customers' coverage.

Recently, with respect to quality improvement activities ("QIAs") that health plans report to HHS, revised regulations no longer provide insurers the option of reporting a flat amount equal to 0.8 percent of earned premium in lieu of reporting the insurers' actual itemized QIA expenditures. This change will impact the Company's future MLR calculations and reporting since we have utilized the 0.8 percent premium election.

Medicaid Regulation - The Company is seeking to substantially grow its Medicaid, dual eligible and dual eligible special needs plan businesses over the next several years. As a result, the Company also is increasing its exposure to changes in government policy with respect to and/or regulation of the various Medicaid, dual eligible and dual eligible special needs plan programs in which the Company participates, including changes in the amounts payable to the Company under those programs.

Since 2017, Managed Medicaid products, including those the Company offers, are subject to a minimum federal MLR of 85%. A Medicaid managed care quality rating system and provider network adequacy requirements also apply to Medicaid products. Because the federal minimum MLR is structured as a "floor," states have the latitude to enact more stringent rules governing these restrictions. For Managed Medicaid products, states may adopt higher minimum MLR requirements, use more stringent definitions of "medical loss ratio" or impose other requirements related to minimum MLR. Minimum MLR requirements and similar actions further limit the level of margin the Company can earn in its Insured Medicaid products while leaving the Company exposed to medical costs that are higher than those reflected in its pricing. The Company also may be subject to significant fines, penalties, premium refunds and litigation if it fails to comply with minimum MLR laws and regulations.

States continue to consider Medicaid expansion; however, 12 states have still not decided to expand as of 2022. States may opt out of the elements of the ACA requiring expansion of Medicaid coverage without losing their current federal Medicaid funding. In addition, the election of new governors and/or state legislatures may impact states' previous decisions regarding Medicaid expansion. Although Congress enacted incentives for states that had not yet done so to expand Medicaid, this incentive alone may not persuade holdout states to expand.

In 2021, Medicaid MCOs faced new requirements and state flexibility that were finalized in the 2020 Medicaid managed care final rule. States now have flexibility related to rate setting and provider network adequacy that could adversely or positively impact our Medicaid plans. Other changes related to managed care operations include beneficiary communications, appeals and grievances, and provider directories.

The economic aspects of the Medicaid, dual eligible and dual eligible special needs plan business vary from state to state and are subject to frequent change. Medicaid premiums are paid by each state and differ from state to state. The federal government and certain states also are considering proposals and legislation for Medicaid and dual eligible program reforms or redesigns, including restrictions on the collection of manufacturer's rebates on pharmaceuticals by Medicaid MCOs and their contracted PBMs, further program, population and/or geographic expansions of risk-based managed care, increasing beneficiary cost-sharing or payment levels, and changes to benefits, reimbursement, eligibility criteria, provider network adequacy requirements (including requiring the inclusion of specified high cost providers in the Company's networks) and program structure. In some states, current Medicaid and dual eligible funding and premium revenue may not be adequate for the Company to continue

program participation. The Company's Medicaid and dual eligible contracts with states (or sponsors of Medicaid managed care plans) are subject to cancellation by the state (or the sponsors of the managed care plans) after a short notice period without cause (e.g., when a state discontinues a managed care program) or in the event of insufficient state funding.

The Company's Medicaid, dual eligible and dual eligible special needs plan products also are heavily regulated by CMS and state Medicaid agencies, which have the right to audit the Company's performance to determine compliance with CMS contracts and regulations. The Company's Medicaid products, dual eligible products and CHIP contracts also are subject to complex federal and state regulations and oversight by state Medicaid agencies regarding the services provided to Medicaid enrollees, payment for those services, network requirements (including mandatory inclusion of specified high-cost providers), and other aspects of these programs, and by external review organizations which audit Medicaid plans on behalf of state Medicaid agencies. The laws, regulations and contractual requirements applicable to the Company and other participants in Medicaid and dual eligible programs, including requirements that the Company submit encounter data to the applicable state agency, are extensive, complex and subject to change. The Company has invested significant resources to comply with these standards, and its Medicaid and dual eligible program compliance efforts will continue to require significant resources. CMS and/or state Medicaid agencies may fine the Company, withhold payments to the Company, seek premium and other refunds, terminate the Company's existing contracts, elect not to award the Company new contracts or not to renew the Company's existing contracts, prohibit the Company from continuing to market and/or enroll members in or refuse to automatically assign members to one or more of the Company's Medicaid or dual eligible products, exclude the Company from participating in one or more Medicaid or dual eligible programs and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with CMS or state regulations or contractual requirements.

The Company cannot predict whether pending or future federal or state legislation or court proceedings will change various aspects of the Medicaid program, nor can it predict the impact those changes will have on its business operations or operating results, but the effects could be materially adverse.

Federal and State Reporting - The Company is subject to extensive financial and business reporting requirements, including penalties for inaccuracies and/or omissions, at both the federal and state level. The Company's ability to comply with certain of these requirements depends on receipt of information from third parties that may not be readily available or reliably provided in all instances. The Company is and will continue to be required to modify its information systems, dedicate significant resources and incur significant expenses to comply with these requirements. However, the Company cannot eliminate the risks of unavailability of or errors in its reports.

Product Design and Administration and Sales Practices - State and/or federal regulatory scrutiny of health care benefit product design and administration and marketing and advertising practices, including the filing of insurance policy forms, the adequacy of provider networks, the accuracy of provider directories, and the adequacy of disclosure regarding products and their administration, is increasing as are the penalties being imposed for inappropriate practices. Medicare, Medicaid and dual eligible products and products offering more limited benefits in particular continue to attract increased regulatory scrutiny.

Guaranty Fund Assessments/Solvency Protection - Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. The Company's assessments generally are based on a formula relating to the Company's health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer governed health plans established under the ACA. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that limit future offsets.

Laws and Regulations Related to the Pharmacy Services Segment

In addition to the laws and regulations discussed above that may affect multiple segments of the Company's business, the Company is subject to federal, state and local statutes and regulations governing the operation of its Pharmacy Services segment specifically. Among these are the following:

PBM Laws and Regulation - Legislation and/or regulations seeking to regulate PBM activities in a comprehensive manner have been proposed or enacted in a number of states. This legislation could adversely affect the Company's ability to conduct business on commercially reasonable terms in states where the legislation is in effect and the Company's ability to standardize

its PBM products and services across state lines. In addition, certain quasi-regulatory organizations, including the National Association of Boards of Pharmacy and the NAIC and the National Council of Insurance Legislators, have issued model regulations or may propose future regulations concerning PBMs and/or PBM activities. Similarly, credentialing organizations such as URAC have established voluntary standards regarding PBM, mail order pharmacy and/or specialty pharmacy activities. While the actions of these quasi-regulatory or standard-setting organizations do not have the force of law, they may influence states to adopt their requirements or recommendations and influence client requirements for PBM, mail order pharmacy and/or specialty pharmacy services. Moreover, any standards established by these organizations could also impact the Company's health plan clients and/or the services provided to those clients and/or the Company's health plans.

The Company's PBM activities also are regulated directly and indirectly at the federal and state levels, including being subject to the False Claims Act and state false claims acts and the AKS and state anti-kickback laws. These laws and regulations govern, and proposed legislation and regulations may govern and/or further restrict, critical PBM practices, including disclosure, receipt and retention of rebates and other payments received from pharmaceutical manufacturers; use of, administration of and/or changes to drug formularies, maximum allowable cost ("MAC") list pricing, average wholesale prices ("AWP") and/or clinical programs; the offering to plan sponsors of pricing that includes retail network "differential" or "spread" (i.e., a difference between the drug price charged to the plan sponsor by a PBM and the price paid by the PBM to the dispensing provider); reconciliation to pricing guarantees; disclosure of data to third parties; drug UM practices; the level of duty a PBM owes its customers; configuration of pharmacy networks; the operations of the Company's pharmacies (including audits of its pharmacies); disclosure of negotiated provider reimbursement rates; disclosure of fees associated with administrative service agreements and patient care programs that are attributable to members' drug utilization; and registration or licensing of PBMs. Failure by the Company or one of its PBM services suppliers to comply with these laws or regulations could result in material fines and/or sanctions and could have a material adverse effect on the Company's operating results and/or cash flows.

The Company's PBM service contracts, including those in which the Company assumes certain risks under performance guarantees or similar arrangements, are generally not subject to insurance regulation by the states. However, state departments of insurance are increasing their oversight of PBM activities due to legislation passing in a number of states requiring PBMs to register or obtain a license with the department, including through market conduct examinations and other audits our licensed entities. In addition, rulemaking is either underway or has already taken place in a number of states with the areas of focus on licensure requirements, pharmacy reimbursement for generics (MAC reimbursement) and pharmacy audits - most of which fall under the state insurance code.

Most-Favored-Nation Rule - In November 2020, HHS released the Most-Favored-Nation Rule (the "MFN Rule"), which requires CMS to take a most-favored-nation approach in calculating payment for Medicare Part B drugs. The MFN Rule will test paying Part B drugs at comparable amounts to the lowest adjusted price paid by any country in the Organization for Economic Co-operation and Development that has a Gross Domestic Product ("GDP") per capita that is at least 60% of the U.S. GDP per capita. The MFN Rule will also test a redesign of the percentage add-on payment structure under Medicare Part B to remove incentives for use of higher-cost drugs through a flat per-dose add-on payment, and will include a financial hardship exemption for participants. The mandatory MFN Rule will operate for seven years, from January 1, 2021 to December 31, 2027. Over the course of the model, CMS will monitor and evaluate the impact of the MFN Rule on beneficiary access to drugs, program costs, and the quality of care for beneficiaries. Further, CMS commits to assess initial impacts of the MFN Rule on quality of care, including access to drugs, prior to beginning performance year 5. Multiple pharmaceutical manufacturers have sued HHS over the rule, and it is currently delayed due to a temporary restraining order prohibiting CMS from implementing it. If implemented, the MFN Rule may impact the ability of the Company to negotiate drug prices and provide competitive products and services to consumers. In August 2021, CMS published a proposed rule to rescind the MFN Rule. It is unclear whether this rescission may be followed by regulatory or legislative alternatives that present similar, or even more substantial, patient access, provider reimbursement, and other concerns.

Pharmacy Network Access Legislation - Medicare Part D and a majority of states now have some form of legislation affecting the Company's (and its health plans' and its health plan clients') ability to limit access to a pharmacy provider network or remove pharmacy network providers. For example, certain "any willing provider" legislation may require the Company or its clients to admit a nonparticipating pharmacy if such pharmacy is willing and able to meet the plan's price and other applicable terms and conditions for network participation. These laws could negatively affect the services and economic benefits achievable through a limited pharmacy provider network. Also, a majority of states now have some form of legislation affecting the Company's ability (and the Company's and its client health plans' ability) to conduct audits of network pharmacies regarding claims submitted to the Company for payment. These laws could negatively affect the Company's ability to recover overpayments of claims submitted by network pharmacies that the Company identifies through pharmacy audits.

Finally, several states have passed legislation that limits the ability of PBMs and health insurers to provide special benefit structures for use with affiliated pharmacies, which could result in reduced savings to clients and consumers.

Pharmacy Pricing Legislation - A number of states have passed legislation regulating the Company's ability to manage and establish MACs for generic prescription drugs. MAC methodology is a common cost management practice used by private and public payors (including CMS) to pay pharmacies for dispensing generic prescription drugs. MAC prices specify the allowable reimbursement by a PBM for a particular strength and dosage of a generic drug that is available from multiple manufacturers but sold at different prices. State legislation can regulate the disclosure of MAC prices and MAC price methodologies, the kinds of drugs that a PBM can pay for at a MAC price, and the rights of pharmacies to appeal a MAC price established by a PBM. These laws could negatively affect the Company's ability to establish MAC prices for generic drugs. Additionally, some states have passed legislation that would create a reimbursement benchmark mandate, such as the national average drug acquisition cost and/or the wholesale acquisition cost ("WAC"), plus a set dispensing fee, for pharmacies in the network.

Formulary and Plan Design Regulation - A number of government entities regulate the administration of prescription drug benefits. HHS regulates how Medicare Part D formularies are developed and administered, including requiring the inclusion of all drugs in certain classes and categories, subject to limited exceptions. Under the ACA, CMS imposes drug coverage requirements for health plans required to cover essential health benefits, including plans offered through federal or state Public Exchanges. Additionally, the NAIC and health care accreditation agencies like NCQA and URAC have developed model acts and standards for formulary development that are often incorporated into government requirements. Many states regulate the scope of prescription drug coverage, as well as the delivery channels to receive prescriptions, for insurers, MCOs and Medicaid managed care plans. The increasing government regulation of formularies could significantly affect the Company's ability to develop and administer formularies, pharmacy networks and other plan design features. Similarly, some states prohibit health plan sponsors from implementing certain restrictive pharmacy benefit plan design features. This regulation could limit or preclude (i) limited networks, (ii) a requirement to use particular providers, (iii) copayment differentials among providers and (iv) formulary tiering practices.

Laws and Regulations Related to the Retail/LTC Segment

In addition to the laws and regulations discussed above that may affect multiple segments of the Company's business, the Company is subject to federal, state and local statutes and regulations governing the operation of its Retail/LTC segment specifically. Among these are the following:

Retail Medical Clinics - States regulate retail medical clinics operated by nurse practitioners or physician assistants through physician oversight, clinic and lab licensure requirements and the prohibition of the corporate practice of medicine. A number of states have implemented or proposed laws or regulations that impact certain components of retail medical clinic operations such as physician oversight, signage, third party contracting requirements, bathroom facilities, and scope of services. These laws and regulations may affect the operation and expansion of the Company's owned and managed retail medical clinics.

Other Laws - Other federal, state and local laws and regulations also impact the Company's retail operations, including laws and regulations governing the practice of optometry, the practice of audiology, the provision of dietician services and the sale of durable medical equipment, contact lenses, eyeglasses, hearing aids and alcohol.

Available Information

CVS Health Corporation was incorporated in Delaware in 1996. The corporate office is located at One CVS Drive, Woonsocket, Rhode Island 02895, telephone (401) 765-1500. CVS Health Corporation's common stock is listed on the New York Stock Exchange under the trading symbol "CVS." General information about the Company is available through the Company's website at *http://www.cvshealth.com*. The Company's financial press releases and filings with the SEC are available free of charge within the Investors section of the Company's website at *http://investors.cvshealth.com*. In addition, the SEC maintains an internet site that contains reports, proxy and information statements and other information regarding issuers, such as the Company, that file electronically with the SEC. The address of that website is *http://www.sec.gov.* The information on or linked to the Company's website is neither a part of nor incorporated by reference in this 10-K or any of the Company's other SEC filings.

In accordance with guidance provided by the SEC regarding use by a company of its websites and social media channels as a means to disclose material information to investors and to comply with its disclosure obligations under SEC Regulation FD, CVS Health Corporation (the "Registrant") hereby notifies investors, the media and other interested parties that it intends to continue to use its media and investor relations website (*http://investors.cvshealth.com/*) and its Twitter feed (@CVSHealthIR)

to publish important information about the Registrant, including information that may be deemed material to investors. The list of social media channels that the Registrant uses may be updated on its media and investor relations website from time to time. The Registrant encourages investors, the media, and other interested parties to review the information the Registrant posts on its website and social media channels as described above, in addition to information announced by the Registrant through its SEC filings, press releases and public conference calls and webcasts.

Item 1A. Risk Factors.

You should carefully consider each of the following risks and uncertainties and all of the other information set forth in this 10-K. These risks and uncertainties and other factors may affect forward-looking statements, including those we make in this 10-K or elsewhere, such as in news releases or investor or analyst calls, meetings or presentations, on our websites or through our social media channels. The risks and uncertainties described below are not the only ones we face. There can be no assurance that we have identified all the risks that affect us. Additional risks and uncertainties not presently known to us or that we currently believe to be immaterial also may adversely affect our businesses. Any of these risks or uncertainties could cause our actual results to differ materially from our expectations and the expected results discussed in our forward-looking statements. You should not consider past results to be an indication of future performance.

If any of the following risks or uncertainties develops into actual events or if the circumstances described in the risks or uncertainties occur or continue to occur, those events or circumstances could have a material adverse effect on our businesses, operating results, cash flows, financial condition and/or stock price, among other effects on us. You should read the following section in conjunction with the MD&A, included in Item 7 of this 10-K, our consolidated financial statements and the related notes, included in Item 8 of this 10-K, and our "Cautionary Statement Concerning Forward-Looking Statements" in this 10-K.

Summary

The following is a summary of the principal risks we face that could negatively impact our businesses, operating results, cash flows and/or financial condition:

Risks Relating to Our Businesses

- The impact COVID-19 will have on our businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be material and adverse.
- We may not be able to accurately forecast health care and other benefit costs.
- Adverse economic conditions in the U.S. and abroad can materially and adversely impact our businesses, operating results, cash flows and financial condition.
- Each of our segments operates in a highly competitive and evolving business environment.
- A change in our Health Care Benefits product mix may adversely affect our profit margins.
- We can provide no assurance that we will be able to compete successfully and profitably on Public Exchanges.
- Negative public perception of the industries in which we operate can adversely affect our businesses, operating results, cash flows and prospects.
- We must maintain and improve our relationships with our customers and increase the demand for our products and services.
- We face risks relating to the availability, pricing and safety profiles of prescription drugs that we purchase and sell.
- The reserves we hold for expected claims in our Insured Health Care Benefits products are based on estimates that involve an extensive degree of judgment and are inherently variable, and any reserve, including a premium deficiency reserve, may be insufficient.
- We are exposed to risks relating to the solvency of other insurers.

Risks From Changes in Public Policy and Other Legal and Regulatory Risks

- We are subject to potential changes in public policy, laws and regulations, including reform of the U.S. health care system and entitlement programs.
- If we fail to comply with applicable laws and regulations we could be subject to significant adverse regulatory actions.
- If our compliance or other systems and processes fail or are deemed inadequate, we may suffer brand and reputational harm and become subject to regulatory actions and/or litigation.

- We routinely are subject to litigation and other adverse legal proceedings, including class actions and *qui tam* actions. Many of these proceedings seek substantial damages which may not be covered by insurance.
- We frequently are subject to regular and special governmental audits, investigations and reviews that could result in changes to our business practices and also could result in material refunds, fines, penalties, civil liabilities, criminal liabilities and other sanctions.
- Our litigation and regulatory risk profiles are changing as we offer new products and services and expand in business areas beyond our historical core businesses.
- We face unique regulatory and other challenges in our Medicare and Medicaid businesses.
- Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues.
- We may not be able to obtain adequate premium rate increases in our Insured Health Care Benefits products, MBRs and operating results and could magnify the adverse impact of increases in health care and other benefit costs and of ACA assessments, fees and taxes.
- Minimum MLR rebate requirements limit the level of margin we can earn in our Insured Health Care Benefits products while leaving us exposed to higher than expected medical costs. Challenges to our minimum MLR rebate methodology and/or reports could adversely affect our operating results.
- Our operating results may be adversely affected by changes in laws and policies governing employers and by union organizing activity.

Risks Associated with Mergers, Acquisitions, and Divestitures

- We may be unable to successfully integrate companies we acquire.
- We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities, which may be unsuccessful, cause us to assume unanticipated liabilities, disrupt our existing businesses, be dilutive or lead us to assume significant debt, among other things.

Risks Related to Our Operations

- Failure to meet customer and investor expectations, including with respect to environmental, social and governance goals, may harm our brand and reputation, our ability to retain and grow our customer base and membership.
- We and our vendors have experienced and continue to experience information security incidents. We can provide no assurance that we or our vendors will be able to contain detect or prevent incident.
- Data governance failures or the failure or disruption of our information technology or infrastructure can adversely affect our reputation, businesses and prospects. Our use and disclosure of members', customers' and other constituents' sensitive information is subject to complex regulations at multiple levels.
- Product liability, product recall or personal injury issues could damage our reputation.
- We face significant competition in attracting and retaining talented employees. Further, managing succession for, and retention of, key executives is critical to our success.
- Sales of our products and services are dependent on our ability to attract and motivate internal sales personnel and independent third-party brokers, consultants and agents. We may be subject to penalties or other regulatory actions as a result of the marketing practices of brokers and agents selling our products.
- Failure of our businesses to effectively collaborate could prevent us from maximizing our operating results.
- Pursuing multiple information technology improvement initiatives simultaneously could make continued development and implementation significantly more challenging.
- We are subject to payment-related risks that could increase our operating costs, expose us to fraud or theft, subject us to potential liability and disrupt our business operations.
- Both our and our vendors' operations are subject to a variety of business continuity hazards and risks that could interrupt our operations or otherwise adversely affect our performance and operating results.

Financial Risks

- We would be adversely affected by downgrades or potential downgrades in our credit ratings, should they occur, or if we do not effectively deploy our capital.
- Goodwill and other intangible assets could, in the future, become impaired.

- Adverse conditions in the U.S. and global capital markets can significantly and adversely affect the value of our investments in debt and equity securities, mortgage loans, alternative instruments and other investments.

Risks Related to Our Relationships with Manufacturers, Providers, Suppliers and Vendors

- We face risks relating to the market availability, pricing, suppliers and safety profiles of prescription drugs and other products that we purchase and sell.
- We need to be able to maintain our ability to contract with providers on competitive terms and develop and maintain attractive networks with high quality providers.
- If our suppliers or service providers fail to meet their contractual obligations to us or to comply with applicable laws or regulations, we may be exposed to brand and reputational harm, litigation and/or regulatory action.
- We may experience increased medical and other benefit costs, litigation risk and customer and member dissatisfaction when providers that do not have contracts with us render services to our Health Care Benefits members.
- Continuing consolidation and integration among providers and other suppliers may increase our costs and increase competition.

Risks Related to COVID-19

The spread of, impact of and response to COVID-19 underscores and amplifies certain risks we face. The impact COVID-19 will have on our businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be material and adverse.

COVID-19 has spread to every state in the U.S., has been declared a pandemic by the World Health Organization and has severely impacted, and is expected to continue to severely impact, the economies of the U.S. and other countries around the world.

The legislative and regulatory environment governing our businesses is dynamic and changing frequently, including the Families First Act, the CARES Act, the American Rescue Plan Act and mandated increases to the medical services we must pay for without a corresponding increase in the premiums we receive in our Health Care Benefits Insured products. As a result of COVID-19, including legislative and/or regulatory responses to COVID-19, the premiums we charge in our Insured Health Care Benefits products may prove to be insufficient to cover the cost of medical services delivered to our Insured medical members, which may increase significantly as a result of higher utilization rates of medical facilities and services and other increases in associated hospital and pharmaceutical costs.

Federal, state and local governmental policies and initiatives to reduce the transmission of COVID-19, including existing and new variants, such as mask and vaccination mandates, restrictions on large gatherings and social distancing directives, may not effectively combat the severity and/or duration of the COVID-19 pandemic and have resulted in, among other things, a reduction in utilization that is discretionary, the cancellation of elective medical procedures, reduced customer traffic and front store sales in our retail pharmacies, our customers being ordered to close or severely curtail their operations, the adoption of work-from-home policies and a reduction in diagnostic reporting due to reductions in health care provider visits and restrictions on our access to providers' medical records, all of which impact our businesses. Among other impacts of these policies and initiatives on our businesses, there may be changes in medical claims submission patterns and an adverse impact on (i) drug utilization due to the reduction in discretionary visits with providers; (ii) front store sales as a result of reduced customer traffic in our retail pharmacies; (iii) medical membership in our Health Care Benefits segment and covered lives in our PBM clients due to reductions in workforce at our existing customers (including due to business failures) as well as reduced willingness to change benefits providers by prospective customers; (iv) benefit costs due to COVID-19 related support programs we have put in place for our medical members and mandated increases to the medical services we must pay for without a corresponding increase in the premiums we receive in our Insured Health Care Benefits products; and (v) the amount, timing and collectability of payments to the Company from customers, clients, government payers and members as a result of the impact of COVID-19 on them. Over time, these policies and initiatives also may cause us to experience increased benefit costs and/or decreased revenues in our Health Care Benefits segment if, as a result of our medical members not seeing their providers as a result of COVID-19, we are unable to implement clinical initiatives to manage benefit costs and chronic conditions of our medical members and appropriately document their risk profiles.

In addition, in response to COVID-19, during the first half of 2020, we began to offer our medical members expanded benefit coverage and became obligated by governmental action to provide other additional coverage. This expanded benefit coverage continued to be provided without a corresponding increase in the premiums we receive in our Insured Health Care Benefits

products. We also are taking actions designed to help provide financial and administrative relief for the health care provider community. Such measures and any further steps we take or are required to take to expand or otherwise modify the services delivered to our Health Care Benefits members, provide relief for the health care provider community, or in connection with the relaxation of social distancing directives and other restrictions on movement and economic activity intended to reduce the spread of COVID-19, including the potential for widespread testing and vaccination, including boosters, as a component of lifting those measures, could adversely impact our benefit costs, MBR and operating results.

The various initiatives we have implemented to slow and/or reduce the impact of COVID-19 and the COVID-19-related support programs we have put in place for our customers, medical members and colleagues have increased our operating expenses and reduced the efficiency of our operations. Our operating results will continue to be adversely affected so long as these initiatives continue or if they are expanded. In addition, any adverse economic conditions that could be caused by COVID-19 may have an adverse impact on our net investment income and the value of our investment portfolio.

The spread of COVID-19, or actions taken to mitigate its spread, could have material and adverse effects on our ability to operate our businesses effectively, including as a result of the complete or partial closure of facilities, labor shortages and/or financial difficulties experienced by third-party service providers. Disruptions in our supply chains, our distribution chains and/or public and private infrastructure, including those caused by industry capacity constraints, material availability, global logistics delays and constraints arising from, among other things, the transportation capacity of ocean shipping containers, and labor availability constraints, could materially and adversely impact our business operations. We have transitioned a significant subset of our colleagues to a remote work environment in an effort to mitigate the spread of COVID-19, as have a significant number of our third-party service providers, which may amplify certain risks to our businesses, including an increased demand for information technology resources, increased risk of phishing and other cybersecurity attacks, increased risk of unauthorized dissemination of sensitive personal information or proprietary or confidential information about us or our medical members or other third-parties and increased risk of business interruptions.

The COVID-19 pandemic continues to evolve and the severity and duration of the pandemic and scope and intensity of the governmental response to it are unknown at this time. We believe COVID-19's impact on our businesses, operating results, cash flows and/or financial condition primarily will be driven by the geographies impacted and the severity and duration of the pandemic; vaccination rates; the severity of any new COVID-19 variants and whether vaccines are effective in combating them; the pandemic's impact on the U.S. and global economies and consumer behavior and health care utilization patterns; and the timing, scope and impact of any additional stimulus legislation as well as other federal, state and local governmental responses to the pandemic. Those primary drivers are beyond our knowledge and control. As a result, the impact COVID-19 will have on our businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be adverse and material. COVID-19 also may result in legal and regulatory proceedings, investigations and claims against us.

Risks Relating to Our Businesses

We may not be able to accurately forecast health care and other benefit costs, which could adversely affect our Health Care Benefits segment's operating results. There can be no assurance that future health care and other benefits costs will not exceed our projections.

As a result of COVID-19, the current economic environment is adverse and less predictable than recently experienced, which has caused and may continue to cause unanticipated and significant volatility in our health care and other benefits costs, including COVID-19 related testing and vaccination and post-acute care skilled nursing facility and behavioral health costs. In January 2021, the President of the United States issued an executive order to support government efforts to expand access, availability and use of COVID-19 diagnostic, screening and surveillance and addressed the cost of COVID-19 testing by facilitating COVID-19 testing free of charge to those who lack comprehensive health insurance and clarifying group health plans' and health insurance issuers' obligations to provide coverage for COVID-19 testing. In January 2022, the HHS announced that commercial health insurers must cover the cost of up to eight rapid COVID-19 OTC test kits per individual per 30-day period. In addition, the timing of vaccine administration to the general public and related costs as well as the identification of new, more infectious strains of the COVID-19 virus and whether the vaccines will be effective against such new strains are uncertain and may impact our MBR. Premiums for our Insured Health Care Benefits products, which comprised 93% of our Health Care Benefits revenues for 2021, are priced in advance based on our forecasts of health care and other benefit costs during a fixed premium period, which is generally twelve months. These forecasts are typically developed several months before the fixed premium period begins, are influenced by historical data (and recent historical data in particular), are dependent on our ability to anticipate and detect medical cost trends and changes in our members' behavior and health care utilization patterns and medical claim submission patterns and require a significant degree of judgment. For example, our revenue on Medicare policies is based on bids submitted in June of the year before the contract year. Cost increases in excess of

our projections cannot be recovered in the fixed premium period through higher premiums. As a result, our profits are particularly sensitive to the accuracy of our forecasts of the increases in health care and other benefit costs that we expect to occur and our ability to anticipate and detect medical cost trends. For 2022, those forecasts include adjustments made to pricing based on prospective expectations for liabilities due to testing, vaccines, direct COVID-19 treatment and deferred care. Risk-adjusted revenue has been adjusted for deferred care, and forecasted enrollment considers assumptions about the economic environment, though COVID-19 related impacts remain uncertain. During periods when health care and other benefit costs, utilization and/or medical costs trends experience significant volatility and medical claim submission patterns are changing rapidly as a result of COVID-19, accurately detecting, forecasting, managing, reserving and pricing for our (and our self-insured customers') medical cost trends and incurred and future health care and other benefits costs is more challenging. There can be no assurance regarding the accuracy of the health care or other benefit cost projections reflected in our pricing, and our health care and other benefit costs (including COVID-19 related testing and vaccination and post-acute care skilled nursing facility and behavioral health costs) are affected by COVID-19 and other external events over which we have no control. Even relatively small differences between predicted and actual health care and other benefit costs as a percentage of premium revenues can result in significant adverse changes in our Health Care Benefits segment's operating results.

A number of factors contribute to rising health care and other benefit costs, including COVID-19, previously uninsured members entering the health care system, changes in members' behavior and health care utilization patterns, turnover in our membership, additional government mandated benefits or other regulatory changes (including under the Families First Act, the CARES Act, and the American Rescue Plan Act), changes in the health status of our members, the aging of the population and other changing demographic characteristics, advances in medical technology, increases in the number and cost of prescription drugs (including specialty pharmacy drugs and ultra-high cost drugs and therapies), direct-to-consumer marketing by drug manufacturers, the increasing influence of social media on our members' health care utilization and other behaviors, changes in health care practices and general economic conditions (such as inflation and employment levels). In addition, government-imposed limitations on Medicare and Medicaid reimbursements to health plans and providers have caused the private sector to bear a greater share of increasing health care and other benefits costs over time, and future amendments to the ACA that increase the uninsured population may amplify this problem. Other factors that affect our health care and other benefit costs include epidemics or other pandemics, changes as a result of the ACA, changes to the ACA and other changes in the regulatory environment, the evolution toward a consumer driven business model, new technologies, influenza-related health care costs (which may be substantial and higher than we expected), clusters of high-cost cases, health care provider and member fraud, and numerous other factors that are or may be beyond our control. For example, the 2020-2021 influenza season was impacted by efforts taken to reduce the spread of COVID-19; and the 2019-2020 influenza season had an earlier than average start and had a higher incidence of influenza than the 2018-2019 influenza season.

Our Health Care Benefits segment's operating results and competitiveness depend in large part on our ability to appropriately manage future health care and other benefit costs through underwriting criteria, product design, provider network configuration, negotiation of favorable provider contracts and medical management programs. Our medical cost management programs may not be successful and may have a smaller impact on health care and benefit costs than we expect. The factors described above may adversely affect our ability to predict and manage health care and other benefit costs, which can adversely affect our competitiveness and operating results.

Furthermore, if we are not able to accurately and promptly anticipate and detect medical cost trends or accurately estimate the cost of incurred but not yet reported claims or reported claims that have not been paid, our ability to take timely corrective actions to limit future health care costs and reflect our current benefit cost experience in our pricing process may be limited, which would further amplify the extent of any adverse impact on our operating results. These risks are particularly acute during periods when health care and other benefit costs, utilization and/or medical cost trends experience significant volatility and medical claim submission patterns are changing rapidly as a result of COVID-19. Such risks are further magnified by the ACA and other existing and future legislation and regulations that limit our ability to price for our projected and/or experienced increases in utilization and/or medical cost trends.

There can be no assurance that future health care and other benefits costs will not exceed our projections.

Adverse economic conditions in the U.S. and abroad can materially and adversely impact our businesses, operating results, cash flows and financial condition, and we do not expect these conditions to improve in the near future.

Adverse economic conditions in the U.S. and abroad, including those caused by COVID-19, can materially and adversely impact our businesses, operating results, cash flows and financial condition, including:

- In our Pharmacy Services segment, by causing drug utilization to decline, reducing demand for PBM services and adversely affecting the financial health of our PBM clients.
- In our Retail/LTC segment, by causing drug utilization to decline, changing consumer purchasing power, preferences and/or spending patterns leading to reduced consumer demand for products sold in our stores and adversely affecting the financial health of our LTC pharmacy customers.
- By causing our existing customers to reduce workforces (including due to business failures), which would reduce our revenues, the number of covered lives in our PBM clients and/or the number of members our Health Care Benefits segment serves.
- By causing our clients and customers and potential clients and customers, particularly those with the most employees or members, and state and local governments, to force us to compete more vigorously on factors such as price and service, including service, discount and other performance guarantees, to retain or obtain their business.
- By causing customers and potential customers of our Health Care Benefits and Retail/LTC segments to purchase fewer products and/or products that generate less profit for us than the ones they currently purchase or otherwise would have purchased.
- By causing customers and potential customers of our Health Care Benefits segment, particularly smaller employers and individuals, to forego obtaining or renewing their health and other coverage with us.
- In our Health Care Benefits segment, by causing unanticipated increases and volatility in utilization of medical and other covered services, including COVID-19 related testing, vaccination and behavioral health services, by our medical members, changes in medical claim submission patterns and/or increases in medical unit costs and/or provider behavior, each of which would increase our costs and limit our ability to accurately detect, forecast, manage, reserve and price for our (and our self-insured customers') medical cost trends and incurred and future health care and other benefits costs.
- By increasing medical unit costs and causing changes in provider behavior in our Health Care Benefits segment as hospitals and other providers attempt to maintain revenue levels in their efforts to adjust to their own COVID-19-related and other economic challenges.
- By weakening the ability or perceived ability of the issuers and/or guarantors of the debt or other securities we hold in our investment portfolio to perform on their obligations to us, which could result in defaults in those securities and has reduced, and may further reduce, the value of those securities and has created, and may continue to create, net realized capital losses for us that reduce our operating results.
- By weakening the ability of our customers, including self-insured customers in our Health Care Benefits segment, medical providers and the other companies with which we do business as well as our medical members to perform their obligations to us or causing them not to perform those obligations, either of which could reduce our operating results.
- By weakening the ability of our former subsidiaries and/or their purchasers to satisfy their lease obligations that we have guaranteed and causing the Company to be required to satisfy those obligations.
- By weakening the financial condition of other insurers, including long-term care insurers and life insurers, which increases the risk that we will receive significant assessments for obligations of insolvent insurers to policyholders and claimants.
- By causing, over time, inflation that could cause interest rates to increase and thereby increase our interest expense and reduce our operating results, as well as decrease the value of the debt securities we hold in our investment portfolio, which would reduce our operating results and/or adversely affect our financial condition.

Furthermore, reductions in workforce by our customers can cause unanticipated increases in the health care and other benefits costs of our Health Care Benefits segment. For example, our business associated with members who have elected to receive benefits under Consolidated Omnibus Budget Reconciliation Act (known as "COBRA") typically has an MBR that is significantly higher than our overall Commercial MBR.

Each of our segments operates in a highly competitive and evolving business environment; and operating income in the industries in which we compete may decline.

Each of our segments, Health Care Benefits, Pharmacy Services, which includes our PBM business, and Retail/LTC, operates in a highly competitive and evolving business environment. Specifically:

- As competition increases in the geographies in which we operate, including competition from new entrants, a significant increase in price compression and/or reimbursement pressures could occur, and this could require us to reevaluate our pricing structures to remain competitive.
- In our Health Care Benefits segment we are seeking to substantially grow our Medicaid, dual eligible and dual eligible special needs plan membership over the next several years. In many instances, to acquire and retain our government

customers' business, we must bid against our competitors in a highly competitive environment. Winning bids often are challenged successfully by unsuccessful bidders, and may also be withdrawn or cancelled by the issuing agency.

- Customer contracts in our Health Care Benefits segment are generally for a period of one year, and our customers have considerable flexibility in moving between us and our competitors. One of the key factors on which we compete for customers, especially in uncertain economic environments, is overall cost. We are therefore under pressure to contain premium price increases despite being faced with increasing health care and other benefit costs and increasing operating costs. If we are unable to increase our prices to reflect, or otherwise mitigate the impact of, increasing costs, our profitability will be adversely affected. If we are unable to limit our price increases, we may lose members to competitors with more favorable pricing, adversely affecting our revenues and operating results. In response to rising prices, our customers may elect to self-insure or to reduce benefits in order to limit increases in their benefit costs. Alternatively, our customers may purchase different types of products from us that are less profitable. Such elections may result in reduced membership in our more profitable Insured products and/or lower premiums for our Insured products, which may adversely affect our revenues and operating results, although such elections also may reduce our health care and other benefit costs. In addition, our Medicare, Medicaid and CHIP products are subject to termination without cause, periodic re-bid, rate adjustment and program redesign, as customers seek to contain their benefit costs, particularly in an uncertain economy, and our exposure to this risk is increasing as we grow our Government products membership. These actions may adversely affect our membership, revenues and operating results.
- We requested increases in our premium rates in our Commercial Health Care Benefits business for 2021 and expect to request increases in those rates for 2022 and beyond in order to adequately price for projected medical cost trends, required expansions of coverage and rating limits, and significant assessments, fees and taxes imposed by federal and state governments, including as a result of the ACA. Our rates also must be adequate to reflect the risk that our products will be selected by people with a higher risk profile or utilization rate than the pool of participants we anticipated when we established pricing for the applicable products (also known as "adverse selection"), particularly in small group Commercial products. These rate increases may be significant and thus heighten the risks of adverse publicity, adverse regulatory action and adverse selection and the likelihood that our requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.
- The competitive success of our Pharmacy Services segment is dependent on our ability to establish and maintain contractual relationships with network pharmacies as PBM clients evaluate adopting narrow or restricted retail pharmacy networks.
- The competitive success of our Retail/LTC segment and our specialty pharmacy operations is dependent on our ability to establish and maintain contractual relationships with PBMs and other payors on acceptable terms as the payors' clients evaluate adopting narrow or restricted retail pharmacy networks.
- In our PBM business, we maintain contractual relationships with brand name drug manufacturers that provide for purchase discounts and/or rebates on drugs dispensed by pharmacies in our retail network and by our specialty and mail order pharmacies (all or a portion of which may be passed on to clients). Manufacturer's rebates often depend on a PBM's ability to meet contractual requirements, including the placement of a manufacturer's products on the PBM's formularies. If we lose our relationship with one or more drug manufacturers, or if the discounts or rebates provided by drug manufacturers decline, our operating results, cash flows and/or prospects could be adversely affected.
- The PBM industry has been experiencing price compression as a result of competitive pressures and increased client demands for lower prices, increased revenue sharing, including sharing in a larger portion of rebates received from drug manufacturers, enhanced service offerings and/or higher service levels. Marketplace dynamics and regulatory changes also have adversely affected our ability to offer plan sponsors pricing that includes the use of retail "differential" or "spread," which could adversely affect our future profitability, and we expect these trends to continue.
- Our retail pharmacy, specialty pharmacy and LTC pharmacy operations have been affected by reimbursement pressure caused by competition, including client demands for lower prices, generic drug pricing, earlier than expected generic drug introductions and network reimbursement pressure. If we are unable to increase our prices to reflect, or otherwise mitigate the impact of, increasing costs, our profitability will be adversely affected. If we are unable to limit our price increases, we may lose customers to competitors with more favorable pricing, adversely affecting our revenues and operating results.
- A shift in the mix of our pharmacy prescription volume towards programs offering lower reimbursement rates as a result of competition or otherwise could adversely affect our margins, including the ongoing shift in pharmacy mix towards 90-day prescriptions at retail and the ongoing shift in pharmacy mix towards Medicare Part D prescriptions.
- PBM client contracts often are for a period of approximately three years. However, PBM clients may require early or periodic re-negotiation of pricing prior to contract expiration. PBM clients are generally well informed, can move between us and our competitors and often seek competing bids prior to expiration of their contracts. We are therefore under pressure to contain price increases despite being faced with increasing drug costs and increasing operating costs. If we are unable to increase our prices to reflect, or otherwise mitigate the impact of, increasing costs, our profitability will be adversely

affected. If we are unable to limit our price increases, we may lose customers to competitors with more favorable pricing, adversely affecting our revenues and operating results.

- The operating results and margins of our LTC business are further affected by the increased efforts of health care payors to negotiate reduced or capitated pricing arrangements and by the financial health of, and purchases and sales of, our LTC customers.

In addition, competitors in each of our businesses may offer services and pricing terms that we may not be willing or able to offer. Competition also may come from new entrants and other sources in the future. Unless we can demonstrate enhanced value to our clients through innovative product and service offerings in the rapidly changing health care industry, we may be unable to remain competitive.

Disruptive innovation by existing or new competitors could alter the competitive landscape in the future and require us to accurately identify and assess such alterations and make timely and effective changes to our strategies and business model to compete effectively. For example, decisions to buy our Health Care Benefits and Pharmacy Services products and services increasingly are made or influenced by consumers, either through direct purchasing (e.g., Medicare Advantage plans and PDPs) or through Public Exchanges and private health insurance exchanges that allow individual choice. Consumers also are increasingly seeking to access consumer goods and health care products and services locally and through other direct channels such as mobile devices and websites. To compete effectively in the consumer-driven marketplace, we will be required to develop or acquire new capabilities, attract new talent and develop new service and distribution relationships that respond to consumer needs and preferences.

Changes in marketplace dynamics or the actions of competitors or manufacturers, including industry consolidation, the emergence of new competitors and strategic alliances, and decisions to exclude us from new narrow or restricted retail pharmacy networks could materially and adversely affect our businesses, operating results, cash flows and/or prospects.

We can provide no assurance that we will be able to compete successfully on Public Exchanges or that our pricing or other actions will result in the profitability of our Public Exchange products.

In January 2022, we entered into the Public Exchanges in eight states. To compete effectively on Public Exchanges, we have developed or acquired the technology, systems, tools and talent necessary to interact with Public Exchanges and engage Public Exchange consumers through enhanced consumer-focused sales, marketing channels and customer interfaces. We have also created new customer service programs and product offerings. While participating on the Public Exchanges, we will have to respond to pricing and other actions taken by existing competitors and regulators as well as potentially disruptive new entrants, which could reduce our profit margins. Due to the price transparency provided by Public Exchanges, when we market products we face competitive pressures from existing and new competitors who may have lower cost structures. Our competitors may bring their Public Exchange and other consumer products to market more quickly, have greater experience marketing to consumers and/or may be targeting the higher margin portions of our business. We can provide no assurance that we will be able to compete successfully or profitably on Public Exchanges or that we will be able to benefit from any opportunities presented by Public Exchanges.

In addition, there can be no assurance that our pricing or other actions will result in the profitability of our Public Exchange products in 2022 or any future year. We have set 2022 premium rates for our Public Exchange products based on our projections, including as to the health status and quantity of membership and utilization of medical and/or other covered services by members. The accuracy of the projections reflected in our pricing may be impacted by (i) adverse selection among individuals who require or utilize more expensive medical and/or other covered services, (ii) other plans' withdrawals from participation in the Public Exchanges we serve and (iii) legislation, regulations, enforcement activity and/or judicial decisions that cause Public Exchanges to operate in a manner different than what we projected in setting our premium rates.

A change in our Health Care Benefits product mix may adversely affect our profit margins.

Our Insured Health Care Benefits products that involve greater potential risk generally tend to be more profitable than our ASC products. Historically, smaller employer groups have been more likely to purchase Insured Health Care Benefits products because such purchasers are generally unable or unwilling to bear greater liability for health care expenditures, although over the last several years even relatively small employers have moved to ASC products. We also serve, and expect to grow our business with, government-sponsored programs, including Medicare and Medicaid, that are subject to competitive bids and have lower profit margins than our Commercial Insured Health Care Benefits products. A shift of enrollees from more profitable products to less profitable products could have a material adverse effect on the Health Care Benefits segment's operating results.

Negative public perception of the industries in which we operate, or of our industries' or our practices, can adversely affect our businesses, operating results, cash flows and prospects.

Our brand and reputation are two of our most important assets, and the industries in which we operate have been and are negatively perceived by the public from time to time. Negative publicity may come as a result of adverse media coverage, litigation against us and other industry participants, the ongoing public debates over drug pricing, PBMs, government involvement in drug pricing and purchasing, changes to the ACA, "surprise" medical bills, governmental hearings and/or investigations, actual or perceived shortfalls regarding our industries' or our own products and/or business practices (including PBM operations, drug pricing and insurance coverage determinations) and social media and other media relations activities. Negative publicity also may come from a failure to meet customer expectations for consistent, high quality and accessible care. This risk may increase as we continue to offer products and services that make greater use of data and as our business model becomes more focused on delivering health care to consumers.

In addition, by working with the U.S. government in the distribution and administration of the COVID-19 vaccine, the Company may be subject to negative publicity related to the government's actions in response to COVID-19 that are outside of the ability of the Company to control.

Negative public perception and/or publicity of our industries in general, or of us or our key vendors, brokers or product distribution networks in particular, can further increase our costs of doing business and adversely affect our operating results and our stock price by:

- adversely affecting our brand and reputation;
- adversely affecting our ability to market and sell our products and/or services and/or retain our existing customers and members;
- requiring us to change our products and/or services;
- reducing or restricting the revenue we can receive for our products and/or services; and/or
- increasing or significantly changing the regulatory and legislative requirements with which we must comply.

We must maintain and improve our relationships with our retail and specialty pharmacy customers and increase the demand for our products and services, including proprietary brands.

The success of our businesses depends in part on customer loyalty, superior customer service and our ability to persuade customers to frequent our retail stores and online sites and to purchase products in additional categories and our proprietary brands. Failure to timely identify or effectively respond to changing consumer preferences and spending patterns, and evolving demographic mixes in the communities we serve, an inability to expand the products being purchased by our clients and customers, or the failure or inability to obtain or offer particular categories of products could adversely affect our relationship with our customers and clients and the demand for our products and services and could result in excess inventories of products.

We offer our retail customers proprietary brand products that are available exclusively at our retail stores and through our online retail sites. The sale of proprietary products subjects us to unique risks including potential product liability risks, mandatory or voluntary product recalls, potential supply chain and distribution chain disruptions for raw materials and finished products, our ability to successfully protect our intellectual property rights and the rights of applicable third parties, and other risks generally encountered by entities that source, market and sell private-label products. We also face similar risks for the other products we sell in our retail operations, including supply chain and distribution chain disruption risk. Any failure to adequately address some or all of these risks could have an adverse effect on our retail business, operating results, cash flows and/or financial condition. Additionally, an increase in the sales of our proprietary brands may adversely affect our sales of products owned by our suppliers and adversely impact certain of our supplier relationships. Our ability to locate qualified, economically stable suppliers who satisfy our requirements, and to acquire sufficient products in a timely and effective manner, is critical to ensuring, among other things, that customer confidence is not diminished. Any failure to develop sourcing relationships with a broad and deep supplier base could adversely affect our operating results and erode customer loyalty.

We also could be adversely affected if we fail to identify or effectively respond to changes in marketplace dynamics. For example, specialty pharmacy represents a significant and growing proportion of prescription drug spending in the U.S., a significant portion of which is dispensed outside of traditional retail pharmacies. Because our specialty pharmacy business focuses on complex and high-cost medications, many of which are made available by manufacturers to a limited number of pharmacies (so-called limited distribution drugs) that serve a relatively limited universe of patients, the future growth of our

specialty pharmacy business depends largely upon expanding our access to key drugs and penetration in certain treatment categories. Any contraction of our base of patients or reduction in demand for the prescriptions we currently dispense could have an adverse effect on our specialty pharmacy business, operating results and cash flows.

We face risks relating to the availability, pricing and safety profiles of prescription drugs that we purchase and sell.

The profitability of our Retail/LTC and Pharmacy Services segments is dependent upon the utilization of prescription drug products. We dispense significant volumes of brand name and generic drugs from our retail, LTC, specialty and mail order pharmacies, and the retail pharmacies in our PBM's network also dispense significant volumes of brand name and generic drugs. Our revenues, operating results and cash flows may decline if physicians cease writing prescriptions for drugs or the utilization of drugs is reduced, including due to:

- increased safety risk profiles or regulatory restrictions;
- manufacturing or other supply issues;
- a reduction in drug manufacturers' participation in federal programs;
- certain products being withdrawn by their manufacturers or transitioned to over-the-counter products;
- future FDA rulings restricting the supply or increasing the cost of products;
- the introduction of new and successful prescription drugs or lower-priced generic alternatives to existing brand name products; or
- inflation in the price of drugs.

In addition, increased utilization of generic drugs (which normally yield a higher gross profit rate than equivalent brand name drugs) has resulted in pressure to decrease reimbursement payments to retail, mail order, specialty and LTC pharmacies for generic drugs, causing a reduction in our margins on sales of generic drugs. Consolidation within the generic drug manufacturing industry and other external factors may enhance the ability of manufacturers to sustain or increase pricing of generic drugs and diminish our ability to negotiate reduced generic drug acquisition costs. Any inability to offset increased brand name or generic prescription drug acquisition costs or to modify our activities to lessen the financial impact of such increased costs could have a significant adverse effect on our operating results.

The reserves we hold for expected claims in our Insured Health Care Benefits products are based on estimates that involve an extensive degree of judgment and are inherently variable. Any reserve, including a premium deficiency reserve, may be insufficient. If actual claims exceed our estimates, our operating results could be materially adversely affected, and our ability to take timely corrective actions to limit future costs may be limited.

A large portion of health care claims are not submitted to us until after the end of the quarter in which services are rendered by providers to our members. Our reported health care costs payable for any particular period reflect our estimates of the ultimate cost of such claims as well as claims that have been reported to us but not yet paid. We also must estimate the amount of rebates payable under the MLR rules of the ACA, CMS and the OPM and the amounts payable by us to, and receivable by us from, the United States federal government under the ACA's remaining premium stabilization program.

Our estimates of health care costs payable are based on a number of factors, including those derived from historical claim experience, but this estimation process also makes use of extensive judgment. Considerable variability is inherent in such estimates, and the accuracy of the estimates is highly sensitive to changes in medical claims submission and processing patterns and/or procedures, turnover and other changes in membership, changes in product mix, changes in the utilization of medical and/or other covered services, including prescription drugs, changes in medical cost trends, changes in our medical management practices and the introduction of new benefits and products. We estimate health care costs payable periodically, and any resulting adjustments, including premium deficiency reserves, are reflected in current-period operating results within benefit costs. For example, as of December 31, 2021 and 2020, we established a premium deficiency reserve of $16 million and $11 million, respectively, related to Medicaid products in the Health Care Benefits segment. A worsening (or improvement) of health care cost trend rates or changes in claim payment patterns from those that we assumed in estimating health care costs payable as of December 31, 2021 would cause these estimates to change in the near term, and such a change could be material.

Furthermore, if we are not able to accurately and promptly anticipate and detect medical cost trends or accurately estimate the cost of incurred but not yet reported claims or reported claims that have not been paid, our ability to take timely corrective actions to limit future health care costs and reflect our current benefit cost experience in our pricing process may be limited, which would further exacerbate the extent of any adverse impact on our operating results. These risks are particularly acute during and following periods when utilization of medical and/or other covered services and/or medical cost trends are below

recent historical levels and in products where there is significant turnover in our membership each year, and such risks are further magnified by the ACA and other legislation and regulations that limit our ability to price for our projected and/or experienced increases in utilization and/or medical cost trends.

Our operating results are affected by the health of the economy in general and in the geographies we serve.

Our businesses are affected by the U.S. economy and consumer confidence in general and in the geographies we serve, including various economic factors, including inflation and changes in consumer purchasing power, preferences and/or spending patterns. An unfavorable, uncertain or volatile economic environment could cause a decline in drug utilization, an increase in health care utilization and dampen demand for PBM services as well as consumer demand for products sold in our retail stores.

If our customers' operating and financial performance deteriorates, or they are unable to make scheduled payments or obtain adequate financing, our customers may not be able to pay timely, or may delay payment of, amounts owed to us. Any inability of our customers to pay us for our products and services may adversely affect our businesses, operating results and cash flows. In addition, both state and federal government sponsored payers, as a result of budget deficits or spending reductions, may suspend payments or seek to reduce their health care expenditures resulting in our customers delaying payments to us or renegotiating their contracts with us.

Further, economic conditions including interest rate fluctuations, changes in capital market conditions and regulatory changes may affect our ability to obtain necessary financing on acceptable terms, our ability to secure suitable store locations under acceptable terms, our ability to execute sale-leaseback transactions under acceptable terms and the value of our investment portfolio. Adverse changes in the U.S. economy, consumer confidence and economic conditions could have an adverse effect on our businesses and financial results. This adverse effect could be further exacerbated by the increasing prevalence of high deductible health plans and health plan designs favoring co-insurance over co-payments as members and other consumers may decide to postpone, or not to seek, medical treatment which may lead them to incur more expensive medical treatment in the future and/or decrease our prescription volumes.

In addition, our Health Care Benefits membership remains concentrated in certain U.S. geographies and in certain industries. Unfavorable changes in health care or other benefit costs or reimbursement rates or increased competition in those geographic areas where our membership is concentrated could therefore have a disproportionately adverse effect on our Health Care Benefits segment's operating results. Our Health Care Benefits membership has been and may continue to be affected by workforce reductions by our customers due to adverse and/or uncertain general economic conditions, especially in the U.S. geographies and industries where our membership is concentrated. As a result, we may not be able to profitably grow and diversify our Health Care Benefits membership geographically, by product type or by customer industry, and our revenues and operating results may be disproportionately affected by adverse changes affecting our customers.

We are exposed to risks relating to the solvency of other insurers.

We are subject to assessments under guaranty fund laws existing in all states for obligations of insolvent insurance companies (including long-term care insurers), HMOs, ACA co-ops and other payors to policyholders and claimants. For example, in the first quarter of 2017, Aetna recorded a discounted estimated liability expense of $231 million pretax for our estimated share of future assessments for long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries. Guaranty funds are maintained by state insurance commissioners to protect policyholders and claimants in the event that an insurer, HMO, ACA co-op and/or other payor becomes insolvent or is unable to meet its financial obligations. These funds are usually financed by assessments against insurers regulated by a state. Future assessments may have an adverse effect on our operating results and cash flows.

Extreme events, or the threat of extreme events, could materially impact our businesses and health care (including behavioral health) costs.

Nuclear, biological or other attacks, or other acts of violence, including active shooter situations, whether as a result of war or terrorism or otherwise; other man-made disasters; natural disasters, such as hurricanes, tropical storms, floods, fires, earthquakes, tsunamis, cyclones, typhoons or extreme weather conditions such as major or extended winter storms, droughts and tornados, whether as a result of climate change or otherwise; epidemics; pandemics and other extreme events can affect the U.S. economy in general, our industries and us specifically. In particular, such extreme events or the threat of such extreme events could result in significant health care (including behavioral health) costs, which also would be affected by the government's actions and the responsiveness of public health agencies and other insurers. Such extreme events or the threat of

such extreme events also could disrupt our supply chains and/or our distribution chains for the products we sell. In addition, our employees and those of our vendors are concentrated in certain large, metropolitan areas which may be particularly exposed to these events. Such events could adversely affect our businesses, operating results and cash flows, and, in the event of extreme circumstances, our financial condition or viability, particularly if our responses to such events are less adequate than those of our competitors.

We may be unable to achieve our environmental, social and governance goals.
We are dedicated to corporate social responsibility and sustainability and face pressures from our colleagues, customers, and stockholders to make significant advancements in environmental, social and governance matters. In part to address these concerns, we established certain goals as part of our ESG strategy. Achievement of our goals is subject to risks and uncertainties, many of which are outside of our control, and it is possible that we may fail to achieve these goals or that our colleagues, customers, or stockholders might not be satisfied with our efforts. These risks and uncertainties include, but are not limited to: our ability to execute our operational strategies and achieve our goals within the currently projected costs and the expected timeframes; the availability and cost of renewable energy and other materials; compliance with, and changes or additions to, global and regional regulations, taxes, charges, mandates or requirements relating to climate-related goals; labor-related regulations and requirements that restrict or prohibit our ability to impose requirements on third party contractors; the actions of competitors and competitive pressures; an acquisition of or merger with another company that has not adopted similar goals or whose progress towards reaching its goals is not as advanced as ours; and the pace of regional and global recovery from the COVID-19 pandemic. A failure to meet our goals could adversely affect public perception of our business, employee morale or customer or stockholder support.

Further, an increasing percentage of colleagues, customers, and stockholders considers sustainability factors in making employment, consumer health care and investment decisions. If we are unable to meet our goals, we may lose colleagues, and have difficulty recruiting new colleagues, investors, customers, or partners, our stock price may be negatively impacted, our reputation may be negatively affected, and it may be more difficult for us to compete effectively, all of which would have an adverse effect on our business, operating results, and financial condition.

Risks From Changes in Public Policy and Other Legal and Regulatory Risks

We are subject to potential changes in public policy, laws and regulations, including reform of the U.S. health care system, which can adversely affect our businesses. Entitlement program reform, if it occurs, could have a material adverse effect on our businesses, operations and/or operating results.

The political environment in which we operate remains uncertain. It is reasonably possible that our business operations and operating results could be materially adversely affected by legislative, regulatory and public policy changes at the federal or state level, increased government involvement in drug reimbursement, pricing, purchasing and/or importation and/or increased regulation of PBMs, including: changes to the regulatory environment for health care and related benefits, including Medicare, the ACA, and related Public Exchange regulations; changes to laws or regulations governing drug reimbursement and/or pricing; changes to the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs; changes to laws and/or regulations governing drug manufacturers' rebates; changes to laws and/or regulations governing reimbursements paid to pharmacists by and/or reporting required by PBMs; changes to immigration policies and/or other public policy initiatives. It is not possible to predict whether or when any such changes will occur or what form any such changes may take (including through the use of U.S. Presidential Executive Orders). Other significant changes to health care and related benefits system legislation or regulation as well as changes with respect to tax and trade policies, tariffs and other government regulations affecting trade between the United States and other countries also are possible and could adversely affect our businesses. If we fail to respond adequately to such changes, including by implementing strategic and operational initiatives, or do not respond as effectively as our competitors, our businesses, operations and operating results may be materially adversely affected.

Efforts to amend the ACA and related regulations are possible. It is also possible that federal and state governments will continue to enact and seriously consider many broad-based legislative and regulatory proposals that will or could materially impact various aspects of the health care and related benefits system and our businesses. Further changes to federal health care and related benefits laws, including the ACA, drug reimbursement and pricing laws, laws governing PBMs and/or laws governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, are probable. We cannot predict the effect, if any, that new health care and related benefits legislation, future changes to the ACA or the implementation of or failure to implement the outstanding provisions of ACA, may have on our Health Care Benefits, Pharmacy Services and/or retail pharmacy, LTC pharmacy operations and/or operating results. The federal and many

state governments also are considering changes in the interpretation, enforcement and/or application of existing programs, laws and regulations, including changes to payments under and funding of Medicare and Medicaid programs and increased regulation of PBMs.

Further, changes in existing federal or state laws or regulations or the adoption of new laws or regulations relating to additional regulation of PBMs (including network restrictions, formulary management affiliate reimbursement, contractual guarantees and reconciliations, or other PBM services), drug pricing or purchasing, patent term extensions and/or purchase discount and/or rebate arrangements with drug manufacturers also could reduce the discounts or rebates we receive. Changes in existing federal or state laws or regulations or the adoption of new laws or regulations relating to claims processing and billing, including our ability to use MAC lists and collect transmission fees, also could adversely affect our profitability. For example, on October 29, 2020, the HHS released a final rule requiring health insurers to disclose drug pricing and cost-sharing information. The final rule requires group health plans and health insurance issuers in the individual and group markets to disclose cost-sharing information upon request, to a participant, beneficiary, or enrollee, which, unless otherwise indicated, for the purpose of the final rules includes an authorized representative, and requires plans and issuers to disclose in-network provider rates, historical out-of-network allowed amounts and the associated billed charges, and negotiated rates for prescription drugs. While the specific regulation requiring PBMs to disclose negotiated price concessions was paused under federal guidance released in August 2021, if it resurfaces, the regulation may result in drug manufacturers lowering discounts or rebates, resulting in higher drug costs for patients and impacting the ability of the Company to negotiate drug prices and provide competitive products and services to consumers.

In addition, in November 2020, the HHS released the Rebate Rule, which eliminates the regulatory safe harbor from prosecution under the AKS for rebates from pharmaceutical companies to PBMs in Medicare Part D and in Medicaid MCOs, replacing it with two far narrower safe harbors designed to directly benefit patients with high out-of-pocket costs and to change the way PBMs are compensated. The new safe harbors are (i) for rebates which are passed on to the patient at the point of sale and (ii) for flat service fee payments made to PBMs which cannot be tied to the list prices of drugs. The PCMA, which represents PBMs, has filed a suit in an effort to block the Rebate Rule, claiming that the Rebate Rule would lead to higher premiums in Medicare Part D and was adopted in an unlawful manner. It is unclear whether the Rebate Rule will be enforceable, whether pharmaceutical companies will respond by reducing list prices, whether list prices in the private market may also be reduced, and what the resulting impact will be to PBMs or the Company. The Bipartisan Infrastructure Act of 2021 delays the effective date of the rebate rule to January 2026, and pending Reconciliation legislation would fully repeal the Rebate Rule.

Additionally, the Consolidated Appropriations Act of 2021 was signed into law in December 2020 and contains transparency provisions requiring group health plans and health insurance issuers to report certain prescription drug costs, overall spending on health services and prescription drugs, and information about premiums and the impact of rebates and other remuneration on premiums and out-of-pocket costs to the Tri-Departments. No later than 18 months after the first submission and bi-annually thereafter, the Tri-Departments will release a public report on drug pricing trends, drug reimbursement, and the impact of drug prices on premiums. In August, the Tri-Departments deferred enforcement of both the December 2021 deadline for reporting 2020 plan year data and the June 2022 deadline for reporting 2021 plan year data to December 2022.

We cannot predict the enactment or content of new legislation or regulations or changes to existing laws or regulations or their enforcement, interpretation or application, or the effect they will have on our business operations or operating results, which could be materially adverse. Even if we could predict such matters, it is not possible to eliminate the adverse impact of public policy changes that would fundamentally change the dynamics of one or more of the industries in which we compete. Examples of such changes include: the federal or one or more state governments fundamentally restructuring or reducing the funding available for Medicare, Medicaid, dual eligible or dual eligible special needs plan programs, increasing its involvement in drug reimbursement, pricing, purchasing and/or importation, changing the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, changing the tax treatment of health or related benefits, or significantly altering the ACA. The likelihood of adverse changes remains high due to state and federal budgetary pressures, and our businesses and operating results could be materially and adversely affected by such changes, even if we correctly predict their occurrence.

For more information on these matters, see "Government Regulation" included in Item 1 of this 10-K.

If we fail to comply with applicable laws and regulations, many of which are highly complex, we could be subject to significant adverse regulatory actions, including monetary penalties, or suffer brand and reputational harm.

Our businesses are subject to extensive regulation and oversight by state, federal and international governmental authorities. The laws and regulations governing our operations and interpretations of those laws and regulations, including those related to human capital and climate change, are increasing in number and complexity, change frequently and can be inconsistent or conflict with one another. In general, these laws and regulations are designed to benefit and protect customers, members and providers rather than us or our investors. In addition, the governmental authorities that regulate our businesses have broad latitude to make, interpret and enforce the laws and regulations that govern us and continue to interpret and enforce those laws and regulations more strictly and more aggressively each year. We also must follow various restrictions on certain of our businesses and the payment of dividends by certain of our subsidiaries put in place by certain state regulators.

Certain of our Pharmacy Services and Retail/LTC operations, products and services are subject to:

- the clinical quality, patient safety and other risks inherent in the dispensing, packaging and distribution of drugs and other health care products and services, including claims related to purported dispensing and other operational errors (any failure by our Pharmacy Services and/or Retail/LTC operations to adhere to the laws and regulations applicable to the dispensing of drugs could subject us to civil and criminal penalties);
- federal and state anti-kickback and other laws that govern our relationship with drug manufacturers, customers and consumers;
- compliance requirements under ERISA, including fiduciary obligations in connection with the development and implementation of items such as drug formularies and preferred drug listings; and
- federal and state legislative proposals and/or regulatory activity that could adversely affect pharmacy benefit industry practices.

Our Health Care Benefits products are highly regulated, particularly those that serve Medicare, Medicaid, dual eligible, dual eligible special needs and small group Commercial customers and members. The laws and regulations governing participation in Medicare Advantage (including dual eligible special needs plans), Medicare Part D, Medicaid, and managed Medicaid plans are complex, are subject to interpretation and can expose us to penalties for non-compliance.

The scope of the practices and activities that are prohibited by federal and state false claims acts is the subject of pending litigation. Claims under federal and state false claims acts can be brought by the government or by private individuals on behalf of the government through a *qui tam* or "whistleblower" suit, and we are a defendant in a number of such proceedings. If we are convicted of fraud or other criminal conduct in the performance of a government program or if there is an adverse decision against us under the False Claims Act, we may be temporarily or permanently suspended from participating in government health care programs, including Medicare Advantage, Medicare Part D, Medicaid, dual eligible and dual eligible special needs plan programs, and we also may be required to pay significant fines and/or other monetary penalties. Whistleblower suits have resulted in significant settlements between governmental agencies and health care companies. The significant incentives and protections provided to whistleblowers under applicable law increase the risk of whistleblower suits.

If we fail to comply with laws and regulations that apply to government programs, we could be subject to criminal fines, civil penalties, premium refunds, prohibitions on marketing or active or passive enrollment of members, corrective actions, termination of our contracts or other sanctions which could have a material adverse effect on our ability to participate in Medicare Advantage, Medicare Part D, Medicaid, dual eligible, dual eligible special needs plan and other programs and on our operating results, cash flows and financial condition.

Our businesses, profitability and growth also may be adversely affected by (i) judicial and regulatory decisions that change and/or expand the interpretations of existing statutes and regulations, impose medical or bad faith liability, increase our responsibilities under ERISA or the remedies available under ERISA, or reduce the scope of ERISA pre-emption of state law claims or (ii) other legislation and regulations. For example, in December 2020, the U.S. Supreme Court upheld an Arkansas law that, among other things, mandates a particular pricing methodology, establishes an appeals process for a pharmacy when the reimbursement is below the pharmacy's acquisition cost, permits a pharmacy to reverse and rebill if they cannot procure the drug from its wholesaler at a price equal to or less than the reimbursement rate, prohibits a PBM from reimbursing a pharmacy less than the amount it reimburses an affiliate on a per unit basis, and permits a pharmacy to decline to dispense if the reimbursement is lower than the pharmacy's acquisition cost. Also, in November 2021, the U.S. Court of Appeals for the Eighth Circuit upheld a North Dakota law that regulates employer-sponsored ERISA health plans and certain PBM practices within Medicare.

If our compliance or other systems and processes fail or are deemed inadequate, we may suffer brand and reputational harm and become subject to regulatory actions and/or litigation.

In addition to being subject to extensive and complex regulations, many of our contracts with customers include detailed requirements. In order to be eligible to offer certain products or bid on certain contracts, we must demonstrate that we have robust systems and processes in place that are designed to maintain compliance with all applicable legal, regulatory and contractual requirements. These systems and processes frequently are reviewed and audited by our customers and regulators. If our systems and processes designed to maintain compliance with applicable legal and contractual requirements, and to prevent and detect instances of, or the potential for, non-compliance fail or are deemed inadequate, we may suffer brand and reputational harm and be subject to regulatory actions, litigation and other proceedings which may result in damages, fines, suspension or loss of licensure, suspension or exclusion from participation in government programs and/or other penalties, any of which could adversely affect our businesses, operating results, cash flows and/or financial condition.

We routinely are subject to litigation and other adverse legal proceedings, including class actions and qui tam actions. Many of these proceedings seek substantial damages which may not be covered by insurance. These proceedings are costly to defend, may result in changes in our business practices, harm our brand and reputation and adversely affect our businesses and operating results.

PBM, retail pharmacy, mail order pharmacy, specialty pharmacy, LTC pharmacy and health care and related benefits are highly regulated industries whose participants frequently are subject to litigation and other adverse legal proceedings. We are currently subject to various litigation and arbitration matters, investigations, regulatory audits, inspections, government inquiries, and regulatory and other legal proceedings, both inside and outside the U.S. Outside the U.S., contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the U.S. Litigation related to our provision of professional services in our medical clinics, pharmacies and LTC operations is increasing as we expand our services along the continuum of health care.

Litigation, and particularly securities, derivative, collective or class action and *qui tam* litigation, is often expensive and disruptive. Many of the legal proceedings against us seek substantial damages (including non-economic or punitive damages and treble damages), and certain of these proceedings also seek changes in our business practices. While we currently have insurance coverage for some potential liabilities, other potential liabilities may not be covered by insurance, insurers may dispute coverage and/or the amount of our insurance may not be enough to cover the damages awarded or costs incurred. In addition, some types of damages, like punitive damages, may not be covered by insurance, and in some jurisdictions the coverage of punitive damages is prohibited. Insurance coverage for all or some forms of liability also may become unavailable or prohibitively expensive in the future.

The outcome of litigation and other adverse legal proceedings is always uncertain, and outcomes that are not justifiable by the evidence or existing law or regulation can and do occur, and the costs incurred frequently are substantial regardless of the outcome. Litigation and other adverse legal proceedings could materially adversely affect our businesses, operating results and/or cash flows because of brand and reputational harm to us caused by such proceedings, the cost of defending such proceedings, the cost of settlement or judgments against us, or the changes in our operations that could result from such proceedings. See Item 3 of this 10-K for additional information.

We frequently are subject to regular and special governmental audits, investigations and reviews that could result in changes to our business practices and also could result in material refunds, fines, penalties, civil liabilities, criminal liabilities and other sanctions.

As one of the largest national retail, mail order, specialty and LTC pharmacy, PBM and health care and related benefits providers, we frequently are subject to regular and special governmental market conduct and other audits, investigations and reviews by, and we receive subpoenas and other requests for information from, various federal and state agencies, regulatory authorities, attorneys general, committees, subcommittees and members of the U.S. Congress and other state, federal and international governmental authorities. For example, we have received CIDs from, and provided documents and information to, the Civil Division of the DOJ in connection with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. CMS and the OIG also are auditing the risk adjustment-related data of certain of our Medicare Advantage plans, and the number of such audits continues to increase. Several such audits, investigations and reviews by governmental authorities currently are pending, some of which may be resolved in 2022, the results of which may be adverse to us.

Federal and state governments have made investigating and prosecuting health care and other insurance fraud, waste and abuse a priority. Fraud, waste and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical and/or other covered services, improper marketing and violations of patient privacy

rights. The regulations and contractual requirements applicable to us and other industry participants are complex and subject to change, making it necessary for us to invest significant resources in complying with our regulatory and contractual requirements. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that our compliance efforts in this area will continue to require significant resources. In addition, our medical costs and the medical expenses of our Health Care Benefits ASC customers may be adversely affected if we do not prevent or detect fraudulent activity by providers and/or members.

Regular and special governmental audits, investigations and reviews by federal, state and international regulators could result in changes to our business practices, and also could result in significant or material premium refunds, fines, penalties, civil liabilities, criminal liabilities or other sanctions, including suspension or exclusion from participation in government programs and suspension or loss of licensure. Any of these audits, investigations or reviews could have a material adverse effect on our businesses, operating results, cash flows and/or financial condition or result in significant liabilities and negative publicity for us.

See "Legal and Regulatory Proceedings" in Note 16 ''Commitments and Contingencies'' included in Item 8 of this 10-K for additional information.

Our litigation and regulatory risk profile are changing as we offer new products and services and expand in business areas beyond our historical core businesses of Health Care Benefits, Pharmacy Services and Retail/LTC.

Historically, we focused primarily on providing Health Care Benefits, Pharmacy Services and Retail/LTC products and services. As a result of our transformation program and other innovation initiatives, we are expanding our presence in the health care space and plan to offer new products and services (such as the home hemodialysis device we are developing) which present a different litigation and regulatory risk profile than the products and services that we historically have offered.

The increased volume of business in areas beyond our historical core businesses and new products and services subject us to litigation and regulatory risks that are different from the risks of providing Health Care Benefits, Pharmacy Services and Retail/LTC products and services and increase significantly our exposure to other risks.

We face unique regulatory and other challenges in our Medicare and Medicaid businesses.

We are seeking to substantially grow the Medicare and Medicaid membership in our Health Care Benefits segment in 2022 and over the next several years. We face unique regulatory and other challenges that may inhibit the growth and profitability of those businesses.

- In January 2021, CMS issued its final notice detailing final 2022 Medicare Advantage benchmark payment rates. Final 2022 Medicare Advantage rates resulted in an increase in industry benchmark rates of approximately 4.1%. We cannot predict future Medicare funding levels, the impact of future federal budget actions or ensure that such changes or actions will not have an adverse effect on our Medicare operating results.
- The organic expansion of our Medicare Advantage and Medicare Part D service area is subject to the ability of CMS to process our requests for service area expansions and our ability to build cost competitive provider networks in the expanded service areas that meet applicable network adequacy requirements. CMS' decisions on our requests for service area expansions also may be affected adversely by compliance issues that arise each year in our Medicare operations.
- CMS regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of the services we provide to our Medicare members. As a result of these audits, we may be subject to significant or material retroactive adjustments to and/or withholding of certain premiums and fees, fines, criminal liability, civil monetary penalties, CMS imposed sanctions (including suspension or exclusion from participation in government programs) or other restrictions on our Medicare, Medicaid and other businesses, including suspension or loss of licensure.
- "Star ratings" from CMS for our Medicare Advantage plans will continue to have a significant effect on our plans' operating results. Only Medicare Advantage plans with a star rating of four or higher (out of five) are eligible for a quality bonus in their basic premium rates. CMS continues to change its rating system to make achieving and maintaining a four or higher star rating more difficult. Our star ratings and past performance scores are adversely affected by the compliance issues that arise each year in our Medicare operations. If our star ratings fall below four for a significant portion of our Medicare Advantage membership or do not match the performance of our competitors or the star rating quality bonuses are reduced or eliminated, our revenues, operating results and cash flows may be significantly adversely affected.

- Payments we receive from CMS for our Medicare Advantage and Medicare Part D businesses also are subject to risk adjustment based on the health status of the individuals we enroll. Elements of that risk adjustment mechanism continue to be challenged by the DOJ, the OIG and CMS itself. Substantial changes in the risk adjustment mechanism, including changes that result from enforcement or audit actions, could materially affect the amount of our Medicare reimbursement, require us to raise prices or reduce the benefits we offer to Medicare beneficiaries, and potentially limit our (and the industry's) participation in the Medicare program.
- Changes to the ability of PBMs to have pharmacy performance programs in place for clients and report payments via direct and indirect reporting mechanisms could impact the Pharmacy Services business.
- Medicare Part D has resulted in increased utilization of prescription medications and puts pressure on our pharmacy gross margin rates due to regulatory and competitive pressures. Further, as a result of the ACA and changes to the retiree drug subsidy rules, clients of our PBM business could decide to discontinue providing prescription drug benefits to their Medicare-eligible members. To the extent this phenomenon occurs, the adverse effects of increasing customer migration into Medicare Part D may outweigh the benefits we realize from growth of our Medicare Part D products.
- Our Medicare Part D operating results and our ability to expand our Medicare Part D business could be adversely affected if: the cost and complexity of Medicare Part D exceed management's expectations or prevent effective program implementation or administration; changes to the regulations regarding how drug costs are reported for Medicare Part D are implemented in a manner that adversely affects the profitability of our Medicare Part D business; changes to the applicable regulations impact our ability to retain fees from third parties including network pharmacies; the government alters Medicare Part D program requirements or reduces funding because of the higher-than-anticipated cost to taxpayers of Medicare Part D or for other reasons; the government mandated use of point-of-sale manufacturer's rebates effective in 2022 continues; the government enacts price controls on certain pharmaceutical products in Medicare Part D; the government makes changes to how pharmacy pay-for-performance is calculated; or reinsurance thresholds are reduced below their current levels.
- We have experienced challenges in obtaining complete and accurate encounter data for our Medicaid products due to difficulties with providers and third-party vendors submitting claims in a timely fashion in the proper format, and with state agencies in coordinating such submissions. As states increase their reliance on encounter data, these difficulties could affect the Medicaid premium rates we receive and how Medicaid membership is assigned to us, which could have a material adverse effect on our Medicaid operating results and cash flows and/or our ability to bid for, and continue to participate in, certain Medicaid programs.
- If we fail to report and correct errors discovered through our own auditing procedures or during a CMS audit or otherwise fail to comply with the applicable laws and regulations, we could be subject to fines, civil monetary penalties or other sanctions, including fines and penalties under the False Claims Act, which could have a material adverse effect on our ability to participate in Medicare Advantage, Medicare Part D or other government programs, and on our operating results, cash flows and financial condition.
- Certain of our Medicaid contracts require the submission of complete and correct encounter data. The accurate and timely reporting of encounter data is increasingly important to the success of our Medicaid programs because more states are using encounter data to determine compliance with performance standards and, in part, to set premium rates. We have expended and may continue to expend additional effort and incur significant additional costs to collect accurate, or to correct inaccurate or incomplete, encounter data and have been and could be exposed to premium withholding, operating sanctions and financial fines and penalties for noncompliance. We have experienced challenges in obtaining complete and accurate encounter data due to difficulties with providers and third-party vendors submitting claims in a timely fashion in the proper format, and with state agencies in coordinating such submissions. As states increase their reliance on encounter data, these difficulties could affect the Medicaid premium rates we receive and how Medicaid membership is assigned to us, which could have a material adverse effect on our Medicaid operating results and cash flows and/or our ability to successfully bid for, and continue to participate in, certain Medicaid programs.

Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues, and we expect that percentage to increase.

Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues, and we expect that percentage to increase. As our government funded businesses grow, our exposure to changes in federal and state government policy with respect to and/or regulation of the various government funded programs in which we participate also increases.

The laws and regulations governing participation in Medicare Advantage (including dual eligible special needs plans), Medicare Part D, Medicaid, and managed Medicaid plans are complex, are subject to interpretation and can expose us to penalties for non-compliance. Federal, state and local governments have the right to cancel or not to renew their contracts with

us on short notice without cause or if funds are not available. Funding for these programs is dependent on many factors outside our control, including general economic conditions, continuing government efforts to contain health care costs and budgetary constraints at the federal or applicable state or local level and general political issues and priorities.

The U.S. federal government and our other government customers also may reduce funding for health care or other programs, cancel or decline to renew contracts with us, or make changes that adversely affect the number of persons eligible for certain programs, the services provided to enrollees in such programs, our premiums and our administrative and health care and other benefit costs, any of which could have a material adverse effect on our businesses, operating results and cash flows. When federal funding is delayed, suspended or curtailed, we continue to receive, and we remain liable for and are required to fund, claims from providers for providing services to beneficiaries of federally funded health benefits programs in which we participate. An extended federal government shutdown or a delay by Congress in raising the federal government's debt ceiling also could lead to a delay, reduction, suspension or cancellation of federal government spending and a significant increase in interest rates that could, in turn, have a material adverse effect on the value of our investment portfolio, our ability to access the capital markets and our businesses, operating results, cash flows and liquidity.

Possible changes in industry pricing benchmarks and drug pricing generally can adversely affect our PBM and Retail/LTC businesses.

It is possible that the pharmaceutical industry, regulators, or federal policymakers may evaluate and/or develop an alternative pricing reference to replace AWP or WAC, which are the pricing references used for many of our PBM and LTC client contracts, drug purchase agreements, retail network contracts, specialty payor agreements and other contracts with third party payors in connection with the reimbursement of drug payments. In addition, many state Medicaid fee-for-service programs have established pharmacy network payments on the basis of Actual Acquisition Cost ("AAC"). The use of an AAC basis in fee for service Medicaid could have an impact on reimbursement practices in Health Care Benefits' Commercial and other Government products. It is also possible that Congress may enact some limited form of price negotiation for Medicare. In addition, CMS also publishes the National Average Drug Acquisition Cost ("NADAC") for certain drugs; NADAC pricing is being adopted in an increasing number of states.

Future changes to the use of AWP, WAC or to other published pricing benchmarks used to establish drug pricing, including changes in the basis for calculating reimbursement by federal and state health care programs and/or other payors, could impact the reimbursement we receive from Medicare and Medicaid programs, the reimbursement we receive from our PBM clients and other payors and/or our ability to negotiate rebates and/or discounts with drug manufacturers, wholesalers, PBMs and retail pharmacies. A failure or inability to fully offset any increased prices or costs or to modify our operations to mitigate the impact of such increases could have a material adverse effect on our operating results. Additionally, any future changes in drug prices could be significantly different than our projections. We cannot predict the effect of these possible changes on our businesses.

We may not be able to obtain adequate premium rate increases in our Insured Health Care Benefits products, which would have an adverse effect on our revenues, MBRs and operating results and could magnify the adverse impact of increases in health care and other benefit costs and of ACA assessments, fees and taxes.

Premium rates for our Insured Health Care Benefits products generally must be filed with state insurance regulators and are subject to their approval, which creates risk for us in the current political and regulatory environment. The ACA generally requires a review by HHS in conjunction with state regulators of premium rate increases that exceed a federally specified threshold (or lower state-specific thresholds set by states determined by HHS to have adequate processes). Rate reviews can magnify the adverse impact on our operating margins, MBRs and operating results of increases in health care and other benefit costs, increased utilization of covered services, and ACA assessments, fees and taxes, by restricting our ability to reflect these increases and/or these assessments, fees and taxes in our pricing. Further, our ability to reflect ACA assessments, fees and taxes in our Medicare, Medicaid and CHIP premium rates is limited.

Since 2013, HHS has issued determinations to health plans that their premium rate increases were "unreasonable," and we continue to experience challenges to appropriate premium rate increases in certain states. Regulators or legislatures in several states have implemented or are considering limits on premium rate increases, either by enforcing existing legal requirements more stringently or proposing different regulatory standards. Regulators or legislatures in several states also have conducted hearings on proposed premium rate increases, which can result, and in some instances have resulted, in substantial delays in implementing proposed rate increases even if they ultimately are approved. Our plans can be excluded from participating in small group Public Exchanges if they are deemed to have a history of "unreasonable" rate increases. Any significant rate increases we may request heighten the risks of adverse publicity, adverse regulatory action and adverse selection and the

likelihood that our requested premium rate increases will be denied, reduced or delayed, which could adversely affect our MBRs and lead to operating margin compression.

We anticipate continued regulatory and legislative action to increase regulation of premium rates in our Insured Health Care Benefits products. We may not be able to obtain rates that are actuarially justified or that are sufficient to make our policies profitable in one or more product lines or geographies. If we are unable to obtain adequate premium rates and/or premium rate increases, it could materially and adversely affect our operating margins and MBRs and our ability to earn adequate returns on Insured Health Care Benefits products in one or more states or cause us to withdraw from certain geographies and/or products.

Minimum MLR rebate requirements limit the level of margin we can earn in our Insured Health Care Benefits products while leaving us exposed to higher than expected medical costs. Challenges to our minimum MLR rebate methodology and/or reports could adversely affect our operating results.

The ACA's minimum MLR rebate requirements limit the level of margin we can earn in Health Care Benefits' Commercial Insured and Medicare Insured businesses. CMS minimum MLR rebate regulations limit the level of margin we can earn in our Medicaid Insured business. Certain portions of our Health Care Benefits Medicaid and FEHB program business also are subject to minimum MLR rebate requirements in addition to but separate from those imposed by the ACA. Minimum MLR rebate requirements leave us exposed to medical costs that are higher than those reflected in our pricing. The process supporting the management and determination of the amount of MLR rebates payable is complex and requires judgment, and the minimum MLR reporting requirements are detailed. CMS has also proposed, but not yet finalized, a definition of "prescription drug price concessions" for commercial MLR calculation purposes, which would make additional PBM information available to plans and the HHS, potentially further complicating the MLR calculation process. Federal and state auditors are challenging our Commercial Health Care Benefits business' compliance with the ACA's minimum MLR requirements as well as our FEHB plans' compliance with OPM's FEHB program-specific minimum MLR requirements. Our Medicare and Medicaid contracts also are subject to minimum MLR audits. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS. Additional challenges to our methodology and/or reports relating to minimum MLR and related rebates by federal and state regulators and private litigants are reasonably possible. The outcome of these audits and additional challenges could adversely affect our operating results.

Our operating results may be adversely affected by changes in laws and policies governing employers and by union organizing activity.

Congress and certain state legislatures continue to consider and pass legislation that increases our costs of doing business, including increased minimum wages and requiring employers to provide paid sick leave or paid family leave. In addition, our employee-related operating costs may be increased by union organizing activity and it is possible that the National Labor Relations Board may adopt regulatory changes through re-making or case law that could facilitate union organizing. If we are unable to reflect these increased expenses in our pricing or otherwise modify our operations to mitigate the effects of such increases, our operating results will be adversely affected.

We face international political, legal and compliance, operational, regulatory, economic and other risks that may be more significant than in our domestic operations.

Our international operations present political, legal, compliance, operational, regulatory, economic and other risks that we do not face or that are more significant than in our domestic operations. These risks vary widely by country and include varying regional and geopolitical business conditions and demands, government intervention and censorship, discriminatory regulation, climate change regulation, nationalization or expropriation of assets and pricing constraints. Our international products need to meet country-specific customer and member preferences as well as country-specific legal requirements, including those related to licensing, data privacy, data storage and data protection.

Our international operations increase our exposure to, and require us to devote significant management resources to implement controls and systems to comply with, the privacy and data protection laws of non-U.S. jurisdictions, such as the EU's GDPR, and the anti-bribery, anti-corruption and anti-money laundering laws of the United States (including the FCPA) and the United Kingdom (including the UK Bribery Act) and similar laws in other jurisdictions. Implementing our compliance policies, internal controls and other systems upon our expansion into new countries and geographies may require the investment of considerable management time and financial and other resources over several years before any significant revenues or profits are generated. Violations of these laws and regulations could result in fines, criminal sanctions against us, our officers or employees, restrictions or outright prohibitions on the conduct of our business, and significant brand and reputational harm. We

must regularly reassess the size, capability and location of our global infrastructure and make appropriate changes, and must have effective change management processes and internal controls in place to address changes in our businesses and operations. Our success depends, in part, on our ability to anticipate these risks and manage these difficulties, and the failure to do so could have a material adverse effect on our brand, reputation, businesses, operating results and/or financial condition.

Our international operations require us to overcome logistical and other challenges based on differing languages, cultures, legal and regulatory schemes and time zones. Our international operations encounter labor laws, standards and customs that can be difficult and make employee relationships less flexible than in our domestic operations and expensive to modify or terminate. In some countries we are required to, or choose to, operate with local business associates, which requires us to manage our relationships with these third parties and may reduce our operational flexibility and ability to quickly respond to business challenges.

In some countries we may be exposed to currency exchange controls or other restrictions that prevent us from transferring funds internationally or converting local currencies into U.S. dollars or other currencies. Fluctuations in foreign currency exchange rates may adversely affect our revenues, operating results and cash flows from our international operations. Some of our operations are, and are increasingly likely to be, in emerging markets where these risks are heightened. Any measures we may implement to reduce the effect of volatile currencies and other risks on our international operations may not be effective.

Risks Associated with Mergers, Acquisitions, and Divestitures

We may be unable to successfully integrate companies we acquire.

Upon the closing of any acquisition we complete, we will need to successfully integrate the products, services and related assets, as well as internal controls into our business operations. If an acquisition is consummated, the integration of the acquired business, its products, services and related assets into our company also may be complex and time-consuming and, if the integration is not fully successful, we may not achieve the anticipated benefits, operating and cost synergies and/or growth opportunities of an acquisition. Potential difficulties that may be encountered in the integration process include the following:

- Integrating personnel, operations and systems (including internal control environments and compliance policies), while maintaining focus on producing and delivering consistent, high quality products and services;
- Coordinating geographically dispersed organizations;
- Disrupting management’s attention from our ongoing business operations;
- Retaining existing customers and attracting new customers;
- Managing inefficiencies associated with integrating our operations; and
- Reconciling post-acquisition costs and liabilities between buyer and seller.

An inability to realize the full extent of the anticipated benefits, operating and cost synergies, innovations and operations efficiencies or growth opportunities of an acquisition, as well as any delays or additional expenses encountered in the integration process, could have a material adverse effect on our businesses and operating results. Furthermore, acquisitions, even if successfully integrated, may fail to further our business strategy as anticipated, expose us to increased competition or challenges with respect to our products, services or service areas, and expose us to additional liabilities associated with an acquired business including risks and liabilities associated with litigation involving the acquired business. Any one of these challenges or risks could impair our ability to realize any benefit from our acquisitions after we have expended resources on them.

We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities, which may be unsuccessful, cause us to assume unanticipated liabilities, disrupt our existing businesses, be dilutive or lead us to assume significant debt, among other things.

We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities as part of our growth strategy. In addition to the integration risks noted above, some other risks we face with respect to acquisitions and other inorganic growth strategies include:

- we frequently compete with other firms, some of which may have greater financial and other resources and a greater tolerance for risk, to acquire attractive companies;
- the acquired, alliance and/or joint venture businesses may not perform as projected;

- the goodwill or other intangible assets established as a result of our acquisitions may be incorrectly valued or may become impaired;
- we may assume unanticipated liabilities, including those that were not disclosed to us or which we underestimated;
- the acquired businesses, or the pursuit of other inorganic growth strategies, could disrupt or compete with our existing businesses, distract management, result in the loss of key employees, divert resources, result in tax costs or inefficiencies and make it difficult to maintain our current business standards, controls, information technology systems, policies, procedures and performance;
- we may finance future acquisitions and other inorganic growth strategies by issuing common stock for some or all of the purchase price, which would dilute the ownership interests of our stockholders;
- we may incur significant debt in connection with acquisitions (whether to finance acquisitions or by assuming debt from the businesses we acquire);
- we may not have the expertise to manage and profitably grow the businesses we acquire, and we may need to rely on the retention of key personnel and other suppliers of businesses we acquire, which may be difficult or impossible to accomplish;
- we may enter into merger or purchase agreements but, due to reasons within or outside our control, fail to complete the related transactions, which could result in termination fees or other penalties that could be material, cause material disruptions to our businesses and operations and adversely affect our brand and reputation;
- in order to complete a proposed acquisition, we may be required to divest certain portions of our business, for which we may not be able to obtain favorable pricing;
- we may be involved in litigation related to mergers or acquisitions, including for matters that occurred prior to the applicable closing, which may be costly to defend and may result in adverse rulings against us that could be material; and
- the integration into our businesses of the businesses and entities we acquire may affect the way in which existing laws and regulations apply to us, including subjecting us to laws and regulations that did not previously apply to us.

In addition, joint ventures present risks that are different from acquisitions, including selection of appropriate joint venture parties, initial and ongoing governance of the joint venture, joint venture compliance activities (including compliance with applicable CMS requirements), growing the joint venture's business in a manner acceptable to all the parties, including other providers in the networks that include joint ventures, maintaining positive relationships among the joint venture parties and the joint venture's customers, and member and business disruption that may occur upon joint venture termination.

Risks Related to Our Operations

Failure to meet customer expectations may harm our brand and reputation, our ability to retain and grow our customer base and membership and our operating results and cash flows.

Our ability to attract and retain customers and members is dependent upon providing cost effective, quality customer service operations (such as call center operations, PBM functions, retail pharmacy and LTC services, retail, mail order and specialty pharmacy prescription delivery, claims processing, customer case installation and online access and tools) that meet or exceed our customers' and members' expectations, either directly or through vendors. As we seek to reduce general and administrative expenses, we must balance the potential impact of cost-saving measures on our customers and other services and performances. If we misjudge the effects of such measures, customers and other services may be adversely affected. We depend on third parties for certain of our customer service, PBM and prescription delivery operations. If we or our vendors fail to provide service that meets our customers' and members' expectations, we may have difficulty retaining or profitably growing our customer base and/or membership, which could adversely affect our operating results. For example, noncompliance with any privacy or security laws or regulations or any security breach involving us or one of our third-party vendors could have a material adverse effect on our businesses, operating results, brand and reputation.

We and our vendors have experienced and continue to experience cyber attacks. We can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of such attacks or other information security (including cybersecurity) risks or threats in the future.

We and our vendors have experienced diverse cyber attacks and expect to continue to experience cyber attacks going forward. As examples, the Company and its vendors have experienced attempts to gain access to systems, denial of service attacks, attempted malware infections, account takeovers, scanning activity, and phishing emails. Attacks can originate from external criminals, terrorists, nation states, or internal actors. The Company is dedicating and will continue to dedicate significant resources and incur significant expenses to maintain and update on an ongoing basis the systems and processes that are

designed to mitigate the information security risks it faces and protect the security of its computer systems, software, networks and other technology assets against attempts by unauthorized parties to obtain access to confidential information, disrupt or degrade service, or cause other damage. The impact of cyber attacks has not been material to the Company's operations or operating results through December 31, 2021. The Board and its Audit Committee and Nominating and Corporate Governance Committee are regularly informed regarding the Company's information security policies, practices and status.

A compromise of our information security controls or of those businesses with whom we interact, which results in confidential information being accessed, obtained, damaged, or used by unauthorized or improper persons, could harm our reputation and expose us to regulatory actions and claims from customers and clients, financial institutions, payment card associations and other persons, any of which could adversely affect our businesses, operating results and financial condition. Because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and may not immediately produce signs of intrusion, we may be unable to anticipate these techniques or to implement adequate preventative measures. Moreover, a data security breach could require that we expend significant resources related to our information systems and infrastructure, and could distract management and other key personnel from performing their primary operational duties. We also could be adversely affected by any significant disruption in the systems of third parties we interact with, including key payors and vendors.

The costs of attempting to protect against the foregoing risks and the costs of responding to an information security incident are significant. Large scale data breaches at other entities increase the challenge we and our vendors face in maintaining the security of our information technology systems and proprietary information and of our customers', members' and other constituents' sensitive information. Following an information security incident, our and/or our vendors' remediation efforts may not be successful, and could result in interruptions, delays or cessation of service, and loss of existing or potential customers and members. In addition, breaches of our and/or our vendors' security measures and the unauthorized access to or dissemination of sensitive personal information or proprietary information or confidential information about us, our customers, our members or other third-parties, could expose our customers', members' and other constituents' private information and our customers, members and other constituents to the risk of financial or medical identity theft, or expose us or other third parties to a risk of loss or misuse of this information, and result in investigations, regulatory enforcement actions, material fines and penalties, loss of customers, litigation or other actions which could have a material adverse effect on our brand, reputation, businesses, operating results and cash flows.

Data governance failures can adversely affect our reputation, businesses and prospects. Our use and disclosure of members', customers' and other constituents' sensitive information is subject to complex regulations at multiple levels. We would be adversely affected if we or our business associates or other vendors fail to adequately protect members', customers' or other constituents' sensitive information.

Our information systems are critical to the operation of our businesses. We collect, process, maintain, retain, evaluate, utilize and distribute large amounts of personal health and financial information and other confidential and sensitive data about our customers, members and other constituents in the ordinary course of our businesses. Some of our information systems rely upon third party systems, including cloud service providers, to accomplish these tasks. The use and disclosure of such information is regulated at the federal, state and international levels, and these laws, rules and regulations are subject to change and increased enforcement activity, such as the California Consumer Privacy Act which went into effect January 1, 2020, the EU's GDPR which began to apply across the EU during 2018 and the audit program implemented by HHS under HIPAA. In some cases, such laws, rules and regulations also apply to our vendors and/or may hold us liable for any violations by our vendors. International laws, rules and regulations governing the use and disclosure of such information are generally more stringent than U.S. laws and regulations, and they vary from jurisdiction to jurisdiction. Noncompliance with any privacy or security laws or regulations, or any security breach, information security incident, and any other incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, sensitive or confidential customer, member or other constituent information, whether by us, by one of our business associates or vendors or by another third party, could require us to expend significant resources to remediate any damage, could interrupt our operations and could adversely affect our brand and reputation, membership and operating results and also could expose and/or has exposed us to mandatory disclosure to the media, litigation (including class action litigation), governmental investigations and enforcement proceedings, material fines, penalties and/or remediation costs, and compensatory, special, punitive and statutory damages, consent orders, adverse actions against our licenses to do business and/or injunctive relief, any of which could adversely affect our businesses, operating results, cash flows or financial condition.

Our businesses depend on our customers', members' and other constituents' willingness to entrust us with their health related and other sensitive personal information. Events that adversely affect that trust, including inadequate disclosure to our members or customers of our uses of their information, failing to keep our information technology systems and our customers', members'

and other constituents' sensitive information secure from significant attack, theft, damage, loss or unauthorized disclosure or access, whether as a result of our action or inaction (including human error) or that of our business associates, vendors or other third parties, could adversely affect our brand and reputation, membership and operating results and also could expose and/or has exposed us to mandatory disclosure to the media, litigation (including class action litigation), governmental investigations and enforcement proceedings, material fines, penalties and/or remediation costs, and compensatory, special, punitive and statutory damages, consent orders, adverse actions against our licenses to do business and/or injunctive relief, any of which could adversely affect our businesses, operating results, cash flows or financial condition. Large scale data breaches at other entities increase the challenge we and our vendors face in maintaining the security of our information technology systems and proprietary information and of our customers', members' and other constituents' sensitive information. There can be no assurance that additional such failures will not occur, or if any do occur, that we will detect them or that they can be sufficiently remediated.

Product liability, product recall or personal injury issues could damage our reputation and have a significant adverse effect on our businesses, operating results, cash flows and/or financial condition.

The products that we sell could become subject to contamination, product tampering, mislabeling, recall or other damage. In addition, errors in the dispensing, packaging or administration of drugs or other products and consuming drugs in a manner that is not prescribed could lead to serious injury or death. Product liability or personal injury claims may be asserted against us with respect to any of the drugs or other products we sell or services we provide. For example, we are a defendant in hundreds of litigation proceedings relating to opioids and the sale of products containing talc. Our businesses involve the provision of professional services, including by pharmacists, physician assistants, nurses and nurse practitioners, which exposes us to professional liability claims. Should a product or other liability issue arise, the coverage available under our insurance programs and the indemnification amounts available to us from third parties may not be adequate to protect us against the financial impact of the related claims. We also may not be able to maintain our existing levels of insurance on acceptable terms in the future. A product liability or personal injury issue or judgment against us or a product recall, tampering, or mislabeling could damage our reputation and have a significant adverse effect on our businesses, operating results and/or financial condition.

We face significant competition in attracting and retaining talented employees. Further, managing succession for, and retention of, key executives is critical to our success, and our failure to do so could adversely affect our businesses, operating results and/or future performance.

Our ability to attract and retain qualified and experienced employees is essential to meet our current and future goals and objectives. There is no guarantee we will be able to attract and retain such employees or that competition among potential employers will not result in increased compensation and/or benefits costs. If we are unable to retain existing employees or attract additional employees, or we experience an unexpected loss of leadership, we could experience a material adverse effect on our businesses, operating results and/or future performance.

In addition, our failure to adequately plan for succession of senior management and other key management roles or the failure of key employees to successfully transition into new roles could have a material adverse effect on our businesses, operating results and/or future performance. The succession plans we have in place and our employment arrangements with certain key executives do not guarantee the services of these executives will continue to be available to us.

Sales of our products and services are dependent on our ability to attract and motivate internal sales personnel and independent third-party brokers, consultants and agents. New distribution channels create new disintermediation risk. We may be subject to penalties or other regulatory actions as a result of the marketing practices of brokers and agents selling our products.

Our products are sold primarily through our sales personnel, who frequently work with independent brokers, consultants and agents who assist in the production and servicing of business. The independent brokers, consultants and agents generally are not dedicated to us exclusively and may frequently recommend and/or market health care benefits products of our competitors. Accordingly, we must compete intensely for their services and allegiance. Our sales could be adversely affected if we are unable to attract, retain or motivate sales personnel and third-party brokers, consultants and agents, or if we do not adequately provide support, training and education to this sales network regarding our complex product portfolio, or if our sales strategy is not appropriately aligned across distribution channels. This risk is heightened as we develop, operate and expand our consumer-oriented products and services and we expand in the health care space and our business model evolves to include a greater focus on consumers and direct-to-consumer sales, such as competing for sales on Insurance Exchanges.

New distribution channels for our products and services continue to emerge, including Private Exchanges operated by health care consultants and technology companies. These channels may make it more difficult for us to directly engage consumers and other customers in the selection and management of their health care benefits, in health care utilization and in the effective navigation of the health care system. We also may be challenged by new technologies and marketplace entrants that could interfere with our existing relationships with customers and health plan members in these areas.

In addition, there have been several investigations regarding the marketing practices of brokers and agents selling health care and other insurance products and the payments they receive. These investigations have resulted in enforcement actions against companies in our industry and brokers and agents marketing and selling those companies' products. For example, CMS and state departments of insurance have increased their scrutiny of the marketing practices of brokers and agents who market Medicare products. These investigations and enforcement actions could result in penalties and the imposition of corrective action plans and/or changes to industry practices, which could adversely affect our ability to market our products.

Failure of our businesses to effectively collaborate could prevent us from maximizing our operating results.

To maximize our overall enterprise value, our various businesses need to collaborate effectively. Our businesses need to be aligned in order to prioritize goals and coordinate the design of new products intended to utilize the offerings of multiple businesses, including our transformation and enterprise modernization programs. In addition, misaligned incentives, information siloes, ineffective product development and failure of our corporate governance policies or procedures, for example significant financial decisions being made at an inappropriate level in our organization, also could prevent us from maximizing our operating results and/or achieving our financial and other projections.

The failure or disruption of our information technology systems or the failure of our information technology infrastructure to support our businesses could adversely affect our reputation, businesses, operating results and cash flows.

Our information systems are subject to damage or interruption from power outages, facility damage, computer and telecommunications failures, computer viruses, security breaches (including credit card or personally identifiable information breaches), cyber attacks, vandalism, catastrophic events and human error. If our information systems are damaged, fail to work properly or otherwise become unavailable, we may incur substantial costs to repair or replace them, and may experience reputational damage, loss of critical information, customer disruption and interruptions or delays in our ability to perform essential functions and implement new and innovative services. In addition, compliance with changes in U.S. and foreign laws and regulations, including privacy and information security laws and standards, may cause us to incur significant expense due to increased investment in technology and the development of new operational processes.

Our business success and operating results depend in part on effective information technology systems and on continuing to develop and implement improvements in technology. Pursuing multiple initiatives simultaneously could make this continued development and implementation significantly more challenging.

Many aspects of our operations are dependent on our information systems and the information collected, processed, stored, and handled by these systems. We rely heavily on our computer systems to manage our ordering, pricing, point-of-sale, pharmacy fulfillment, inventory replenishment, claims processing, customer loyalty and subscription programs, finance and other processes. Throughout our operations, we collect, process, maintain, retain, evaluate, utilize and distribute large amounts of confidential and sensitive data and information, including personally identifiable information and protected health information, that our customers, members and other constituents provide to purchase products or services, enroll in programs or services, register on our websites, interact with our personnel, or otherwise communicate with us. In addition, for these operations, we depend in part on the secure transmission of confidential information over public networks.

We have many different information and other technology systems supporting our businesses (including as a result of our acquisitions). Our businesses depend in large part on these systems to adequately price our products and services; accurately establish reserves, process claims and report operating results; and interact with providers, employer plan sponsors, customers, members, consumers and vendors in an efficient and uninterrupted fashion. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Certain of our technology systems (including software) are older, legacy systems that are less flexible, less efficient and require a significant ongoing commitment of capital and human resources to maintain, protect and enhance them and to integrate them with our other systems. We must re-engineer and reduce the number of these systems to meet changing consumer and vendor preferences and needs, improve our productivity and reduce our operating expenses. We also need to develop or acquire new technology systems, contract with new vendors or modify certain of our existing systems to support the consumer-oriented and transformation products and services we are developing, operating and expanding and/or to meet current

and developing industry and regulatory standards, including to keep pace with continuing changes in information processing technology and emerging cybersecurity risks and threats. If we fail to achieve these objectives, our ability to profitably grow our business and/or our operating results may be adversely affected.

In addition, information technology and other technology and process improvement projects, including our transformation and enterprise modernization programs, frequently are long-term in nature and may take longer to complete and cost more than we expect and may not deliver the benefits we project once they are complete. If we do not effectively and efficiently secure, manage, integrate and enhance our technology portfolio (including vendor sourced systems), we could, among other things, have problems determining health care and other benefit cost estimates and/or establishing appropriate pricing, meeting the needs of customers, consumers, providers, members and vendors, developing and expanding our consumer-oriented products and services or keeping pace with industry and regulatory standards, and our operating results may be adversely affected.

We are subject to payment-related risks that could increase our operating costs, expose us to fraud or theft, subject us to potential liability and disrupt our business operations.

We accept payments using a variety of methods, including cash, checks, credit cards, debit cards, gift cards, mobile payments and potentially other technologies in the future. Acceptance of these payment methods subjects us to rules, regulations, contractual obligations and compliance requirements, including payment network rules and operating guidelines, data security standards and certification requirements, and rules governing electronic funds transfers. These requirements may change in the future, which could make compliance more difficult or costly. For certain payment options, including credit and debit cards, we pay interchange and other fees, which could increase periodically thereby raising our operating costs. We rely on third parties to provide payment processing services, including the processing of credit cards, debit cards, and various other forms of electronic payment. If these vendors are unable to provide these services to us, or if their systems are compromised, our operations could be disrupted. The payment methods that we offer also expose us to potential fraud and theft by persons seeking to obtain unauthorized access to, or exploit any weaknesses in, the payment systems we use. If we fail to abide by applicable rules or requirements, or if data relating to our payment systems is compromised due to a breach or misuse, we may be responsible for any costs incurred by payment card issuing banks and other third parties or subject to fines and higher transaction fees. In addition, our reputation and ability to accept certain types of payments could each be harmed resulting in reduced sales and adverse effects on our operating results.

Both our and our vendors' operations are subject to a variety of business continuity hazards and risks, any of which could interrupt our operations or otherwise adversely affect our performance and operating results.

We and our vendors are subject to business continuity hazards and other risks, including natural disasters, utility and other mechanical failures, acts of war or terrorism, acts of civil unrest, disruption of communications, data security and preservation, disruption of supply or distribution, safety regulation and labor difficulties. The occurrence of any of these or other events to us or our vendors might disrupt or shut down our operations or otherwise adversely affect our operations. We also may be subject to certain liability claims in the event of an injury or loss of life, or damage to property, resulting from such events. Although we have developed procedures for crisis management and disaster recovery and business continuity plans and maintain insurance policies that we believe are customary and adequate for our size and industry, our insurance policies include limits and exclusions and, as a result, our coverage may be insufficient to protect against all potential hazards and risks incident to our businesses. In addition, our crisis management and disaster recovery procedures and business continuity plans may not be effective. Should any such hazards or risks occur, or should our insurance coverage be inadequate or unavailable, our businesses, operating results, cash flows and financial condition could be adversely affected.

Financial Risks

We would be adversely affected if we do not effectively deploy our capital. Downgrades or potential downgrades in our credit ratings, should they occur, could adversely affect our brand and reputation, businesses, operating results, cash flows and financial condition.

Our operations generate significant capital, and we have the ability to raise additional capital. The manner in which we deploy our capital, including investments in our businesses, our operations (such as information technology and other strategic and capital projects), dividends, acquisitions, share and/or debt repurchases, repayment of debt, reinsurance or other capital uses, impacts our financial strength, claims paying ability and credit ratings issued by nationally-recognized statistical rating organizations. Credit ratings issued by nationally-recognized statistical rating organizations are broadly distributed and generally used throughout our industries. Our ratings reflect each rating organization's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to our insureds. We believe our credit ratings and

the financial strength and claims paying ability of our principal insurance and HMO subsidiaries are important factors in marketing our Health Care Benefits products to certain of our customers.

Each of the ratings organizations reviews our ratings periodically, and there can be no assurance that our current ratings will be maintained in the future. Downgrades in our ratings could adversely affect our businesses, operating results, cash flows and financial condition.

Goodwill and other intangible assets could, in the future, become impaired.

As of December 31, 2021 and December 31, 2020, we had $108.1 billion and $110.7 billion, respectively, of goodwill and other intangible assets. Goodwill and indefinite-lived intangible assets are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that the carrying value may not be recoverable. When evaluating goodwill for potential impairment, we compare the fair value of our reporting units to their respective carrying amounts. We estimate the fair value of our reporting units using a combination of a discounted cash flow method and a market multiple method. If the carrying amount of a reporting unit exceeds its estimated fair value, a goodwill impairment loss is recognized in an amount equal to the excess to the extent of the goodwill balance. Indefinite-lived intangible assets are tested for impairment by comparing the estimated fair value of the asset to its carrying value. The Company estimates the fair value of its indefinite-lived trademarks using the relief from royalty method under the income approach. If the carrying value of the asset exceeds its estimated fair value, an impairment loss is recognized, and the asset is written down to its estimated fair value. Definite-lived intangible assets are tested for impairment whenever events or changes in circumstances indicate that the carrying value of such an asset may not be recoverable. If indicators of impairment are present, the Company first compares the carrying amount of the asset group to the estimated future cash flows associated with the asset group (undiscounted). If the estimated future cash flows used in this analysis are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to the asset group's estimated future cash flows (discounted).

Estimated fair values could change if, for example, there are changes in the business climate, industry-wide changes, changes in the competitive environment, adverse legal or regulatory actions or developments, changes in capital structure, cost of debt, interest rates, capital expenditure levels, operating cash flows or market capitalization. Because of the significance of our goodwill and intangible assets, any future impairment of these assets could require material noncash charges to our operating results, which also could have a material adverse effect on our financial condition.

Adverse conditions in the U.S. and global capital markets can significantly and adversely affect the value of our investments in debt and equity securities, mortgage loans, alternative investments and other investments, and our operating results and/or our financial condition.

The global capital markets, including credit markets, continue to experience volatility and uncertainty. As an insurer, we have a substantial investment portfolio that supports our policy liabilities and surplus and is comprised largely of debt securities of issuers located in the U.S. As a result, the income we earn from our investment portfolio is largely driven by the level of interest rates in the U.S., and to a lesser extent the international financial markets; and volatility, uncertainty and/or disruptions in the global capital markets, particularly the U.S. credit markets, and governments' monetary policy, particularly U.S. monetary policy, can significantly and adversely affect the value of our investment portfolio, our operating results and/or our financial condition by:

- significantly reducing the value and/or liquidity of the debt securities we hold in our investment portfolio and creating realized capital losses that reduce our operating results and/or unrealized capital losses that reduce our shareholders' equity;
- keeping interest rates low on high-quality short-term or medium-term debt securities (such as we have experienced during recent years) and thereby materially reducing our net investment income and operating results as the proceeds from securities in our investment portfolio that mature or are otherwise disposed of continue to be reinvested in lower yielding securities;
- reducing the fair values of our investments if interest rates rise;
- causing non-performance of or defaults on their obligations to us by third parties, including customers, issuers of securities in our investment portfolio, mortgage borrowers and/or reinsurance and/or derivatives counterparties;
- making it more difficult to value certain of our investment securities, for example if trading becomes less frequent, which could lead to significant period-to-period changes in our estimates of the fair values of those securities and cause period-to-period volatility in our net income and shareholders' equity;

- reducing our ability to issue short-term debt securities at attractive interest rates, thereby increasing our interest expense and decreasing our operating results; and
- reducing our ability to issue other securities.

Although we seek, within guidelines we deem appropriate, to match the duration of our assets and liabilities and to manage our credit and counterparty exposures, a failure adequately to do so could adversely affect our net income and our financial condition and, in extreme circumstances, our cash flows.

Risks Related to Our Relationships with Manufacturers, Providers, Suppliers and Vendors

We face risks relating to the market availability, pricing, suppliers and safety profiles of prescription drugs and other products that we purchase and sell.

Our Retail/LTC segment and our mail order and specialty pharmacy operations generate revenues in significant part by dispensing prescription drugs. Our PBM business generates revenues primarily by contracting with clients to provide prescription drugs and related health care services to plan members. As a result, we are dependent on our relationships with prescription drug manufacturers and suppliers. We acquire a substantial amount of our mail order and specialty pharmacies' prescription drug supply from a limited number of suppliers. Certain of our agreements with such suppliers are short-term and cancelable by either party without cause. In addition, these agreements may allow the supplier to distribute through channels other than us. Certain of these agreements also allow pricing and other terms to be adjusted periodically for changing market conditions or required service levels. A termination or modification to any of these relationships could adversely affect our prescription drug supply and have a material adverse effect on our businesses, operating results and financial condition. Moreover, many products distributed by our pharmacies are manufactured with ingredients that are susceptible to supply shortages. In some cases, we depend upon a single source of supply. Any such supply shortages or loss of any such single source of supply could adversely affect our operating results and cash flows.

Much of the branded and generic drug product that we sell in our pharmacies, and much of the other merchandise we sell, is manufactured in whole or in substantial part outside of the United States. In most cases, the products or merchandise are imported by others and sold to us. As a result, significant changes in tax or trade policies, tariffs or trade relations between the United States and other countries, such as the imposition of unilateral tariffs on imported products, could result in significant increases in our costs, restrict our access to suppliers, depress economic activity, and have a material adverse effect on our businesses, operating results and cash flows. In addition, other countries may change their business and trade policies and such changes, as well as any negative sentiments towards the United States in response to increased import tariffs and other changes in U.S. trade regulations, could adversely affect our businesses.

Our suppliers are independent entities subject to their own operational and financial risks that are outside our control. If our current suppliers were to stop selling prescription drugs to us or delay delivery, including as a result of supply shortages, supplier production disruptions, supplier quality issues, closing or bankruptcies of our suppliers, or for other reasons, we may be unable to procure alternatives from other suppliers in a timely and efficient manner and on acceptable terms, or at all.

Our operating results may be adversely affected if we are unable to contract with providers on competitive terms and develop and maintain attractive networks with high quality providers.

We are seeking to enhance our health care provider networks by entering into joint ventures and other collaborative risk-sharing arrangements with providers. Providers' willingness to enter these arrangements with us depends upon, among other things, our ability to provide them with up to date quality of care data to support these value-based contracts. These arrangements are designed to give providers incentives to engage in population health management and optimize delivery of health care to our members. These arrangements also may allow us to expand into new geographies, target new customer groups, increase membership and reduce medical costs and, if we provide technology or other services to the relevant health system or provider organization, may contribute to our revenue and earnings from alternative sources. If such arrangements do not result in the lower medical costs that we project or if we fail to attract providers to such arrangements, or are less successful at implementing such arrangements than our competitors, our medical costs may not be competitive and may be higher than we project, our attractiveness to customers may be reduced, we may lose or be unable to grow medical membership, and our ability to profitably grow our business and/or our operating results may be adversely affected.

While we believe joint ventures, accountable care organizations ("ACOs") and other non-traditional health care provider organizational structures present opportunities for us, the implementation of our joint ventures and other non-traditional structure strategies may not achieve the intended results, which could adversely affect our operating results and cash flows.

Among other things, joint ventures require us to maintain collaborative relationships with our counterparties, continue to gain access to provider rates that make the joint ventures economically sustainable and devote significant management time to the operation and management of the joint ventures. We may not be able to achieve these objectives in one or more of our joint ventures, which could adversely affect our operating results and cash flows.

If our suppliers or service providers fail to meet their contractual obligations to us or to comply with applicable laws or regulations, we may be exposed to brand and reputational harm, litigation and/or regulatory action. This risk is particularly high in our Medicare, Medicaid, dual eligible and dual eligible special needs plan programs.

In addition to our suppliers, we contract with various third parties to perform certain functions and services and provide us with certain information technology systems. Our arrangements with suppliers and these third parties may expose us to public scrutiny, adversely affect our brand and reputation, expose us to litigation or regulatory action, and otherwise make our operations vulnerable if we fail to adequately oversee, monitor and regulate their performance or if they fail to meet their contractual obligations to us or to comply with applicable laws or regulations, including those related to human capital and climate change. For example, certain of our vendors have been responsible for releases of sensitive information of our members and employees, which has caused us to incur additional expenses and given rise to regulatory actions and litigation against us.

These risks are particularly high in our in Medicare Advantage (including dual eligible special needs plans), Medicare Part D, Medicaid, and managed Medicaid plans, where third parties may perform medical management and other member related services for us. Any failure of our or these third parties' prevention, detection or control systems related to regulatory compliance, compliance with our internal policies, data security and/or cybersecurity or any incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, members', customers' or other constituents' sensitive information could require us to expend significant resources to remediate any damage, interrupt our operations and adversely affect our brand and reputation and also expose us to whistleblower, class action and other litigation, other proceedings, prohibitions on marketing or active or passive enrollment of members, corrective actions, fines, sanctions and/or penalties, any of which could adversely affect our businesses, operating results, cash flows and/or financial condition.

We may experience increased medical and other benefit costs, litigation risk and customer and member dissatisfaction when providers that do not have contracts with us render services to our Health Care Benefits members.

Some providers that render services to our Health Care Benefits members do not have contracts with us. In those cases, we do not have a pre-established understanding with these providers as to the amount of compensation that is due to them for services rendered to our members. In some states, the amount of compensation due to these nonparticipating providers is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover the difference between what we have paid them and the amount they charged us from our members, which may result in customer and member dissatisfaction. For example, in October 2018, an arbitrator awarded certain claimant hospitals approximately $150 million in a proceeding relating to Aetna's out-of-network benefit payment and administration practices, and in March 2019 that award was reduced to approximately $86 million. Such disputes may cause us to pay higher medical or other benefit costs than we projected.

Continuing consolidation and integration among providers and other suppliers may increase our medical and other covered benefits costs, make it difficult for us to compete in certain geographies and create new competitors.

Hospitals and other providers and health systems continue to consolidate across the health care industry. While this consolidation could increase efficiency and has the potential to improve the delivery of health care services, it also reduces competition and the number of potential contracting parties in certain geographies. These health systems also are increasingly forming and considering forming health plans to directly offer health insurance in competition with us, a process that has been accelerated by the ACA. In addition, ACOs (including Commercial and Medicaid-only ACOs developed as a result of state Medicaid laws), practice management companies, consolidation among and by integrated health systems and other changes in the organizational structures that physicians, hospitals and other providers adopt continues to change the way these providers interact with us and the competitive landscape in which we operate. These changes may increase our medical and other covered benefits costs, may affect the way we price our products and services and estimate our medical and other covered benefits costs and may require us to change our operations, including by withdrawing from certain geographies where we do not have a significant presence across our businesses or are unable to collaborate or contract with providers on acceptable terms. Each of these changes may adversely affect our businesses and operating results.

Item 1B. Unresolved Staff Comments.

There are no unresolved SEC Staff Comments.

Item 2. Properties.

The Company's principal office is an owned building complex located in Woonsocket, Rhode Island, which totals approximately one million square feet. The Company also leases office space in other locations in the United States.

Health Care Benefits Segment

The Health Care Benefits segment's principal office is an owned building complex located in Hartford, Connecticut, which totals approximately 1.7 million square feet. The Health Care Benefits segment also owns or leases office space in other locations in the United States and several other countries.

Pharmacy Services Segment

The Pharmacy Services segment includes owned or leased mail service dispensing pharmacies, call centers, on-site pharmacy stores, retail specialty pharmacy stores, specialty mail service pharmacies and branches for infusion and enteral services throughout the United States.

Retail/LTC Segment

As of December 31, 2021, the Retail/LTC segment operated the following properties:

- Approximately 8,075 retail stores, of which approximately 5% were owned. Net selling space for retail stores was approximately 79.8 million square feet as of December 31, 2021.
- Approximately 1,865 retail pharmacies within retail chains, as well as approximately 80 clinics in Target Corporation ("Target") stores;
- Owned distribution centers and leased distribution facilities throughout the United States totaling approximately 10.7 million square feet; and
- Owned and leased LTC pharmacies throughout the United States and an owned LTC repackaging facility.

In connection with certain business dispositions completed between 1995 and 1997, the Company continues to guarantee lease obligations for 72 former stores. The Company is indemnified for these guarantee obligations by the respective initial purchasers. These guarantees generally remain in effect for the initial lease term and any extension thereof pursuant to a renewal option provided for in the lease prior to the time of the disposition. For additional information on these guarantees, see "Lease Guarantees" in Note 16 ''Commitments and Contingencies'' included in Item 8 of this 10-K.

Management believes that the Company's owned and leased facilities are suitable and adequate to meet the Company's anticipated needs. At the end of the existing lease terms, management believes the leases can be renewed or replaced by alternative space. For additional information on the right-of-use assets and lease liabilities associated with the Company's leases, see Note 6 ''Leases'' included in Item 8 of this 10-K.

Item 3. Legal Proceedings.

The information contained in Note 16 ''Commitments and Contingencies'' included in Item 8 of this 10-K is incorporated herein by reference.

Item 4. Mine Safety Disclosures.

Not applicable.

Information about our Executive Officers

The following sets forth the name, age and biographical information for each of the Registrant's executive officers as of February 9, 2022. In each case the officer's term of office extends to the date of the meeting of the Board following the next annual meeting of stockholders of CVS Health Corporation. Previous positions and responsibilities held by each of the executive officers over the past five years or more are indicated below:

Troyen A. Brennan, M.D., age 67, Executive Vice President and Chief Medical Officer of CVS Health Corporation since November 2008; Executive Vice President and Chief Medical Officer of Aetna Inc. from February 2006 through November 2008.

James D. Clark, age 57, Senior Vice President - Controller and Chief Accounting Officer of CVS Health Corporation since November 2018; Vice President - Finance and Accounting of CVS Pharmacy, Inc. from September 2009 through October 2018.

Daniel P. Finke, age 51, Executive Vice President of CVS Health Corporation and President of Health Care Benefits since February 2021; Executive Vice President, Commercial Business and Markets of Aetna Inc. from February 2020 through January 2021; Executive Vice President, Consumer Health and Service of Aetna Inc. from June 2018 through January 2020; Senior Vice President, Network and Clinical Services of Aetna Inc. from January 2016 through May 2018.

Shawn M. Guertin, age 58, Executive Vice President and Chief Financial Officer of CVS Health Corporation since May 2021; Executive Vice President, Chief Financial Officer and Chief Enterprise Risk Officer of Aetna Inc. from February 2013 through May 2019; Senior Vice President, Finance of Aetna Inc. from April 2011 through January 2013.

Laurie P. Havanec, age 61, Executive Vice President and Chief People Officer of CVS Health Corporation since February 2021; Executive Vice President and Chief People Officer, Otis Worldwide Corporation, an elevator, escalator and moving walkway manufacturer, from October 2019 through January 2021; Corporate Vice President, Talent of United Technologies Corporation, a multinational manufacturing conglomerate, from April 2017 through October 2019; Vice President - Human Resources, Institution Businesses of Aetna Inc. from 2013 through March 2017.

Alan M. Lotvin, M.D., age 60, Executive Vice President of CVS Health Corporation and President of CVS Caremark since March 2020; Executive Vice President - Transformation of CVS Health Corporation from June 2018 through February 2020; Executive Vice President - Specialty Pharmacy, CVS Caremark from November 2012 through May 2018.

Karen S. Lynch, age 59, President and Chief Executive Officer of CVS Health Corporation since February 2021; Executive Vice President of CVS Health Corporation from November 2018 through January 2021; President of Aetna Inc. from January 2015 through January 2021; and a director of CVS Health Corporation since February 2021. Ms. Lynch is also a member of the board of directors of U.S. Bancorp, a banking and financial services company.

Thomas M. Moriarty, age 58, Executive Vice President and General Counsel of CVS Health Corporation since October 2012; Chief Policy and External Affairs Officer since March 2017; Chief Strategy Officer from March 2014 through February 2017.

Michelle A. Peluso, age 49, Executive Vice President and Chief Customer Officer of CVS Health Corporation since January 2021 and Co-President of Retail since January 2022; Senior Vice President, Digital Sales and Chief Marketing Officer, IBM, a multinational technology corporation, from February 2016 through January 2021; Chief Executive Officer, Gilt Groupe, Inc., an online shopping destination, from 2013 through February 2016. Ms. Peluso is also a member of the board of directors of Nike, Inc., an athletic footwear and clothing manufacturer.

Jonathan C. Roberts, age 66, Executive Vice President and Chief Operating Officer of CVS Health Corporation since March 2017; Executive Vice President of CVS Health Corporation and President of CVS Caremark from September 2012 through February 2017.

Prem Shah, age 42, Executive Vice President and Chief Pharmacy Officer of CVS Health Corporation since November 2021 and Co-President of Retail since January 2022; Executive Vice President, Specialty and Product Innovation , CVS Caremark from August 2018 through November 2021; Vice President - Specialty Pharmacy, CVS Caremark from February 2013 through July 2018.

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.

Market Information

CVS Health Corporation's common stock is listed on the New York Stock Exchange under the symbol "CVS."

Dividends

During 2021, 2020 and 2019, the quarterly cash dividend was $0.50 per share. In December 2021, the Board authorized a 10% increase in the quarterly cash dividend to $0.55 per share effective in 2022. CVS Health Corporation has paid cash dividends every quarter since becoming a public company. Future dividends will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

See Note 12 ''Shareholders' Equity'' included in Item 8 of this 10-K for information regarding CVS Health Corporation's dividends.

Holders of Common Stock

As of February 2, 2022, there were 24,946 registered holders of the registrant's common stock according to the records maintained by the registrant's transfer agent.

Issuer Purchases of Equity Securities

The following share repurchase programs have been authorized by the Board:

In billions **Authorization Date**	**Authorized**	**Remaining as of December 31, 2021**
December 9, 2021 ("2021 Repurchase Program")	$ 10.0	$ 10.0
November 2, 2016 ("2016 Repurchase Program")	15.0	—

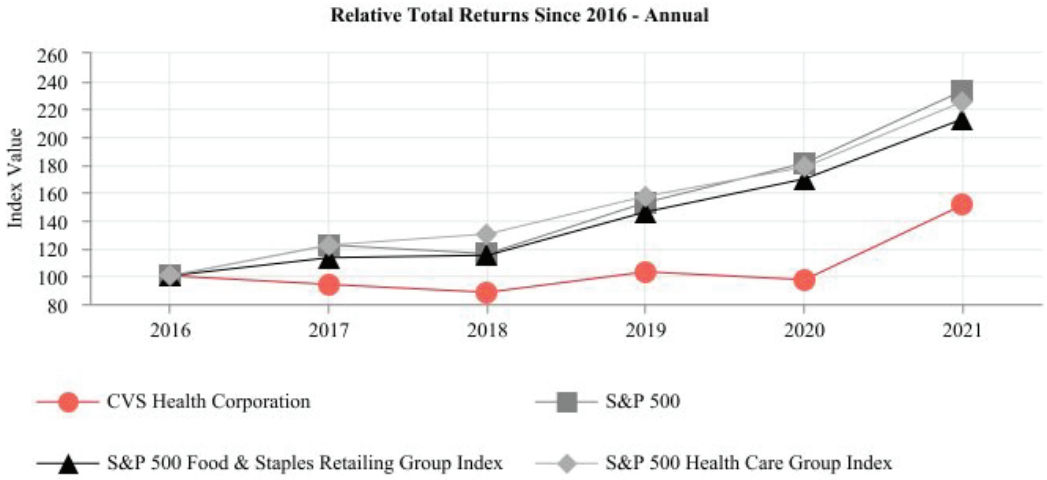
Each of the share Repurchase Programs was effective immediately. The 2016 Repurchase program was terminated effective December 9, 2021. The 2021 Repurchase Program permits the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase ("ASR") transactions, and/or other derivative transactions. The 2021 Repurchase Program can be modified or terminated by the Board at any time. During the three months ended December 31, 2021, the Company did not repurchase any shares of common stock.

Pursuant to the authorization under the 2021 Repurchase Program, the Company entered into a $1.5 billion fixed dollar ASR with Barclays Bank PLC ("Barclays"). Upon payment of the $1.5 billion purchase price on January 4, 2022, the Company received a number of shares of CVS Health Corporation's common stock equal to 80% of the $1.5 billion notional amount of the ASR or approximately 11.6 million shares at a price of $103.34 per share, which were placed into treasury stock in January 2022. At the conclusion of the ASR, the Company may receive additional shares equal to the remaining 20% of the $1.5 billion notional amount. The ultimate number of shares the Company may receive will depend on the daily volume-weighted average price of the Company's stock over an averaging period, less a discount. It is also possible, depending on such weighted average price, that the Company will have an obligation to Barclays which, at the Company's option, could be settled in additional cash or by issuing shares. Under the terms of the ASR, the maximum number of shares that could be delivered to the Company is 29.0 million.

See Note 12 ''Shareholders' Equity'' included in Item 8 of this 10-K for additional information regarding the Company's share repurchases.

Stock Performance Graph

The following graph compares the cumulative total shareholder return on CVS Health Corporation's common stock (assuming reinvestment of dividends) with the cumulative total return on the S&P 500 Index, the S&P 500 Food and Staples Retailing Industry Group Index and the S&P 500 Healthcare Sector Group Index from December 31, 2016 through December 31, 2021. The graph assumes a $100 investment in shares of CVS Health Corporation's common stock on December 31, 2016.



	December 31,					
	2016	2017	2018	2019	2020	2021
CVS Health Corporation	$ 100	$ 94	$ 88	$ 103	$ 97	$ 151
S&P 500 (1)	100	122	116	153	181	233
S&P 500 Food & Staples Retailing Group Index (2)	100	113	115	146	170	213
S&P 500 Health Care Group Index (1) (3)	100	122	130	157	178	225

(1) Includes CVS Health Corporation.
(2) Includes five companies (COST, KR, SYY, WBA, WMT).
(3) Includes 64 companies.

The year-ended values of each investment shown in the preceding graph are based on share price appreciation plus dividends, with the dividends reinvested as of the last business day of the month during which such dividends were ex-dividend. The calculations exclude trading commissions and taxes. Total shareholder returns from each investment can be calculated from the year-end investment values shown beneath the graph.

Item 6. Reserved

Not applicable.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations. ("MD&A")

The following discussion and analysis should be read in conjunction with the audited consolidated financial statements and related notes included in Item 8 of this Annual Report on Form 10-K (this "10-K"), "Risk Factors" included in Item 1A of this 10-K and the "Cautionary Statement Concerning Forward-Looking Statements" in this 10-K.

Overview of Business

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health," the "Company," "we," "our" or "us"), is a diversified health solutions company united around a common purpose of helping people on their path to better health. In an increasingly connected and digital world, we are meeting people wherever they are and changing health care to meet their needs. The Company has more than 9,900 retail locations, nearly 1,200 walk-in medical clinics, a leading pharmacy benefits manager with approximately 110 million plan members with expanding specialty pharmacy solutions and a dedicated senior pharmacy care business serving more than one million patients per year. The Company also serves an estimated 35 million people through traditional, voluntary and consumer-directed health insurance products and related services, including expanding Medicare Advantage offerings and a leading standalone Medicare Part D prescription drug plan ("PDP"). The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

The Company has four reportable segments: Health Care Benefits, Pharmacy Services, Retail/LTC and Corporate/Other, which are described below.

Overview of the Health Care Benefits Segment

The Health Care Benefits segment operates as one of the nation's leading diversified health care benefits providers. The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make more informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental and behavioral health plans, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services, and health information technology products and services. The Health Care Benefits segment also provided workers' compensation administrative services through its Coventry Health Care Workers' Compensation business ("Workers' Compensation business") prior to the sale of this business on July 31, 2020. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates. The Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk for medical and dental care costs) as "ASC." In addition, effective January 2022, the Company entered the individual public health insurance exchanges ("Public Exchanges") in eight states through which it sells Insured plans directly to individual consumers.

Overview of the Pharmacy Services Segment

The Pharmacy Services segment provides a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services and mail order pharmacy. In addition, through the Pharmacy Services segment, the Company provides specialty pharmacy and infusion services, clinical services, disease management services, medical spend management and pharmacy and/or other administrative services for providers and federal 340B drug pricing program covered entities ("Covered Entities"). The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, PDPs, Medicaid managed care plans, plans offered on Public Exchanges and private health insurance exchanges, other sponsors of health benefit plans throughout the United States and Covered Entities. The Pharmacy Services segment operates retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services.

Overview of the Retail/LTC Segment

The Retail/LTC segment sells prescription drugs and a wide assortment of health and wellness products and general merchandise, provides health care services through its MinuteClinic® walk-in medical clinics, provides medical diagnostic testing, administers vaccinations for illnesses such as influenza, coronavirus disease 2019 ("COVID-19") and shingles and conducts long-term care pharmacy ("LTC") operations, which distribute prescription drugs and provide related pharmacy

consulting and other ancillary services to long-term care facilities and other care settings. As of December 31, 2021, the Retail/LTC segment operated more than 9,900 retail locations, nearly 1,200 MinuteClinic locations as well as online retail pharmacy websites, LTC pharmacies and onsite pharmacies. For the year ended December 31, 2021, the Company dispensed approximately 26.4% of the total retail pharmacy prescriptions in the United States.

Overview of the Corporate/Other Segment

The Company presents the remainder of its financial results in the Corporate/Other segment, which primarily consists of:

- Management and administrative expenses to support the Company's overall operations, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments, expenses associated with the Company's investments in its transformation and enterprise modernization programs and acquisition-related integration costs; and
- Products for which the Company no longer solicits or accepts new customers such as large case pensions and long-term care insurance products.

COVID-19

The COVID-19 pandemic and its emerging new variants continue to impact the U.S. and other countries around the world. Our strong local presence and scale in communities across the country has enabled us to continue to play an indispensable role in the national response to COVID-19, as well as provide seamless support for our customers wherever they need us: in our CVS locations, in their homes, and virtually. The COVID-19 pandemic had a significant impact on the Company's operating results for the years ended December 31, 2021 and 2020, primarily in the Company's Health Care Benefits and Retail/LTC segments.

Health Care Benefits Segment

Beginning in mid-March 2020, the health system experienced a significant reduction in utilization of medical services ("utilization") that is discretionary and the cancellation of elective medical procedures. Utilization remained below historical levels through April 2020, began to recover in May and June 2020 and reached more normal levels in the third and fourth quarters of 2020, with select geographies impacted by COVID-19 waves. In response to COVID-19, the Company provided expanded benefit coverage to its members, including cost-sharing waivers for COVID-19 related treatments, as well as assistance to members through premium credits, telehealth cost-sharing waivers and other investments. During 2020, COVID-19 also resulted in a shift in the Company's medical membership. The Company experienced declines in Commercial membership due to reductions in workforce at our existing customers, substantially offset by increases in Medicaid membership primarily as a result of the suspension of eligibility redeterminations and increased unemployment.

During the year ended December 31, 2021, overall medical costs in the first quarter were generally consistent with historical baseline levels in the aggregate, however the segment experienced increased COVID-19 testing and treatment costs and lower Medicare risk-adjusted revenue. During the second quarter, COVID-19 testing and treatment costs persisted, however at levels significantly lower than those observed during the first quarter. Beginning in the third quarter of 2021, medical costs once again increased primarily driven by the spread of emerging new variants of COVID-19, which resulted in increased testing and treatment costs throughout the remainder of the year.

Retail/LTC Segment

During March 2020, the Company experienced increased prescription volume due to the greater use of 90-day prescriptions and early refills of maintenance medications, as well as increased front store volume as consumers prepared for the COVID-19 pandemic. Beginning in the second quarter and continuing throughout the remainder of the year, the Company experienced reduced customer traffic in its retail pharmacies and MinuteClinic locations due to shelter-in-place orders as well as reduced new therapy prescriptions and decreased long-term care prescription volume as a result of the COVID-19 pandemic. In addition, the Company incurred incremental operating expenses associated with the Company's COVID-19 pandemic response efforts and waived fees associated with prescription home delivery and associated front store products. During 2020, the Company also played a key role in supporting the local communities in which it operates through the administration of diagnostic testing at its CVS Pharmacy® locations, as well as in long-term care facilities, at community-based testing sites in underserved areas and through its Return Ready℠ solution. The Company also began administering COVID-19 vaccinations in long-term care facilities during December 2020.

During the first quarter of 2021, the Company experienced reduced customer traffic in its retail pharmacies, which reflected the impact of a weak cough, cold and flu season, while it administered the highest quarterly volume of COVID-19 diagnostic tests. The Company began administering COVID-19 vaccines in its retail pharmacies during February 2021. During the second quarter, the segment generated earnings from COVID-19 vaccines and saw improved customer traffic as vaccinated customers began more actively shopping in CVS locations. During the third and fourth quarters, emerging new variants drove the continued administration of COVID-19 vaccinations (including boosters) and diagnostic testing, while the segment also generated earnings from the sale of over-the-counter ("OTC") test kits in the front store. During the year ended December 31, 2021, the Company administered more than 32 million COVID-19 tests and more than 59 million COVID-19 vaccines and sold more than 22 million OTC test kits.

The COVID-19 pandemic continues to evolve. We believe COVID-19's impact on our businesses, operating results, cash flows and/or financial condition primarily will be driven by the geographies impacted and the severity and duration of the pandemic; the pandemic's impact on the U.S. and global economies and consumer behavior and health care utilization patterns; and the timing, scope and impact of stimulus legislation as well as other federal, state and local governmental responses to the pandemic. Those primary drivers are beyond our knowledge and control. As a result, the impact COVID-19 will have on our businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be adverse and material.

Results of Operations

The following information summarizes the Company's results of operations for 2021 compared to 2020. For discussion of the Company's results of operations for 2020 compared to 2019, see "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2020 filed with the U.S. Securities and Exchange Commission (the "SEC") on February 16, 2021.

Summary of Consolidated Financial Results

				Change			
	Year Ended December 31,			2021 vs. 2020		2020 vs. 2019	
In millions	**2021**	**2020**	**2019**	**$**	**%**	**$**	**%**
Revenues:							
Products	$ 203,738	$ 190,688	$ 185,236	$ 13,050	6.8 %	$ 5,452	2.9 %
Premiums	76,132	69,364	63,122	6,768	9.8 %	6,242	9.9 %
Services	11,042	7,856	7,407	3,186	40.6 %	449	6.1 %
Net investment income	1,199	798	1,011	401	50.3 %	(213)	(21.1)%
Total revenues	292,111	268,706	256,776	23,405	8.7 %	11,930	4.6 %
Operating costs:							
Cost of products sold	175,803	163,981	158,719	11,822	7.2 %	5,262	3.3 %
Benefit costs	64,260	55,679	52,529	8,581	15.4 %	3,150	6.0 %
Store impairments	1,358	—	231	1,358	100.0 %	(231)	(100.0)%
Goodwill impairment	431	—	—	431	100.0 %	—	— %
Operating expenses	37,066	35,135	33,310	1,931	5.5 %	1,825	5.5 %
Total operating costs	278,918	254,795	244,789	24,123	9.5 %	10,006	4.1 %
Operating income	13,193	13,911	11,987	(718)	(5.2)%	1,924	16.1 %
Interest expense	2,503	2,907	3,035	(404)	(13.9)%	(128)	(4.2)%
Loss on early extinguishment of debt	452	1,440	79	(988)	(68.6)%	1,361	1,722.8 %
Other income	(182)	(206)	(124)	24	11.7 %	(82)	(66.1)%
Income before income tax provision	10,420	9,770	8,997	650	6.7 %	773	8.6 %
Income tax provision	2,522	2,569	2,366	(47)	(1.8)%	203	8.6 %
Income from continuing operations	7,898	7,201	6,631	697	9.7 %	570	8.6 %
Loss from discontinued operations, net of tax	—	(9)	—	9	100.0 %	(9)	(100.0)%
Net income	7,898	7,192	6,631	706	9.8 %	561	8.5 %
Net (income) loss attributable to noncontrolling interests	12	(13)	3	25	192.3 %	(16)	(533.3)%
Net income attributable to CVS Health	$ 7,910	$ 7,179	$ 6,634	$ 731	10.2 %	$ 545	8.2 %

Commentary - 2021 compared to 2020

Revenues

- Total revenues increased $23.4 billion or 8.7% in 2021 compared to 2020. The increase in total revenues was primarily driven by growth across all segments.
- Please see "Segment Analysis" later in this MD&A for additional information about the revenues of the Company's segments.

Operating expenses

- Operating expenses increased $1.9 billion or 5.5% in 2021 compared to 2020. The increase in operating expenses was primarily due to incremental costs associated with growth in the business, including costs associated with the administration of COVID-19 vaccinations and diagnostic testing in the Retail/LTC segment. The increase in operating expenses was partially offset by the repeal of the non-deductible health insurer fee ("HIF") for 2021 and gains from anti-trust legal settlements of $263 million recorded in 2021.

- Operating expenses as a percentage of total revenues decreased to 12.7% in 2021 compared to 13.1% in 2020. The decrease in operating expenses as a percentage of total revenues was primarily due to the increases in total revenues referred to above.
- Please see “Segment Analysis” later in this MD&A for additional information about the operating expenses of the Company’s segments.

Operating income
- Operating income decreased $718 million or 5.2% in 2021 compared to 2020. The decrease in operating income was primarily due to:
    - A store impairment charge of approximately $1.4 billion recorded in the fourth quarter of 2021 related to planned retail store closures over the next three years;
    - Decreased operating income in the Health Care Benefits segment, driven by higher COVID-19 related costs in 2021 compared to the prior year, including the impact of the deferral of elective procedures and other discretionary utilization in response to the COVID-19 pandemic during 2020, as well as the absence of pre-tax income of $307 million associated with the receipt of amounts owed to the Company under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the “ACA”) risk corridor program (“ACA risk corridor receipt”); and
    - A $431 million goodwill impairment charge associated with the LTC business in the Retail/LTC segment recorded during the third quarter of 2021, partially offset by:
    - Increased prescription and front store volume and the administration of COVID-19 vaccinations and diagnostic testing in the Retail/LTC segment;
    - Improved purchasing economics and growth in specialty pharmacy in the Pharmacy Services segment;
    - Gains from anti-trust legal settlements of $263 million recorded in 2021; and
    - Lower acquisition-related integration costs in 2021 compared to the prior year.
- Please see “Segment Analysis” later in this MD&A for additional information about the operating income of the Company’s segments.

Interest expense
- Interest expense decreased $404 million in 2021 compared to 2020, due to lower debt in the year ended December 31, 2021. See “Liquidity and Capital Resources” later in this report for additional information.

Loss on early extinguishment of debt
- During 2021, the loss on early extinguishment of debt relates to the Company’s repayment of approximately $2.3 billion of its outstanding senior notes in December 2021 pursuant to its early redemption make-whole provision for such senior notes, which resulted in a loss on early extinguishment of debt of $89 million, and the repayment of approximately $2.0 billion of its outstanding senior notes pursuant to its tender offer for such notes in August 2021, which resulted in a loss on early extinguishment of debt of $363 million. During 2020, the loss on early extinguishment of debt relates to the Company’s repayment of $6.0 billion of its outstanding senior notes pursuant to its tender offers for such senior notes in August 2020, which resulted in a loss on early extinguishment of debt of $766 million, and the repayment of $4.5 billion of its outstanding senior notes pursuant to its tender offers for such senior notes in December 2020, which resulted in a loss on early extinguishment of debt of $674 million. See Note 8 ‘‘Borrowings and Credit Agreements’’ included in Item 8 of this 10-K for additional information.

Income tax provision
- The Company’s effective income tax rate decreased to 24.2% in 2021 compared to 26.3% in the prior year primarily due to the repeal of the non-deductible HIF for 2021 and the favorable impact of a prior year refund claim approved by the Internal Revenue Service during the fourth quarter of 2021. The decrease was partially offset by the absence of the favorable resolution of certain tax matters in the fourth quarter of 2020.

Loss from discontinued operations
- In connection with certain business dispositions completed between 1995 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Linens ‘n Things and Bob’s Stores, each of which subsequently filed for bankruptcy. The Company’s loss from discontinued operations in 2020 primarily included lease-related costs required to satisfy these lease guarantees.

- See “Discontinued Operations” in Note 1 ‘‘Significant Accounting Policies’’ and “Lease Guarantees” in Note 16 ‘‘Commitments and Contingencies’’ included in Item 8 of this 10-K for additional information about the Company’s discontinued operations and the Company’s lease guarantees, respectively.

Outlook for 2022

With respect to 2022, the Company believes you should consider the following important information:

- The Health Care Benefits segment is expected to benefit from Medicare and Commercial membership growth, partially offset by membership declines in its Medicaid products. The projected MBR is expected to decrease compared to 2021, reflecting a combination of expected improved pricing and a reduction in COVID-19 related medical costs. While the Company still expects a net negative impact from COVID-19 in 2022 within the Health Care Benefits segment, the expectation is the impact will be less adverse than what was experienced in 2021.
- The Pharmacy Services segment is expected to benefit from the Company's ability to drive further improvements in purchasing economics and continued growth in specialty pharmacy, partially offset by continued price compression and state regulation of pharmacy pricing.
- The Retail/LTC segment is expected to continue to benefit from increased prescription volume and improved generic drug purchasing, partially offset by continued pharmacy reimbursement pressure and incremental operating expenses associated with the Company's minimum wage investment. The Company expects that COVID-19 vaccinations and diagnostic testing will continue in 2022, albeit at lower levels than those experienced during 2021. The Company expects to see continued strength in Front Store sales, including sales of OTC test kits, in 2022. The extent of COVID-19 vaccinations, diagnostic testing and OTC test kit sales will be dependent upon various factors including vaccine hesitancy, the emergence of new variants, government testing initiatives and the availability and administration of pediatric and booster vaccinations.
- The Company is expected to benefit from the continuation of its enterprise-wide cost savings initiatives, which aim to reduce the Company's operating cost structure in a way that improves the consumer experience and is sustainable. Key drivers include:
    - Investments in digital, technology and analytics capabilities that will streamline processes and improve outcomes,
    - Implementing workforce and workplace strategies, and
    - Deploying vendor and procurement strategies.
- The Company expects changes to its business environment to continue as elected and other government officials at the national and state levels continue to propose and enact significant modifications to public policy and existing laws and regulations that govern or impact the Company's businesses.
- The COVID-19 pandemic continues to impact the economies of the U.S. and other countries around the world. The Company believes COVID-19's impact on its businesses, operating results, cash flows and/or financial condition primarily will be driven by the geographies impacted and the severity and duration of the pandemic, as well as the pandemic's impact on the U.S. and global economies, global supply chain, consumer behavior, and health care utilization patterns. In addition, as described in the "Government Regulation" section of this Form 10-K, federal, state and local governmental policies and initiatives designed to reduce the transmission of COVID-19 and emerging new variants may not effectively combat the severity and/or duration of the COVID-19 pandemic, and have resulted in a myriad of impacts on the Company's businesses. Those primary drivers are beyond the Company's knowledge and control. As a result, the impact COVID-19 will have on the Company's businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be adverse and material.

The Company's current expectations described above are forward-looking statements. Please see "Risk Factors" included in Item 1A of this 10-K and the "Cautionary Statement Concerning Forward-Looking Statements" in this 10-K for information regarding important factors that may cause the Company's actual results to differ from those currently projected and/or otherwise materially affect the Company.

Segment Analysis

The following discussion of segment operating results is presented based on the Company's reportable segments in accordance with the accounting guidance for segment reporting and is consistent with the segment disclosure in Note 17 ''Segment Reporting'' included in Item 8 of this 10-K.

The Company has three operating segments, Health Care Benefits, Pharmacy Services and Retail/LTC, as well as a Corporate/Other segment. The Company's segments maintain separate financial information, and the Company's chief operating decision maker (the "CODM") evaluates the segments' operating results on a regular basis in deciding how to allocate resources among the segments and in assessing segment performance. The CODM evaluates the performance of the Company's segments based on adjusted operating income, which is defined as operating income (GAAP measure) excluding the impact of amortization of intangible assets and other items, if any, that neither relate to the ordinary course of the Company's business nor reflect the Company's underlying business performance. See the reconciliations of operating income (GAAP measure) to adjusted operating income below for further context regarding the items excluded from operating income in determining adjusted operating income. The Company uses adjusted operating income as its principal measure of segment performance as it enhances the Company's ability to compare past financial performance with current performance and analyze underlying business performance and trends. Non-GAAP financial measures the Company discloses, such as consolidated adjusted operating income, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

The following is a reconciliation of financial measures of the Company's segments to the consolidated totals:

In millions	Health Care Benefits	Pharmacy Services [1]	Retail/ LTC	Corporate/ Other	Intersegment Eliminations [2]	Consolidated Totals
2021						
Total revenues	$ 82,186	$ 153,022	$ 100,105	$ 721	$ (43,923)	$ 292,111
Adjusted operating income (loss)	5,012	6,859	7,623	(1,471)	(711)	17,312
2020						
Total revenues	75,467	141,938	91,198	426	(40,323)	268,706
Adjusted operating income (loss)	6,188	5,688	6,146	(1,306)	(708)	16,008
2019						
Total revenues	69,604	141,491	86,608	512	(41,439)	256,776
Adjusted operating income (loss)	5,202	5,129	6,705	(1,000)	(697)	15,339

(1) Total revenues of the Pharmacy Services segment include approximately $11.6 billion, $10.9 billion and $11.5 billion of retail co-payments for 2021, 2020 and 2019, respectively. See Note 1 ''Significant Accounting Policies'' included in Item 8 of this 10-K for additional information about retail co-payments.

(2) Intersegment revenue eliminations relate to intersegment revenue generating activities that occur between the Health Care Benefits segment, the Pharmacy Services segment, and/or the Retail/LTC segment. Intersegment adjusted operating income eliminations occur when members of Pharmacy Services Segment clients ("PSS members") enrolled in Maintenance Choice® elect to pick up maintenance prescriptions at one of the Company's retail pharmacies instead of receiving them through the mail. When this occurs, both the Pharmacy Services and Retail/LTC segments record the adjusted operating income on a stand-alone basis.

The following are reconciliations of consolidated operating income (GAAP measure) to consolidated adjusted operating income, as well as reconciliations of segment GAAP operating income to segment adjusted operating income:

	Year Ended December 31, 2021					
In millions	**Health Care Benefits**	**Pharmacy Services**	**Retail/ LTC**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
Operating income (loss) (GAAP measure)	$ 3,521	$ 6,667	$ 5,322	$ (1,606)	$ (711)	$ 13,193
Amortization of intangible assets [1]	1,552	192	512	3	—	2,259
Acquisition-related integration costs [2]	—	—	—	132	—	132
Store impairments [3]	—	—	1,358	—	—	1,358
Goodwill impairment [4]	—	—	431	—	—	431
Acquisition purchase price adjustment outside of measurement period [5]	(61)	—	—	—	—	(61)
Adjusted operating income (loss)	$ 5,012	$ 6,859	$ 7,623	$ (1,471)	$ (711)	$ 17,312

	Year Ended December 31, 2020					
In millions	**Health Care Benefits**	**Pharmacy Services**	**Retail/ LTC**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
Operating income (loss) (GAAP measure)	$ 5,166	$ 5,454	$ 5,640	$ (1,641)	$ (708)	$ 13,911
Amortization of intangible assets [1]	1,598	234	506	3	—	2,341
Acquisition-related integration costs [2]	—	—	—	332	—	332
Gain on divestiture of subsidiary [6]	(269)	—	—	—	—	(269)
Receipt of fully reserved ACA risk corridor receivable [7]	(307)	—	—	—	—	(307)
Adjusted operating income (loss)	$ 6,188	$ 5,688	$ 6,146	$ (1,306)	$ (708)	$ 16,008

	Year Ended December 31, 2019					
In millions	**Health Care Benefits**	**Pharmacy Services**	**Retail/ LTC**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
Operating income (loss) (GAAP measure)	$ 3,639	$ 4,735	$ 5,793	$ (1,483)	$ (697)	$ 11,987
Amortization of intangible assets [1]	1,563	394	476	3	—	2,436
Acquisition-related integration costs [2]	—	—	—	480	—	480
Store impairments [3]	—	—	231	—	—	231
Loss on divestiture of subsidiary [6]	—	—	205	—	—	205
Adjusted operating income (loss)	$ 5,202	$ 5,129	$ 6,705	$ (1,000)	$ (697)	$ 15,339

(1) The Company's acquisition activities have resulted in the recognition of intangible assets as required under the acquisition method of accounting which consist primarily of trademarks, customer contracts/relationships, covenants not to compete, technology, provider networks and value of business acquired. Definite-lived intangible assets are amortized over their estimated useful lives and are tested for impairment when events indicate that the carrying value may not be recoverable. The amortization of intangible assets is reflected in the Company's GAAP consolidated statements of operations in operating expenses within each segment. Although intangible assets contribute to the Company's revenue generation, the amortization of intangible assets does not directly relate to the underwriting of the Company's insurance products, the services performed for the Company's customers or the sale of the Company's products or services. Additionally, intangible asset amortization expense typically fluctuates based on the size and timing of the Company's acquisition activity. Accordingly, the Company believes excluding the amortization of intangible assets enhances the Company's and investors' ability to compare the Company's past financial performance with its current performance and to analyze underlying business performance and trends. Intangible asset amortization excluded from the related non-GAAP financial measure represents the entire amount recorded within the Company's GAAP financial statements, and the revenue generated by the associated intangible assets has not been excluded from the related non-GAAP financial measure. Intangible asset amortization is excluded from the related non-GAAP financial measure because the amortization, unlike the related revenue, is not affected by operations of any particular period unless an intangible asset becomes impaired or the estimated useful life of an intangible asset is revised.

(2) In 2021, 2020 and 2019, acquisition-related integration costs relate to the Company's acquisition ("Aetna Acquisition") of Aetna Inc. ("Aetna"). The acquisition-related integration costs are reflected in the Company's GAAP consolidated statements of operations in operating expenses within the Corporate/Other segment.

(3) During the year ended December 31, 2021, the store impairment charge relates to the write down of operating lease right-of-use assets and property and equipment in connection with the planned closure of approximately 900 retail stores between 2022 and 2024. During the year ended December 31, 2019, the store impairment charges related to the write down of operating lease right-of-use assets in connection with the planned closure of 68 underperforming retail pharmacy stores in 2019 and 2020. The store impairment charges are reflected in the Company's GAAP consolidated statements of operations within the Retail/LTC segment.

(4) During the year ended December 31, 2021, the goodwill impairment charge relates to the LTC reporting unit within the Retail/LTC segment.
(5) In June 2021, the Company received $61 million related to a purchase price working capital adjustment for an acquisition completed during the first quarter of 2020. The resolution of this matter occurred subsequent to the acquisition accounting measurement period and is reflected in the Company's GAAP consolidated statement of operations for the year ended December 31, 2021 as a reduction of operating expenses within the Health Care Benefits segment.
(6) In 2020, the gain on divestiture of subsidiary represents the pre-tax gain on the sale of the Workers' Compensation business, which the Company sold on July 31, 2020 for approximately $850 million. The gain on divestiture is reflected as a reduction of operating expenses in the Company's GAAP consolidated statement of operations within the Health Care Benefits segment. In 2019, the loss on divestiture of subsidiary represents the pre-tax loss on the sale of Onofre, which occurred on July 1, 2019. The loss on divestiture primarily relates to the elimination of the cumulative translation adjustment from accumulated other comprehensive income and is reflected in the Company's GAAP consolidated statement of operations in operating expenses within the Retail/LTC segment.
(7) In 2020, the Company received $313 million owed to it under the ACA's risk corridor program that was previously fully reserved for as payment was uncertain. After considering offsetting items such as the ACA's minimum medical loss ratio ("MLR") rebate requirements and premium taxes, the Company recognized pre-tax income of $307 million in the Company's GAAP consolidated statement of operations within the Health Care Benefits segment.

Health Care Benefits Segment

The following table summarizes the Health Care Benefits segment's performance for the respective periods:

	Year Ended December 31,			Change			
				2021 vs. 2020		2020 vs. 2019	
In millions, except percentages and basis points ("bps")	**2021**	**2020**	**2019**	**$**	**%**	**$**	**%**
Revenues:							
Premiums	$ 76,064	$ 69,301	$ 63,031	$ 6,763	9.8 %	$ 6,270	9.9 %
Services	5,536	5,683	5,974	(147)	(2.6)%	(291)	(4.9)%
Net investment income	586	483	599	103	21.3 %	(116)	(19.4)%
Total revenues	82,186	75,467	69,604	6,719	8.9 %	5,863	8.4 %
Benefit costs	64,662	56,083	53,092	8,579	15.3 %	2,991	5.6 %
MBR (Benefit costs as a % of premium revenues)	85.0 %	80.9 %	84.2%	410 bps		(330) bps	
Operating expenses	$ 14,003	$ 14,218	$ 12,873	$ (215)	(1.5)%	$ 1,345	10.4 %
Operating expenses as a % of total revenues	17.0 %	18.8 %	18.5 %				
Operating income	$ 3,521	$ 5,166	$ 3,639	$ (1,645)	(31.8)%	$ 1,527	42.0 %
Operating income as a % of total revenues	4.3 %	6.8 %	5.2 %				
Adjusted operating income [1]	$ 5,012	$ 6,188	$ 5,202	$ (1,176)	(19.0)%	$ 986	19.0 %
Adjusted operating income as a % of total revenues	6.1 %	8.2 %	7.5 %				
Premium revenues (by business):							
Government	$ 55,739	$ 48,928	$ 41,818	$ 6,811	13.9 %	$ 7,110	17.0 %
Commercial	20,325	20,373	21,213	(48)	(0.2)%	(840)	(4.0)%

(1) See "Segment Analysis" above in this MD&A for a reconciliation of operating income (GAAP measure) to adjusted operating income for the Health Care Benefits segment, which represents the Company's principal measure of segment performance.

Commentary - 2021 compared to 2020

Revenues

- Total revenues increased $6.7 billion, or 8.9%, to $82.2 billion in 2021 compared to 2020 primarily driven by growth in the Government Services business, partially offset by the unfavorable impact of the repeal of the HIF for 2021 and the absence of the ACA risk corridor receipt.

Medical Benefit Ratio ("MBR")

- Medical benefit ratio is calculated as benefit costs divided by premium revenues and represents the percentage of premium revenues spent on medical benefits for the Company's Insured members. Management uses MBR to assess the underlying business performance and underwriting of its insurance products, understand variances between actual results and expected results and identify trends in period-over-period results. MBR provides management and investors with information useful in assessing the operating results of the Company's Insured Health Care Benefits products.
- The MBR increased from 80.9% to 85.0% in 2021 compared to the prior year. The increase was primarily driven by higher COVID-19 related costs in 2021 compared to the prior year, including the impact of the deferral of elective procedures and other discretionary utilization in response to the COVID-19 pandemic during 2020 and the repeal of the HIF for 2021, partially offset by improved underlying performance in the current year.

Operating expenses

- Operating expenses in the Health Care Benefits segment include selling, general and administrative expenses and depreciation and amortization expenses.
- Operating expenses decreased $215 million, or 1.5%, in 2021 compared to 2020. The decrease in operating expenses was primarily due to the repeal of the HIF for 2021, partially offset by incremental operating expenses to support the growth in the Government Services business described above and the net impact of the sale of the Workers' Compensation business sold on July 31, 2020.

Adjusted operating income

- Adjusted operating income decreased $1.2 billion, or 19.0%, in 2021 compared to 2020. The decrease in adjusted operating income was primarily driven by higher COVID-19 related costs in 2021 compared to the prior year, including the impact of the deferral of elective procedures and other discretionary utilization in response to the COVID-19 pandemic during 2020. The decrease was partially offset by improved performance in the underlying Government Services business and higher favorable development of prior-years' health care cost estimates in 2021 compared to the prior year.

The following table summarizes the Health Care Benefits segment's medical membership as of December 31, 2021 and 2020:

	2021			2020		
In thousands	**Insured**	**ASC**	**Total**	**Insured**	**ASC**	**Total**
Medical membership:						
Commercial	3,258	13,530	16,788	3,258	13,644	16,902
Medicare Advantage	2,971	—	2,971	2,705	—	2,705
Medicare Supplement	1,285	—	1,285	1,082	—	1,082
Medicaid	2,333	471	2,804	2,100	623	2,723
Total medical membership	9,847	14,001	23,848	9,145	14,267	23,412
Supplemental membership information:						
Medicare Prescription Drug Plan (standalone)			5,777			5,490

Medical Membership

- Medical membership represents the number of members covered by the Company's Insured and ASC medical products and related services at a specified point in time. Management uses this metric to understand variances between actual medical membership and expected amounts as well as trends in period-over-period results. This metric provides management and investors with information useful in understanding the impact of medical membership on segment total revenues and operating results.
- Medical membership as of December 31, 2021 of 23.8 million increased 436,000 compared with December 31, 2020, primarily reflecting increases in Medicare and Medicaid products, partially offset by declines in Commercial self-insured membership.

Medicare Update

On January 15, 2021, the U.S. Centers for Medicare & Medicaid Services ("CMS") issued its final notice detailing final 2022 Medicare Advantage benchmark payment rates. Final 2022 Medicare Advantage rates resulted in an increase in industry benchmark rates of approximately 4.1%.

The ACA ties a portion of each Medicare Advantage plan's reimbursement to the plan's "star ratings." Plans must have a star rating of four or higher (out of five) to qualify for bonus payments. CMS released the Company's 2022 star ratings in October 2021. The Company's 2022 star ratings will be used to determine which of the Company's Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2023. Based on the Company's membership at December 31, 2021, 87% of the Company's Medicare Advantage members were in plans with 2022 star ratings of at least 4.0 stars, compared to 83% of the Company's Medicare Advantage members being in plans with 2021 star ratings of at least 4.0 stars based on the Company's membership at December 31, 2020.

Pharmacy Services Segment

The following table summarizes the Pharmacy Services segment's performance for the respective periods:

	Year Ended December 31,			Change			
				2021 vs. 2020		2020 vs. 2019	
In millions, except percentages	**2021**	**2020**	**2019**	**$**	**%**	**$**	**%**
Revenues:							
Products	$ 151,851	$ 140,950	$ 140,946	$ 10,901	7.7 %	$ 4	— %
Services	1,171	988	545	183	18.5 %	443	81.3 %
Total revenues	153,022	141,938	141,491	11,084	7.8 %	447	0.3 %
Cost of products sold	144,894	135,045	135,245	9,849	7.3 %	(200)	(0.1)%
Operating expenses	1,461	1,439	1,511	22	1.5 %	(72)	(4.8)%
Operating expenses as a % of total revenues	1.0 %	1.0 %	1.1 %				
Operating income	$ 6,667	$ 5,454	$ 4,735	$ 1,213	22.2 %	$ 719	15.2 %
Operating income as a % of total revenues	4.4 %	3.8 %	3.3 %				
Adjusted operating income [1]	$ 6,859	$ 5,688	$ 5,129	$ 1,171	20.6 %	$ 559	10.9 %
Adjusted operating income as a % of total revenues	4.5 %	4.0 %	3.6 %				
Revenues (by distribution channel):							
Pharmacy network [2]	$ 91,715	$ 85,045	$ 88,755	$ 6,670	7.8 %	$ (3,710)	(4.2)%
Mail choice [3]	60,547	56,071	52,141	4,476	8.0 %	3,930	7.5 %
Other	760	822	595	(62)	(7.5)%	227	38.2 %
Pharmacy claims processed: [4]							
Total	2,244.7	2,112.9	2,014.2	131.8	6.2 %	98.7	4.9 %
Pharmacy network [2]	1,914.0	1,790.1	1,704.0	123.9	6.9 %	86.1	5.1 %
Mail choice [3]	330.7	322.8	310.2	7.9	2.4 %	12.6	4.1 %
Generic dispensing rate: [4]							
Total	86.8 %	88.2 %	88.2 %				
Pharmacy network [2]	87.0 %	88.7 %	88.7 %				
Mail choice [3]	85.6 %	85.3 %	85.1 %				

(1) See "Segment Analysis" above in this MD&A for a reconciliation of operating income (GAAP measure) to adjusted operating income for the Pharmacy Services segment, which represents the Company's principal measure of segment performance.

(2) Pharmacy network is defined as claims filled at retail and specialty retail pharmacies, including the Company's retail pharmacies and LTC pharmacies, but excluding Maintenance Choice® activity, which is included within the mail choice category. Maintenance Choice permits eligible client plan members to fill their maintenance prescriptions through mail order delivery or at a CVS Pharmacy retail store for the same price as mail order.

(3) Mail choice is defined as claims filled at a Pharmacy Services mail order facility, which includes specialty mail claims inclusive of Specialty Connect® claims picked up at a retail pharmacy, as well as prescriptions filled at the Company's retail pharmacies under the Maintenance Choice program.

(4) Includes an adjustment to convert 90-day prescriptions to the equivalent of three 30-day prescriptions. This adjustment reflects the fact that these prescriptions include approximately three times the amount of product days supplied compared to a normal prescription.

Commentary - 2021 compared to 2020

Revenues

- Total revenues increased $11.1 billion, or 7.8%, to $153.0 billion in 2021 compared to 2020. The increase was primarily driven by increased pharmacy claims volume, growth in specialty pharmacy and brand inflation, partially offset by continued price compression.

Operating expenses

- Operating expenses in the Pharmacy Services segment include selling, general and administrative expenses; depreciation and amortization expense; and expenses related to specialty retail pharmacies, which include store and administrative payroll, employee benefits and occupancy costs.
- Operating expenses as a percentage of total revenues remained consistent at 1.0% in both 2021 and 2020.

Adjusted operating income

- Adjusted operating income increased $1.2 billion, or 20.6%, in 2021 compared to 2020. The increase in adjusted operating income was primarily driven by improved purchasing economics which reflected increased contributions from the products and services of the Company's group purchasing organization and specialty pharmacy (including pharmacy and/or administrative services for providers and Covered Entities). These increases were partially offset by continued price compression.
- As you review the Pharmacy Services segment's performance in this area, you should consider the following important information about the business:
    - The Company's efforts to (i) retain existing clients, (ii) obtain new business and (iii) maintain or improve the rebates, fees and/or discounts the Company receives from manufacturers, wholesalers and retail pharmacies continue to have an impact on adjusted operating income. In particular, competitive pressures in the PBM industry have caused the Company and other PBMs to continue to share with clients a larger portion of rebates, fees and/or discounts received from pharmaceutical manufacturers. In addition, marketplace dynamics and regulatory changes have limited the Company's ability to offer plan sponsors pricing that includes retail network "differential" or "spread," and the Company expects these trends to continue. The "differential" or "spread" is any difference between the drug price charged to plan sponsors, including Medicare Part D plan sponsors, by a PBM and the price paid for the drug by the PBM to the dispensing provider.

Pharmacy claims processed

- Total pharmacy claims processed represents the number of prescription claims processed through our pharmacy benefits manager and dispensed by either our retail network pharmacies or our own mail and specialty pharmacies. Management uses this metric to understand variances between actual claims processed and expected amounts as well as trends in period-over-period results. This metric provides management and investors with information useful in understanding the impact of pharmacy claim volume on segment total revenues and operating results.
- The Company's pharmacy network claims processed on a 30-day equivalent basis increased 6.9% to 1.9 billion claims in 2021 compared to 1.8 billion claims in 2020. The increase in pharmacy network claims processed was primarily driven by net new business and COVID-19 vaccinations, as well as increased new therapy prescriptions, which were adversely impacted by the COVID-19 pandemic during 2020.
- The Company's mail choice claims processed on a 30-day equivalent basis increased 2.4% to 330.7 million claims in 2021 compared to 322.8 million claims in 2020. The increase in mail choice claims was primarily driven by net new business and the continued adoption of Maintenance Choice offerings.
- Excluding the impact of COVID-19 vaccinations, total pharmacy claims processed increased 4.2%, on a 30-day equivalent basis, in 2021 compared to the prior year.

Generic dispensing rate

- Generic dispensing rate is calculated by dividing the Pharmacy Services segment's generic drug prescriptions processed or filled by its total prescriptions processed or filled. Management uses this metric to evaluate the effectiveness of the business at encouraging the use of generic drugs when they are available and clinically appropriate, which aids in decreasing costs for client members and retail customers. This metric provides management and investors with information useful in understanding trends in segment total revenues and operating results.
- The Pharmacy Services segment's total generic dispensing rate decreased to 86.8% in 2021 compared to 88.2% in the prior year. The decrease in the segment's generic dispensing rate was primarily driven by an increase in brand prescriptions, largely attributable to COVID-19 vaccinations in 2021. Excluding the impact of COVID-19 vaccinations, the segment's total generic dispensing rate increased to 88.5% in 2021.

Retail/LTC Segment

The following table summarizes the Retail/LTC segment's performance for the respective periods:

	Year Ended December 31,			Change			
				2021 vs. 2020		2020 vs. 2019	
In millions, except percentages	**2021**	**2020**	**2019**	**$**	**%**	**$**	**%**
Revenues:							
Products	$ 95,652	$ 89,944	$ 85,729	$ 5,708	6.3 %	$ 4,215	4.9 %
Services	4,436	1,254	879	3,182	253.7 %	375	42.7 %
Net investment income	17	—	—	17	100.0 %	—	— %
Total revenues	100,105	91,198	86,608	8,907	9.8 %	4,590	5.3 %
Cost of products sold	72,832	67,284	62,688	5,548	8.2 %	4,596	7.3 %
Store impairments	1,358	—	231	1,358	100.0 %	(231)	(100.0)%
Goodwill impairment	431	—	—	431	100.0 %	—	— %
Operating expenses	20,162	18,274	17,896	1,888	10.3 %	378	2.1 %
Operating expenses as a % of total revenues	20.1 %	20.0 %	20.7 %				
Operating income	$ 5,322	$ 5,640	$ 5,793	$ (318)	(5.6)%	$ (153)	(2.6)%
Operating income as a % of total revenues	5.3 %	6.2 %	6.7 %				
Adjusted operating income [1]	$ 7,623	$ 6,146	$ 6,705	$ 1,477	24.0 %	$ (559)	(8.3)%
Adjusted operating income as a % of total revenues	7.6 %	6.7 %	7.7 %				
Revenues (by major goods/service lines):							
Pharmacy	$ 76,121	$ 70,176	$ 66,442	$ 5,945	8.5 %	$ 3,734	5.6 %
Front Store	21,315	19,655	19,422	1,660	8.4 %	233	1.2 %
Other	2,652	1,367	744	1,285	94.0 %	623	83.7 %
Net investment income	17	—	—	17	100.0 %	—	— %
Prescriptions filled [2]	1,587.6	1,465.2	1,417.2	122.4	8.4 %	48.0	3.4 %
Same store sales increase: [3]							
Total	8.9 %	5.6 %	3.7 %				
Pharmacy	9.3 %	7.0 %	4.5 %				
Front Store	7.6 %	0.9 %	1.1 %				
Prescription volume [2]	9.3 %	4.7 %	7.2 %				
Generic dispensing rate [2]	85.7 %	88.3 %	88.3 %				

(1) See "Segment Analysis" above in this MD&A for a reconciliation of operating income (GAAP measure) to adjusted operating income for the Retail/LTC segment, which represents the Company's principal measure of segment performance.

(2) Includes an adjustment to convert 90-day prescriptions to the equivalent of three 30-day prescriptions. This adjustment reflects the fact that these prescriptions include approximately three times the amount of product days supplied compared to a normal prescription.

(3) Same store sales and prescription volume represent the change in revenues and prescriptions filled in the Company's retail pharmacy stores that have been operating for greater than one year, expressed as a percentage that indicates the increase or decrease relative to the comparable prior period. Same store metrics exclude revenues from MinuteClinic, revenues and prescriptions from LTC operations and, in 2019, revenues and prescriptions from stores in Brazil. Management uses these metrics to evaluate the performance of existing stores on a comparable basis and to inform future decisions regarding existing stores and new locations. Same-store metrics provide management and investors with information useful in understanding the portion of current revenues and prescriptions resulting from organic growth in existing locations versus the portion resulting from opening new stores.

Commentary - 2021 compared to 2020

Revenues

- Total revenues increased $8.9 billion, or 9.8%, to $100.1 billion in 2021 compared to 2020. The increase was primarily driven by increased prescription and front store volume, the administration of COVID-19 vaccinations and diagnostic testing, as well as brand inflation. These increases were partially offset by continued pharmacy reimbursement pressure and the impact of recent generic introductions. COVID-19 vaccinations, diagnostic testing and OTC test kit sales contributed approximately 45% of the increase in the segment's revenues in 2021 compared to the prior year. The prior year reflected

the ongoing expansion of the Company's diagnostic testing program which began in April 2020, an immaterial impact from COVID-19 vaccinations which began in December 2020 and no OTC test kit sales.

- Pharmacy same store sales increased 9.3% in 2021 compared to 2020. The increase was driven by the 9.3% increase in pharmacy same store prescription volume on a 30-day equivalent basis and brand inflation. These increases were partially offset by continued pharmacy reimbursement pressure and the impact of recent generic introductions.
- Front store same store sales increased 7.6% in 2021 compared to 2020. The increase was primarily due to strength in consumer health, including the sale of OTC test kits, as well as increased beauty and personal care sales in 2021.
- Other revenues increased 94.0% in 2021 compared to 2020. The increase was primarily due to increased COVID-19 diagnostic testing in 2021.

Store impairments

- During 2021, the Company recorded a store impairment charge of approximately $1.4 billion related to the write-down of operating lease right-of-use assets and property and equipment in connection with the planned closure of approximately 900 retail stores between 2022 and 2024. See Note 6 ''Leases'' included in Item 8 of this 10-K for additional information.

Goodwill impairment

- During 2021, the Company recorded a $431 million goodwill impairment charge related to the LTC reporting unit within the Retail/LTC segment. See Note 5 ''Goodwill and Other Intangibles'' included in Item 8 of this 10-K for additional information.

Operating expenses

- Operating expenses in the Retail/LTC segment include store payroll, store employee benefits, store occupancy costs, selling expenses, advertising expenses, depreciation and amortization expense and certain administrative expenses.
- Operating expenses increased $1.9 billion, or 10.3%, in 2021 compared to 2020. The increase was primarily due to incremental costs associated with increased volume including COVID-19 vaccinations and diagnostic testing, as well as increased investments in the segment's capabilities and colleague compensation and benefits. These increases were partially offset by gains from anti-trust legal settlements of $231 million recorded in 2021, the absence of incremental expenses associated with the Company's initial COVID-19 pandemic mitigation efforts incurred in 2020 and the impact of cost savings initiatives in 2021.
- Operating expenses as a percentage of total revenues remained relatively consistent at 20.1% and 20.0% in 2021 and 2020, respectively.

Adjusted operating income

- Adjusted operating income increased $1.5 billion, or 24.0%, in 2021 compared to 2020. The increase in adjusted operating income was primarily driven by the administration of COVID-19 vaccinations and diagnostic testing, the increased prescription and front store volume described above, improved generic drug purchasing and gains from anti-trust legal settlements of $231 million recorded in 2021. These increases were partially offset by continued pharmacy reimbursement pressure and increased investments in the segment's capabilities and colleague compensation and benefits.
- As you review the Retail/LTC segment's performance in this area, you should consider the following important information about the business:
    - The segment's adjusted operating income benefited from the administration of COVID-19 vaccinations, diagnostic testing and OTC test kit sales which contributed approximately 30% of the segment's adjusted operating income in 2021.
    - The segment's adjusted operating income has been adversely affected by the efforts of managed care organizations, PBMs and governmental and other third-party payors to reduce their prescription drug costs, including the use of restrictive networks, as well as changes in the mix of business within the pharmacy portion of the Retail/LTC segment. If the pharmacy reimbursement pressure accelerates, the segment may not be able to grow revenues, and its adjusted operating income could be adversely affected.
    - The increased use of generic drugs has positively impacted the segment's adjusted operating income but has resulted in third-party payors augmenting their efforts to reduce reimbursement payments to retail pharmacies for prescriptions. This trend, which the Company expects to continue, reduces the benefit the segment realizes from brand-to-generic drug conversions.

Prescriptions filled

- Prescriptions filled represents the number of prescriptions dispensed through the Retail/LTC segment's pharmacies. Management uses this metric to understand variances between actual prescriptions dispensed and expected amounts as well

as trends in period-over-period results. This metric provides management and investors with information useful in understanding the impact of prescription volume on segment total revenues and operating results.

- Prescriptions filled increased 8.4%, on a 30-day equivalent basis, in 2021 compared to 2020 primarily driven by COVID-19 vaccinations and the continued adoption of patient care programs, as well as increased new therapy prescriptions, which were adversely impacted by the COVID-19 pandemic in 2020. Excluding the impact of COVID-19 vaccinations, prescriptions filled increased 4.3%, on a 30-day equivalent basis, in 2021 compared to the prior year.

Generic dispensing rate

- Generic dispensing rate is calculated by dividing the Retail/LTC segment's generic drug prescriptions filled by its total prescriptions filled. Management uses this metric to evaluate the effectiveness of the business at encouraging the use of generic drugs when they are available and clinically appropriate, which aids in decreasing costs for client members and retail customers. This metric provides management and investors with information useful in understanding trends in segment total revenues and operating results.
- The Retail/LTC segment's generic dispensing rate decreased to 85.7% in 2021 compared to 88.3% in the prior year. The decrease in the segment's generic dispensing rate was primarily driven by an increase in brand prescriptions, largely attributable to COVID-19 vaccinations in 2021. Excluding the impact of COVID-19 vaccinations, the segment's total generic dispensing rate increased to 89.0% in 2021.

Corporate/Other Segment

The following table summarizes the Corporate/Other segment's performance for the respective periods:

	Year Ended December 31,			Change			
				2021 vs. 2020		2020 vs. 2019	
In millions, except percentages	**2021**	**2020**	**2019**	**$**	**%**	**$**	**%**
Revenues:							
Premiums	$ 68	$ 63	$ 91	$ 5	7.9 %	$ (28)	(30.8)%
Services	57	48	9	9	18.8 %	39	433.3 %
Net investment income	596	315	412	281	89.2 %	(97)	(23.5)%
Total revenues	721	426	512	295	69.2 %	(86)	(16.8)%
Cost of products sold	37	—	—	37	100.0 %	—	— %
Benefit costs	212	221	285	(9)	(4.1)%	(64)	(22.5)%
Operating expenses	2,078	1,846	1,710	232	12.6 %	136	8.0 %
Operating loss	(1,606)	(1,641)	(1,483)	35	2.1 %	(158)	(10.7)%
Adjusted operating loss [1]	(1,471)	(1,306)	(1,000)	(165)	(12.6)%	(306)	(30.6)%

(1) See "Segment Analysis" above in this MD&A for a reconciliation of Corporate/Other segment operating loss (GAAP measure) to adjusted operating loss, which represents the Company's principal measure of segment performance.

Commentary - 2021 compared to 2020

Revenues

- Revenues primarily relate to products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products.
- Total revenues increased $295 million in 2021 compared to 2020. The increase was primarily driven by higher net investment income, primarily driven by private equity investments and increased net realized capital gains in 2021 compared to 2020.

Adjusted operating loss

- Adjusted operating loss increased $165 million in 2021 compared to 2020. The increase was primarily driven by higher employee benefit costs and incremental operating expenses associated with the Company's investments in transformation, partially offset by the increase in net investment income in 2021 described above.

Liquidity and Capital Resources

Cash Flows

The Company maintains a level of liquidity sufficient to allow it to meet its cash needs in the short-term. Over the long term, the Company manages its cash and capital structure to maximize shareholder return, maintain its financial condition and maintain flexibility for future strategic initiatives. The Company continuously assesses its regulatory capital requirements, working capital needs, debt and leverage levels, debt maturity schedule, capital expenditure requirements, dividend payouts, potential share repurchases and future investments or acquisitions. The Company believes its operating cash flows, commercial paper program, credit facilities, as well as any potential future borrowings, will be sufficient to fund these future payments and long-term initiatives. As of December 31, 2021, the Company had approximately $9.4 billion in cash and cash equivalents, approximately $3.8 billion of which was held by the parent company or nonrestricted subsidiaries.

The net change in cash, cash equivalents and restricted cash for the years ended December 31, 2021, 2020 and 2019 was as follows:

				Change			
	Year Ended December 31,			2021 vs. 2020		2020 vs. 2019	
In millions	2021	2020	2019	$	%	$	%
Net cash provided by operating activities	$ 18,265	$ 15,865	$ 12,848	$ 2,400	15.1 %	$ 3,017	23.5 %
Net cash used in investing activities	(5,261)	(5,534)	(3,339)	273	4.9 %	(2,195)	(65.7)%
Net cash used in financing activities	(11,356)	(7,696)	(7,654)	(3,660)	(47.6)%	(42)	(0.5)%
Net increase in cash, cash equivalents and restricted cash	$ 1,648	$ 2,635	$ 1,855	$ (987)	(37.5)%	$ 780	42.0 %

Commentary - 2021 compared to 2020

- *Net cash provided by operating activities* increased by $2.4 billion in 2021 compared to 2020 due primarily to the timing of payments and higher operating income in the Retail/LTC segment. The increase was partially offset by reduced benefit costs due to the deferral of elective procedures and other discretionary utilization in the Health Care Benefits segment as a result of the COVID-19 pandemic, which favorably impacted operating cash flows in 2020 and did not recur during the current year.
- *Net cash used in investing activities* decreased by $273 million in 2021 compared to 2020 primarily due to increased proceeds from the sale and maturity of investments and a decrease in cash used for acquisitions, partially offset by the absence of $840 million in proceeds from the sale of the Workers' Compensation business in 2020 and increased purchases of investments during 2021 compared to the prior year. In addition, cash used in investing activities reflected the following activity:
    - Gross capital expenditures remained relatively consistent at approximately $2.5 billion and $2.4 billion in 2021 and 2020, respectively. During 2021, approximately 64% of the Company's total capital expenditures were for technology, digital and other strategic initiatives and 36% were for store, fulfillment and support facilities expansion and improvements.
- *Net cash used in financing activities* increased to $11.4 billion in 2021 compared to $7.7 billion in 2020. The increase in cash used in finance activities primarily related to lower proceeds from the issuance of long-term debt, partially offset by lower repayments of long-term debt during 2021 compared to the prior year.

Included in net cash used in investing activities for the years ended December 31, 2021, 2020 and 2019 was the following store development activity: [1]

	2021	2020	2019
Total stores (beginning of year)	9,962	9,896	9,921
New and acquired stores [2]	58	156	102
Closed stores [2]	(81)	(90)	(127)
Total stores (end of year)	9,939	9,962	9,896
Relocated stores [2]	17	18	23

(1) Includes retail drugstores and pharmacies within retail chains, primarily in Target Corporation ("Target") stores.

(2) Relocated stores are not included in new and acquired stores or closed stores totals.

Short-term Borrowings

Commercial Paper and Back-up Credit Facilities
The Company did not have any commercial paper outstanding as of December 31, 2021 or 2020. In connection with its commercial paper program, the Company maintains a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 17, 2023, a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 16, 2024, and a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 11, 2026. The credit facilities allow for borrowings at various rates that are dependent, in part, on the Company's public debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately 0.03%, regardless of usage. As of December 31, 2021 and 2020, there were no borrowings outstanding under any of the Company's back-up credit facilities.

Federal Home Loan Bank of Boston ("FHLBB")
A subsidiary of the Company is a member of the FHLBB. As a member, the subsidiary has the ability to obtain cash advances, subject to certain minimum collateral requirements. The maximum borrowing capacity available from the FHLBB as of December 31, 2021 was approximately $995 million. At both December 31, 2021 and 2020, there were no outstanding advances from the FHLBB.

Long-term Borrowings

2021 Notes
On August 18, 2021, the Company issued $1.0 billion aggregate principal amount of 2.125% unsecured senior notes due September 15, 2031 for total proceeds of $987 million, net of discounts, underwriting fees and offering expenses. The net proceeds of this offering were used for the purchase of senior notes in connection with the Company's cash tender offer in August 2021 as described below.

2020 Notes
On December 16, 2020, the Company issued $750 million aggregate principal amount of 1.3% unsecured senior notes due August 21, 2027 and $1.25 billion aggregate principal amount of 1.875% unsecured senior notes due February 28, 2031 for total proceeds of approximately $1.99 billion, net of discounts and underwriting fees. The $750 million aggregate principal amount of 1.3% unsecured senior notes represent a further issuance of the Company's 1.3% unsecured senior notes due August 21, 2027 initially issued in an aggregate principal amount of $1.5 billion on August 21, 2020.

On August 21, 2020, the Company issued $1.5 billion aggregate principal amount of 1.3% unsecured senior notes due August 21, 2027, $1.25 billion aggregate principal amount of 1.75% unsecured senior notes due August 21, 2030 and $1.25 billion aggregate principal amount of 2.7% unsecured senior notes due August 21, 2040 (collectively, the "August 2020 Notes") for total proceeds of approximately $3.97 billion, net of discounts and underwriting fees.

On March 31, 2020, the Company issued $750 million aggregate principal amount of 3.625% unsecured senior notes due April 1, 2027, $1.5 billion aggregate principal amount of 3.75% unsecured senior notes due April 1, 2030, $1.0 billion aggregate principal amount of 4.125% unsecured senior notes due April 1, 2040 and $750 million aggregate principal amount of 4.25% unsecured senior notes due April 1, 2050 (collectively, the "March 2020 Notes") for total proceeds of approximately $3.95 billion, net of discounts and underwriting fees.

The net proceeds of these offerings were used for general corporate purposes, which may include working capital, capital expenditures, as well as the repurchase and/or repayment of indebtedness.

During March 2020, the Company entered into several interest rate swap transactions to manage interest rate risk. These agreements were designated as cash flow hedges and were used to hedge the exposure to variability in future cash flows resulting from changes in interest rates related to the anticipated issuance of the March 2020 Notes. In connection with the issuance of the March 2020 Notes, the Company terminated all outstanding cash flow hedges. The Company paid a net amount of $7 million to the hedge counterparties upon termination, which was recorded as a loss, net of tax, of $5 million in accumulated other comprehensive income and will be reclassified as interest expense over the life of the March 2020 Notes. See Note 13 ''Other Comprehensive Income'' included in Item 8 of this 10-K for additional information.

Early Extinguishments of Debt
In December 2021, the Company redeemed for cash the remaining $2.3 billion of its outstanding 3.7% senior notes due 2023. In connection with the early redemption of such senior notes, the Company paid a make-whole premium of $80 million in excess of the aggregate principal amount of the senior notes that were redeemed, wrote-off $8 million of unamortized deferred financing costs and incurred $1 million in fees, for a total loss on early extinguishment of debt of $89 million.

In August 2021, the Company purchased approximately $2.0 billion of its outstanding 4.3% senior notes due 2028 through a cash tender offer. In connection with the purchase of such senior notes, the Company paid a premium of $332 million in excess of the aggregate principal amount of the senior notes that were purchased, wrote-off $26 million of unamortized deferred financing costs and incurred $5 million in fees, for a total loss on early extinguishment of debt of $363 million.

In December 2020, the Company purchased $4.5 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $113 million of its 4.0% senior notes due 2023, $1.4 billion of its 3.7% senior notes due 2023, $1.0 billion of its 4.1% senior notes due 2025 and $2.0 billion of its 4.3% senior notes due 2028. In connection with the purchase of such senior notes, the Company paid a premium of $619 million in excess of the aggregate principal amount of the senior notes that were purchased, wrote-off $45 million of unamortized deferred financing costs and incurred $10 million in fees, for a total loss on early extinguishment of debt of $674 million.

In August 2020, the Company purchased $6.0 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $723 million of its 4.0% senior notes due 2023, $2.3 billion of its 3.7% senior notes due 2023 and $3.0 billion of its 4.1% senior notes due 2025. In connection with the purchase of such senior notes, the Company paid a premium of $706 million in excess of the aggregate principal amount of the senior notes that were purchased, wrote-off $47 million of unamortized deferred financing costs and incurred $13 million in fees, for a total loss on early extinguishment of debt of $766 million.

In August 2019, the Company purchased $4.0 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $1.3 billion of its 3.125% senior notes due 2020, $723 million of its floating rate notes due 2020, $328 million of its 4.125% senior notes due 2021, $297 million of 4.125% senior notes due 2021 issued by Aetna, $413 million of 5.45% senior notes due 2021 issued by Coventry Health Care, Inc., a wholly-owned subsidiary of Aetna, and $962 million of its 3.35% senior notes due 2021. In connection with the purchase of such senior notes, the Company paid a premium of $76 million in excess of the aggregate principal amount of the senior notes that were purchased, incurred $8 million in fees and recognized a net gain of $5 million on the write-off of net unamortized deferred financing premiums, for a net loss on early extinguishment of debt of $79 million.

See Note 8 ‘‘Borrowings and Credit Agreements’’ and Note 12 ‘‘Shareholders’ Equity’’ included in Item 8 of this 10-K for additional information about debt issuances, debt repayments, share repurchases and dividend payments.

Derivative Financial Instruments

The Company uses derivative financial instruments in order to manage interest rate and foreign exchange risk and credit exposure. The Company’s use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps.

Debt Covenants

The Company’s back-up revolving credit facilities, unsecured senior notes and unsecured floating rate notes (see Note 8 ‘‘Borrowings and Credit Agreements’’ included in Item 8 of this 10-K) contain customary restrictive financial and operating covenants. These covenants do not include an acceleration of the Company’s debt maturities in the event of a downgrade in the Company’s credit ratings. The Company does not believe the restrictions contained in these covenants materially affect its financial or operating flexibility. As of December 31, 2021, the Company was in compliance with all of its debt covenants.

Debt Ratings

As of December 31, 2021, the Company’s long-term debt was rated “Baa2” by Moody’s Investors Service, Inc. (“Moody’s”) and “BBB” by Standard & Poor’s Financial Services LLC (“S&P”), and its commercial paper program was rated “P-2” by Moody’s and “A-2” by S&P. The outlook on the Company’s long-term debt is “Stable” by Moody’s and “Positive” by S&P. In assessing the Company’s credit strength, the Company believes that both Moody’s and S&P considered, among other things, the Company’s capital structure and financial policies as well as its consolidated balance sheet, its historical acquisition activity

and other financial information. Although the Company currently believes its long-term debt ratings will remain investment grade, it cannot guarantee the future actions of Moody's and/or S&P. The Company's debt ratings have a direct impact on its future borrowing costs, access to capital markets and new store operating lease costs.

Share Repurchase Programs

During the years ended December 31, 2021, 2020 and 2019, the Company did not repurchase any shares of common stock. See Note 12 ''Shareholders' Equity'' included in Item 8 of this 10-K for additional information on the Company's share repurchase program.

Quarterly Cash Dividend

During 2021, 2020 and 2019, the quarterly cash dividend was $0.50 per share. In December 2021, CVS Health Corporation's Board of Directors (the "Board") authorized a 10% increase in the quarterly cash dividend to $0.55 per share effective in 2022. CVS Health Corporation has paid cash dividends every quarter since becoming a public company. Future dividends will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

Future Cash Requirements

The following table summarizes certain estimated future cash requirements under the Company's various contractual obligations at December 31, 2021, in total and disaggregated into current and long-term obligations. The table below does not include future payments of claims to health care providers or pharmacies because certain terms of these payments are not determinable at December 31, 2021 (for example, the timing and volume of future services provided under fee-for-service arrangements and future membership levels for capitated arrangements).

In millions	Total	Current	Long-Term
Operating lease liabilities [1]	$ 26,070	$ 2,685	$ 23,385
Finance lease liabilities [1]	2,068	122	1,946
Contractual lease obligations with Target [2]	2,419	—	2,419
Long-term debt [3]	55,443	4,154	51,289
Interest payments on long-term debt [3]	31,668	2,196	29,472
Other long-term liabilities on the consolidated balance sheets [4]			
Future policy benefits [5]	5,553	416	5,137
Unpaid claims [5]	1,589	324	1,265
Policyholders' funds [5] [6]	1,761	1,266	495
Total	$ 126,571	$ 11,163	$ 115,408

(1) Refer to Note 6 ''Leases'' included in Item 8 of this 10-K for additional information regarding the maturity of lease liabilities under operating and finance leases.

(2) The Company leases pharmacy and clinic space from Target. See Note 6 ''Leases'' included in Item 8 of this 10-K for additional information regarding the lease arrangements with Target. Amounts related to such operating and finance leases are reflected within the operating lease liabilities and finance lease liabilities in the table above. Pharmacy lease amounts due in excess of the remaining estimated economic life of the buildings are reflected in the table above assuming equivalent stores continue to operate through the term of the arrangements.

(3) Refer to Note 8 ''Borrowings and Credit Agreements'' included in Item 8 of this 10-K for additional information regarding the maturities of debt principal. Interest payments on long-term debt are calculated using outstanding balances and interest rates in effect on December 31, 2021.

(4) Payments of other long-term liabilities exclude Separate Accounts liabilities of approximately $5.1 billion because these liabilities are supported by assets that are legally segregated and are not subject to claims that arise out of the Company's business.

(5) Total payments of future policy benefits, unpaid claims and policyholders' funds include $728 million, $1.6 billion and $186 million, respectively, of reserves for contracts subject to reinsurance. The Company expects the assuming reinsurance carrier to fund these obligations and has reflected these amounts as reinsurance recoverable assets on the consolidated balance sheets.

(6) Customer funds associated with group life and health contracts of approximately $3.0 billion have been excluded from the table above because such funds may be used primarily at the customer's discretion to offset future premiums and/or for refunds, and the timing of the related cash flows cannot be determined. Additionally, net unrealized capital gains on debt securities supporting experience-rated products of $92 million, before tax, have been excluded from the table above.

Restrictions on Certain Payments

In addition to general state law restrictions on payments of dividends and other distributions to stockholders applicable to all corporations, health maintenance organizations ("HMOs") and insurance companies are subject to further regulations that, among other things, may require those companies to maintain certain levels of equity (referred to as surplus) and restrict the

amount of dividends and other distributions that may be paid to their equity holders. These regulations are not directly applicable to CVS Health Corporation as a holding company, since CVS Health Corporation is not an HMO or an insurance company. In addition, in connection with the Aetna Acquisition, the Company made certain undertakings that require prior regulatory approval of dividends by certain of its HMOs and insurance companies. The additional regulations and undertakings applicable to the Company's HMO and insurance company subsidiaries are not expected to affect the Company's ability to service the Company's debt, meet other financing obligations or pay dividends, or the ability of any of the Company's subsidiaries to service their debt or other financing obligations. Under applicable regulatory requirements and undertakings, at December 31, 2021, the maximum amount of dividends that may be paid by the Company's insurance and HMO subsidiaries without prior approval by regulatory authorities was $2.9 billion in the aggregate.

The Company maintains capital levels in its operating subsidiaries at or above targeted and/or required capital levels and dividends amounts in excess of these levels to meet liquidity requirements, including the payment of interest on debt and stockholder dividends. In addition, at the Company's discretion, it uses these funds for other purposes such as funding share and debt repurchase programs, investments in new businesses and other purposes considered advisable.

At December 31, 2021 and 2020, the Company held investments of $450 million and $524 million, respectively, that are not accounted for as Separate Accounts assets but are legally segregated and are not subject to claims that arise out of the Company's business. See Note 3 ''Investments'' included in Item 8 of this 10-K for additional information on investments related to the 2012 conversion of an existing group annuity contract from a participating to a non-participating contract.

Solvency Regulation

The National Association of Insurance Commissioners (the "NAIC") utilizes risk-based capital ("RBC") standards for insurance companies that are designed to identify weakly-capitalized companies by comparing each company's adjusted surplus to its required surplus (the "RBC Ratio"). The RBC Ratio is designed to reflect the risk profile of insurance companies. Within certain ratio ranges, regulators have increasing authority to take action as the RBC Ratio decreases. There are four levels of regulatory action, ranging from requiring an insurer to submit a comprehensive financial plan for increasing its RBC to the state insurance commissioner to requiring the state insurance commissioner to place the insurer under regulatory control. At December 31, 2021, the RBC Ratio of each of the Company's primary insurance subsidiaries was above the level that would require regulatory action. The RBC framework described above for insurers has been extended by the NAIC to health organizations, including HMOs. Although not all states had adopted these rules at December 31, 2021, at that date, each of the Company's active HMOs had a surplus that exceeded either the applicable state net worth requirements or, where adopted, the levels that would require regulatory action under the NAIC's RBC rules. External rating agencies use their own capital models and/or RBC standards when they determine a company's rating.

Critical Accounting Policies

The Company prepares the consolidated financial statements in conformity with generally accepted accounting principles, which require management to make certain estimates and apply judgment. Estimates and judgments are based on historical experience, current trends and other factors that management believes to be important at the time the consolidated financial statements are prepared. On a regular basis, the Company reviews its accounting policies and how they are applied and disclosed in the consolidated financial statements. While the Company believes the historical experience, current trends and other factors considered by management support the preparation of the consolidated financial statements in conformity with generally accepted accounting principles, actual results could differ from estimates, and such differences could be material.

Significant accounting policies are discussed in Note 1 ‘‘Significant Accounting Policies’’ included in Item 8 of this 10-K. Management believes the following accounting policies include a higher degree of judgment and/or complexity and, thus, are considered to be critical accounting policies. The Company has discussed the development and selection of these critical accounting policies with the Audit Committee of the Board (the “Audit Committee”), and the Audit Committee has reviewed the disclosures relating to them.

Revenue Recognition

Health Care Benefits Segment
Health Care Benefits revenue is principally derived from insurance premiums and fees billed to customers. Revenue is recognized based on customer billings, which, in the Company’s Commercial business, reflect contracted rates per member and the number of covered members recorded in the Company’s records at the time the billings are prepared. Billings are generally sent monthly for coverage during the following month. Revenue related to the Company’s Government business is collected monthly from the U.S. federal government and various government agencies based on fixed payment rates and member eligibility.

The Company’s billings may be subsequently adjusted to reflect enrollment changes due to member terminations or other factors. These adjustments are known as retroactivity adjustments. In each period, the Company estimates the amount of future retroactivity and adjusts the recorded revenue accordingly. As information regarding actual retroactivity amounts becomes known, the Company refines its estimates and records any required adjustments to revenues in the period in which they arise. A significant difference in the actual level of retroactivity compared to estimated levels would have a significant effect on the Company’s operating results.

Premium Revenue
Premiums are recognized as revenue in the month in which the enrollee is entitled to receive health care services. Premiums are reported net of an allowance for estimated terminations and uncollectible amounts. Additionally, premium revenue subject to the MLR rebate requirements of the ACA is recorded net of the estimated minimum MLR rebates for the current calendar year. Premiums related to unexpired contractual coverage periods (unearned premiums) are reported as other insurance liabilities on the consolidated balance sheets and recognized as revenue when earned.

Some of the Company’s contracts allow for premiums to be adjusted to reflect actual experience or the relative health status of Insured members. Such adjustments are reasonably estimable at the outset of the contract, and adjustments to those estimates are made based on actual experience of the customer emerging under the contract and the terms of the underlying contract.

Services Revenue
Services revenue relates to contracts that can include various combinations of services or series of services which generally are capable of being distinct and accounted for as separate performance obligations. The Health Care Benefits segment’s services revenue primarily consists of ASC fees received in exchange for performing certain claim processing and member services for ASC members. ASC fee revenue is recognized over the period the service is provided. Some of the Company’s administrative services contracts include guarantees with respect to certain functions, such as customer service response time, claim processing accuracy and claim processing turnaround time, as well as certain guarantees that a plan sponsor’s benefit claim experience will fall within a certain range. With any of these guarantees, the Company is financially at risk if the conditions of the arrangements are not met, although the maximum amount at risk typically is limited to a percentage of the fees otherwise payable to the Company by the customer involved. Each period the Company estimates its obligations under the terms of these guarantees and records its estimate as an offset to services revenues.

Accounting for Medicare Part D

Revenues include insurance premiums earned by the Company's PDPs, which are determined based on the PDP's annual bid and related contractual arrangements with CMS. The insurance premiums include a beneficiary premium, which is the responsibility of the PDP member, and can be subsidized by CMS in the case of low-income members, and a direct premium paid by CMS. Premiums collected in advance are initially recorded within other insurance liabilities and are then recognized ratably as revenue over the period in which members are entitled to receive benefits.

Revenues also include a risk-sharing feature of the Medicare Part D program design referred to as the risk corridor. The Company estimates variable consideration in the form of amounts payable to, or receivable from, CMS under the risk corridor, and adjusts revenue based on calculations of additional subsidies to be received from or owed to CMS at the end of the reporting year.

In addition to Medicare Part D premiums, the Company receives additional payments each month from CMS related to catastrophic reinsurance, low-income cost-sharing subsidies and coverage gap benefits. If the subsidies received differ from the amounts earned from actual prescriptions transferred, the difference is recorded in either accounts receivable, net or accrued expenses.

Pharmacy Services Segment

The Pharmacy Services segment sells prescription drugs directly through its mail service dispensing pharmacies and indirectly through the Company's retail pharmacy network. The Company's pharmacy benefit arrangements are accounted for in a manner consistent with a master supply arrangement as there are no contractual minimum volumes and each prescription is considered a separate purchasing decision and distinct performance obligation transferred at a point in time. PBM services performed in connection with each prescription claim are considered part of a single performance obligation which culminates in the dispensing of prescription drugs.

The Company recognizes revenue using the gross method at the contract price negotiated with its clients when the Company has concluded it controls the prescription drug before it is transferred to the client plan members. The Company controls prescriptions dispensed indirectly through its retail pharmacy network because it has separate contractual arrangements with those pharmacies, has discretion in setting the price for the transaction and assumes primary responsibility for fulfilling the promise to provide prescription drugs to its client plan members while also performing the related PBM services.

Revenues include (i) the portion of the price the client pays directly to the Company, net of any discounts earned on brand name drugs or other discounts and refunds paid back to the client (see "Drug Discounts" and "Guarantees" below), (ii) the price paid to the Company by client plan members for mail order prescriptions and the price paid to retail network pharmacies by client plan members for retail prescriptions ("retail co-payments"), and (iii) claims based administrative fees for retail pharmacy network contracts. Sales taxes are not included in revenues.

The Company recognizes revenue when control of the prescription drugs is transferred to customers, in an amount that reflects the consideration the Company expects to be entitled to receive in exchange for those prescription drugs. The Company has established the following revenue recognition policies for the Pharmacy Services segment:

- Revenues generated from prescription drugs sold by mail service dispensing pharmacies are recognized when the prescription drug is delivered to the client plan member. At the time of delivery, the Company has performed substantially all of its performance obligations under its client contracts and does not experience a significant level of returns or reshipments.
- Revenues generated from prescription drugs sold by third party pharmacies in the Company's retail pharmacy network and associated administrative fees are recognized at the Company's point-of-sale, which is when the claim is adjudicated by the Company's online claims processing system and the Company has transferred control of the prescription drug and completed all of its performance obligations.

For contracts under which the Company acts as an agent or does not control the prescription drugs prior to transfer to the client plan member, revenue is recognized using the net method.

Drug Discounts

The Company records revenue net of manufacturers' rebates earned by its clients based on their plan members' utilization of brand-name formulary drugs. The Company estimates these rebates at period-end based on actual and estimated claims data and its estimates of the manufacturers' rebates earned by its clients. The estimates are based on the best available data at period-end and recent history for the various factors that can affect the amount of rebates due to the client. The Company adjusts its rebates

payable to clients to the actual amounts paid when these rebates are paid or as significant events occur. Any cumulative effect of these adjustments is recorded against revenues at the time it is identified. Adjustments generally result from contract changes with clients or manufacturers that have retroactive rebate adjustments, differences between the estimated and actual product mix subject to rebates, or whether the brand name drug was included in the applicable formulary. The effect of adjustments between estimated and actual manufacturers' rebate amounts has not been material to the Company's operating results or financial condition.

Guarantees

The Company also adjusts revenues for refunds owed to clients resulting from pricing guarantees and performance against defined service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's operating results or financial condition.

Retail/LTC Segment

Retail Pharmacy

The Company's retail drugstores recognize revenue at the time the customer takes possession of the merchandise. For pharmacy sales, each prescription claim is its own arrangement with the customer and is a performance obligation, separate and distinct from other prescription claims under other retail network arrangements. Revenues are adjusted for refunds owed to third party payers resulting from pricing guarantees and performance against defined value-based service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's operating results or financial condition.

Revenue from Company gift cards purchased by customers is deferred as a contract liability until goods or services are transferred. Any amounts not expected to be redeemed by customers (i.e., breakage) are recognized based on historical redemption patterns.

Customer returns are not material to the Company's operating results or financial condition. Sales taxes are not included in revenues.

Loyalty and Other Programs

The Company's customer loyalty program, ExtraCare®, consists of two components, ExtraSavings™ and ExtraBucks® Rewards. ExtraSavings are coupons that are recorded as a reduction of revenue when redeemed as the Company concluded that they do not represent a promise to the customer to deliver additional goods or services at the time of issuance because they are not tied to a specific transaction or spending level.

ExtraBucks Rewards are accumulated by customers based on their historical spending levels. Thus, the Company has determined that there is an additional performance obligation to those customers at the time of the initial transaction. The Company allocates the transaction price to the initial transaction and the ExtraBucks Rewards transaction based upon the relative standalone selling price, which considers historical redemption patterns for the rewards. Revenue allocated to ExtraBucks Rewards is recognized as those rewards are redeemed. At the end of each period, unredeemed ExtraBucks Rewards are reflected as a contract liability.

The Company also offers a subscription-based membership program, CarePass®, under which members are entitled to a suite of benefits delivered over the course of the subscription period, as well as a promotional reward that can be redeemed for future goods and services. Subscriptions are paid for on a monthly or annual basis at the time of or in advance of the Company delivering the goods and services. Revenue from these arrangements is recognized as the performance obligations are satisfied.

Long-term Care

Revenue is recognized when control of the promised goods or services is transferred to customers in an amount that reflects the consideration the Company expects to be entitled to receive in exchange for those goods or services. Each prescription claim represents a separate performance obligation of the Company, separate and distinct from other prescription claims under customer arrangements. A significant portion of long-term care revenue from sales of pharmaceutical and medical products is reimbursed by the federal Medicare Part D program and, to a lesser extent, state Medicaid programs. The Company monitors its revenues and receivables from these reimbursement sources, as well as long-term care facilities and other third party insurance payors, and reduces revenue at the revenue recognition date to properly account for the variable consideration due to anticipated differences between billed and reimbursed amounts. Accordingly, the total revenues and receivables reported in the Company's consolidated financial statements are recorded at the amount expected to be ultimately received from these payors.

Patient co-payments associated with Medicare Part D, certain state Medicaid programs, Medicare Part B and certain third party payors typically are not collected at the time products are delivered or services are rendered, but are billed to the individuals as part of normal billing procedures and subject to normal accounts receivable collections procedures.

Walk-In Medical Clinics
For services provided by the Company's walk-in medical clinics, revenue recognition occurs for completed services provided to patients, with adjustments taken for third party payor contractual obligations and patient direct bill historical collection rates.

Impairments of Debt Securities

The Company regularly reviews its debt securities to determine whether a decline in fair value below the cost basis or carrying value has occurred. If a debt security is in an unrealized loss position and the Company has the intent to sell the security, or it is more likely than not that the Company will have to sell the security before recovery of its amortized cost basis, the amortized cost basis of the security is written down to its fair value and the difference is recognized in net income. If a debt security is in an unrealized loss position and the Company does not have the intent to sell and it is more likely than not that the Company will not have to sell such security before recovery of its amortized cost basis, the Company bifurcates the impairment into credit-related and non-credit related components. The amount of the credit-related component is recorded as an allowance for credit losses and recognized in net income, and the amount of the non-credit related component is included in other comprehensive income. The Company analyzes all facts and circumstances believed to be relevant for each investment when performing this analysis, in accordance with applicable accounting guidance.

In evaluating whether a credit related loss exists, the Company considers a variety of factors including: the extent to which the fair value is less than the amortized cost basis; adverse conditions specifically related to the issuer of a security, an industry or geographic area; the payment structure of the security; the failure of the issuer of the security to make scheduled interest or principle payments; and any changes to the rating of the security by a rating agency.

During the years ended December 31, 2021 and 2020, the Company recorded yield-related impairment losses on debt securities of $42 million and $49 million, respectively. During the years ended December 31, 2021 and 2020, the Company did not record credit-related impairment losses on debt securities. During the year ended December 31, 2019, the Company recorded other-than-temporary impairment ("OTTI") losses on debt securities of $24 million.

The risks inherent in assessing the impairment of a debt security include the risk that market factors may differ from projections and the risk that facts and circumstances factored into the Company's assessment may change with the passage of time. Unexpected changes to market factors and circumstances that were not present in past reporting periods are among the factors that may result in a current period decision to sell debt securities that were not impaired in prior reporting periods.

Vendor Allowances and Purchase Discounts

Vendor and manufacturer receivables were $10.6 billion and $9.8 billion as of December 31, 2021 and 2020, respectively, the majority of which relate to purchase discounts and vendor allowances as described below.

Pharmacy Services Segment
The Pharmacy Services segment receives purchase discounts on products purchased. Contractual arrangements with vendors, including manufacturers, wholesalers and retail pharmacies, normally provide for the Pharmacy Services segment to receive purchase discounts from established list prices in one, or a combination, of the following forms: (i) a direct discount at the time of purchase, (ii) a discount for the prompt payment of invoices or (iii) when products are purchased indirectly from a manufacturer (e.g., through a wholesaler or retail pharmacy), a discount (or rebate) paid subsequent to dispensing. These rebates are recognized when prescriptions are dispensed and are generally calculated and billed to manufacturers within 30 days of the end of each completed quarter. Historically, the effect of adjustments resulting from the reconciliation of rebates recognized to the amounts billed and collected has not been material to the Company's operating results or financial condition. The Company accounts for the effect of any such differences as a change in accounting estimate in the period the reconciliation is completed. The Pharmacy Services segment also receives additional discounts under its wholesaler contracts if it exceeds contractually defined purchase volumes. In addition, the Pharmacy Services segment receives fees from pharmaceutical manufacturers for administrative services. Purchase discounts and administrative service fees are recorded as a reduction of cost of products sold.

Retail/LTC Segment
Vendor allowances received by the Retail/LTC segment reduce the carrying cost of inventory and are recognized in cost of products sold when the related inventory is sold, unless they are specifically identified as a reimbursement of incremental costs for promotional programs and/or other services provided. Amounts that are directly linked to advertising commitments are recognized as a reduction of advertising expense (included in operating expenses) when the related advertising commitment is satisfied. Any such allowances received in excess of the actual cost incurred also reduce the carrying cost of inventory. The total value of any upfront payments received from vendors that are linked to purchase commitments is initially deferred. The deferred amounts are then amortized to reduce cost of products sold over the life of the contract based upon sales volume. The total value of any upfront payments received from vendors that are not linked to purchase commitments is also initially deferred. The deferred amounts are then amortized to reduce cost of products sold on a straight-line basis over the life of the related contract.

The Company establishes a receivable for vendor income that is earned but not yet received based on historical trends and data. The majority of vendor receivables are collected within the following fiscal quarter. Historically, adjustments to the Company's vendor receivables resulting from the reconciliation of receivables recognized to the amounts collected have not been material to the Company's operating results or financial condition.

There have not been any material changes in the way the Company accounts for vendor allowances or purchase discounts during the past three years.

Inventory

Inventories are valued at the lower of cost or net realizable value using the weighted average cost method.

The value of ending inventory is reduced for estimated inventory losses that have occurred during the interim period between physical inventory counts. Physical inventory counts are taken on a regular basis in each retail store and LTC pharmacy, and a continuous cycle count process is the primary procedure used to validate the inventory balances on hand in each distribution center and mail facility to ensure that the amounts reflected in the consolidated financial statements are properly stated. The Company's accounting for inventory contains uncertainty since management must use judgment to estimate the inventory losses that have occurred during the interim period between physical inventory counts. When estimating these losses, a number of factors are considered which include historical physical inventory results on a location-by-location basis and current physical inventory loss trends.

The total reserve for estimated inventory losses covered by this critical accounting policy was $522 million and $369 million as of December 31, 2021 and 2020, respectively. Although management believes there is sufficient current and historical information available to record reasonable estimates for estimated inventory losses, it is possible that actual results could differ. In order to help investors assess the aggregate risk, if any, associated with the inventory-related uncertainties discussed above, a ten percent (10%) pre-tax change in estimated inventory losses, which is a reasonably likely change, would increase or decrease the total reserve for estimated inventory losses by approximately $52 million as of December 31, 2021.

Although management believes that the estimates discussed above are reasonable and the related calculations conform to generally accepted accounting principles, actual results could differ from such estimates, and such differences could be material.

Right-of-Use Assets and Lease Liabilities

The Company determines if an arrangement contains a lease at the inception of a contract. Right-of-use assets represent the Company's right to use an underlying asset for the lease term and lease liabilities represent the Company's obligation to make lease payments arising from the lease. Right-of-use assets and lease liabilities are recognized at the commencement date of the lease, renewal date of the lease or significant remodeling of the lease space based on the present value of the remaining future minimum lease payments. As the interest rate implicit in the Company's leases is not readily determinable, the Company utilizes its incremental borrowing rate, determined by class of underlying asset, to discount the lease payments. The operating lease right-of-use assets also include lease payments made before commencement and are reduced by lease incentives. The Company evaluates the recoverability of its right-of-use assets as described in "Long-Lived Asset Impairment" below.

The Company's real estate leases typically contain options that permit renewals for additional periods of up to five years each. For real estate leases, the options to extend are not considered reasonably certain at lease commencement because the Company reevaluates each lease on a regular basis to consider the economic and strategic incentives of exercising the renewal options and

regularly opens or closes stores to align with its operating strategy. Generally, the renewal option periods are not included within the lease term and the associated payments are not included in the measurement of the right-of-use asset and lease liability. Similarly, renewal options are not included in the lease term for non-real estate leases because they are not considered reasonably certain of being exercised at lease commencement. Leases with an initial term of 12 months or less are not recorded on the balance sheets, and lease expense is recognized on a straight-line basis over the term of the short-term lease.

For real estate leases, the Company accounts for lease components and nonlease components as a single lease component. Certain real estate leases require additional payments based on sales volume, as well as reimbursement for real estate taxes, common area maintenance and insurance, which are expensed as incurred as variable lease costs. Other real estate leases contain one fixed lease payment that includes real estate taxes, common area maintenance and insurance. These fixed payments are considered part of the lease payment and included in the right-of-use assets and lease liabilities.

Long-Lived Asset Impairment

Recoverability of Definite-Lived Assets
The Company evaluates the recoverability of long-lived assets, excluding goodwill and indefinite-lived intangible assets, which are tested for impairment using separate tests described below, whenever events or changes in circumstances indicate that the carrying value of such an asset may not be recoverable. The Company groups and evaluates these long-lived assets for impairment at the lowest level at which individual cash flows can be identified. If indicators of impairment are present, the Company first compares the carrying amount of the asset group to the estimated future cash flows associated with the asset group (undiscounted). If the estimated future cash flows used in this analysis are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to the asset group's estimated future cash flows (discounted). If required, an impairment loss is recorded for the portion of the asset group's carrying value that exceeds the asset group's estimated future cash flows (discounted).

The long-lived asset impairment loss calculation contains uncertainty since management must use judgment to estimate each asset group's future sales, profitability and cash flows. When preparing these estimates, the Company considers historical results and current operating trends and consolidated sales, profitability and cash flow results and forecasts. These estimates can be affected by a number of factors including general economic and regulatory conditions, efforts of third party organizations to reduce their prescription drug costs and/or increased member co-payments, the continued efforts of competitors to gain market share and consumer spending patterns.

During the fourth quarter of 2021, the Company completed a strategic review of its retail business and announced the creation of new formats for its stores to continue to drive higher engagement with customers. As part of this review, the Company evaluated changes in population, consumer buying patterns and future health needs to ensure it has the right kinds of stores in the right locations for consumers and for the business. In connection with this initiative, on November 17, 2021, the Board of Directors of CVS Health Corporation (the "Board") authorized the closing of approximately 900 stores over the next three years. The Company expects to close approximately 300 stores each year between 2022 and 2024. As a result, management determined that there were indicators of impairment with respect to the impacted stores' asset groups, including the associated operating lease right-of-use assets and property and equipment. A long-lived asset impairment test was performed during the fourth quarter of 2021 and the results of the impairment test indicated that the fair value of certain retail store asset groups were lower than their respective carrying values. Accordingly, in the three months ended December 31, 2021, the Company recorded a store impairment charge of approximately $1.4 billion, consisting of a write down of approximately $1.1 billion related to operating lease right-of-use assets and $261 million related to property and equipment, within the Retail/LTC segment.

There were no material impairment charges recognized on long-lived assets in the year ended December 31, 2020. During the year ended December 31, 2019, the Company recorded store impairment charges of $231 million, primarily related to operating lease right-of-use asset impairment charges.

Recoverability of Goodwill
Goodwill represents the excess of amounts paid for acquisitions over the fair value of the net identifiable assets acquired. Goodwill is subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that the carrying value may not be recoverable. Goodwill is tested for impairment on a reporting unit basis. The impairment test is performed by comparing the reporting unit's fair value with its net book value (or carrying amount), including goodwill. The fair value of the reporting units is estimated using a combination of a discounted cash flow method and a market multiple method. If the net book value (carrying amount) of the reporting unit exceeds its fair value, the reporting unit's goodwill is considered to be impaired, and an impairment is recognized in an amount equal to the excess.

The determination of the fair value of the reporting units requires the Company to make significant assumptions and estimates. These assumptions and estimates primarily include the selection of appropriate peer group companies; control premiums and valuation multiples appropriate for acquisitions in the industries in which the Company competes; discount rates; terminal growth rates; and forecasts of revenue, operating income, depreciation and amortization, income taxes, capital expenditures and future working capital requirements. When determining these assumptions and preparing these estimates, the Company considers each reporting unit's historical results and current operating trends; consolidated revenues, profitability and cash flow results and forecasts; and industry trends. The Company's estimates can be affected by a number of factors, including general economic and regulatory conditions; the risk-free interest rate environment; the Company's market capitalization; efforts of customers and payers to reduce costs, including their prescription drug costs, and/or increase member co-payments; the continued efforts of competitors to gain market share, consumer spending patterns and the Company's ability to achieve its revenue growth projections and execute on its cost reduction initiatives.

2021 Goodwill Impairment Test

During the third quarter of 2021, the Company performed its required annual impairment tests of goodwill. The results of the impairment tests indicated an impairment of the goodwill associated with the LTC reporting unit, as the reporting unit's carrying value exceeded its fair value as of the testing date. The results of the impairment tests of the remaining reporting units indicated that there was no impairment of goodwill as of the testing date. The fair values of the reporting units with goodwill exceeded their carrying values by significant margins, with the exception of the Commercial Business reporting unit, which exceeded its carrying value by approximately 3%.

As discussed in Note 5 ''Goodwill and Other Intangibles'' included in Item 8 of this 10-K, during 2021, the LTC reporting unit has continued to face challenges that have impacted the Company's ability to grow the LTC reporting unit's business at the rate estimated when its 2020 goodwill impairment test was performed. These challenges include lower net facility admissions, net long-term care facility customer losses and the prolonged adverse impact of the COVID-19 pandemic and the emerging new variants, which resulted in more significant declines in occupancy rates experienced by the Company's long-term care facility customers than previously anticipated. During the third quarter of 2021, LTC management updated their 2021 annual forecast and submitted their long-term plan which showed deterioration in the financial results for the remainder of 2021 and beyond. The Company utilized these updated projections in performing its annual impairment test, which indicated that the fair value of the LTC reporting unit was lower than its carrying value, resulting in a $431 million goodwill impairment charge in the third quarter of 2021. The fair value of the LTC reporting unit was determined using a combination of a discounted cash flow method and a market multiple method. Subsequent to the impairment charge recorded in the third quarter of 2021, there is no remaining goodwill balance in the LTC reporting unit.

The Company has experienced declines in its Commercial Insured medical membership subsequent to the closing date of the Aetna Acquisition and may continue to do so for a number of reasons, including as a result of the competitive Commercial business environment. In addition, COVID-19 and the emerging new variants have had and may continue to have an adverse impact on medical membership in the Commercial business due to reductions in workforce at existing customers (including due to business failures) as well as reduced willingness to change benefit providers by prospective customers. The Company's fair value estimate is sensitive to significant assumptions including changes in medical membership, revenue growth rate, operating income and the discount rate. Although the Company believes the financial projections used to determine the fair value of the Commercial Business reporting unit in the third quarter of 2021 were reasonable and achievable, the challenges described above may affect the Company's ability to increase medical membership or operating income in the Commercial Business reporting unit at the rate estimated when such goodwill impairment test was performed and may continue to do so. As of December 31, 2021, the goodwill balance in the Commercial Business reporting unit was $26.5 billion.

2020 Goodwill Impairment Test

During the third quarter of 2020, the Company performed its required annual impairment test of goodwill. The results of this impairment test indicated that there was no impairment of goodwill as of the testing date. The goodwill impairment test resulted in the fair values of all of the Company's reporting units exceeding their carrying values by significant margins, with the exception of the Commercial Business and LTC reporting units, which exceeded their carrying values by approximately 6% and 12%, respectively.

2019 Goodwill Impairment Test

During the third quarter of 2019, the Company performed its required annual impairment test of goodwill. The results of this impairment test indicated that there was no impairment of goodwill as of the testing date. The goodwill impairment test resulted in the fair values of all of the Company's reporting units exceeding their carrying values by significant margins, with the exception of the Commercial Business and LTC reporting units, which exceeded their carrying values by approximately 4% and 9%, respectively.

Recoverability of Indefinite-Lived Intangible Assets
Indefinite-lived intangible assets are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that their carrying value may not be recoverable. Indefinite-lived intangible assets are tested by comparing the estimated fair value of the asset to its carrying value. If the carrying value of the asset exceeds its estimated fair value, an impairment loss is recognized, and the asset is written down to its estimated fair value.

The indefinite-lived intangible asset impairment loss calculation contains uncertainty since management must use judgment to estimate fair value based on the assumption that, in lieu of ownership of an intangible asset, the Company would be willing to pay a royalty in order to utilize the benefits of the asset. Fair value is estimated by discounting the hypothetical royalty payments to their present value over the estimated economic life of the asset. These estimates can be affected by a number of factors including general economic conditions, availability of market information and the profitability of the Company. There were no impairment losses recognized on indefinite-lived intangible assets in any of the years ended December 31, 2021, 2020 or 2019.

Health Care Costs Payable

At December 31, 2021 and 2020, 75% and 77% respectively, of health care costs payable are estimates of the ultimate cost of (i) services rendered to the Company's Insured members but not yet reported to the Company and (ii) claims which have been reported to the Company but not yet paid (collectively, "IBNR"). Health care costs payable also include an estimate of the cost of services that will continue to be rendered after the financial statement date if the Company is obligated to pay for such services in accordance with contractual or regulatory requirements. The remainder of health care costs payable is primarily comprised of pharmacy and capitation payables, other amounts due to providers pursuant to risk sharing agreements and accruals for state assessments. The Company develops its estimate of IBNR using actuarial principles and assumptions that consider numerous factors. See Note 1 ''Significant Accounting Policies'' included in Item 8 of this 10-K for additional information on the Company's reserving methodology.

During 2021 and 2020, the Company observed an increase in completion factors relative to those assumed at the prior year end. After considering the claims paid in 2021 and 2020 with dates of service prior to the fourth quarter of the previous year, the Company observed assumed incurred claim weighted average completion factors that were 21 and 4 basis points higher, respectively, than previously estimated, resulting in a decrease of $207 million and $35 million in 2021 and 2020, respectively, in health care costs payable that related to the prior year. The Company has considered the pattern of changes in its completion factors when determining the completion factors used in its estimates of IBNR as of December 31, 2021. However, based on historical claim experience, it is reasonably possible that the Company's estimated weighted average completion factors may vary by plus or minus 13 basis points from the Company's assumed rates, which could impact health care costs payable by approximately plus or minus $186 million pretax.

Also during 2021 and 2020, the Company observed that health care costs for claims with claim incurred dates of three months or less before the financial statement date were lower than previously estimated. Specifically, after considering the claims paid in 2021 and 2020 with claim incurred dates for the fourth quarter of the previous year, the Company observed health care costs that were 5.0% and 4.0% lower, respectively, for each fourth quarter than previously estimated, resulting in a reduction of $581 million and $394 million in 2021 and 2020, respectively, in health care costs payable that related to prior year.

Management considers historical health care cost trend rates together with its knowledge of recent events that may impact current trends when developing estimates of current health care cost trend rates. When establishing reserves as of December 31, 2021, the Company increased its assumed health care cost trend rates for the most recent three months by 1.8% from health care cost trend rates recently observed. Health care cost trend rates during the past two years have been impacted by utilization changes driven by the COVID-19 pandemic. The impact has not been uniform, with products and select geographies experiencing utilization impacts due to COVID-19 waves. Based on historical claim experience, it is reasonably possible that the Company's estimated health care cost trend rates may vary by plus or minus 3.5% from the assumed rates, which could impact health care costs payable by plus or minus $450 million pretax.

Income Taxes

The Company accounts for income taxes using the asset and liability method. Deferred tax assets and liabilities are established for any temporary differences between financial and tax reporting bases and are adjusted as needed to reflect changes in the enacted tax rates expected to be in effect when the temporary differences reverse. Such adjustments are recorded in the period

in which changes in tax laws are enacted, regardless of when they are effective. Deferred tax assets are reduced, if necessary, by a valuation allowance to the extent future realization of those losses, deductions or other tax benefits is sufficiently uncertain.
Significant judgment is required in determining the provision for income taxes and the related taxes payable and deferred tax assets and liabilities since, in the ordinary course of business, there are transactions and calculations where the ultimate tax outcome is uncertain. Additionally, the Company's tax returns are subject to audit by various domestic and foreign tax authorities that could result in material adjustments based on differing interpretations of the tax laws. Although management believes that its estimates are reasonable and are based on the best available information at the time the provision is prepared, actual results could differ from these estimates resulting in a final tax outcome that may be materially different from that which is reflected in the consolidated financial statements.

The tax benefit from an uncertain tax position is recognized only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position. The tax benefits recognized in the consolidated financial statements from such positions are then measured based on the largest benefit that has a greater than 50% likelihood of being realized upon settlement with the related tax authority. Interest and/or penalties related to uncertain tax positions are recognized in the income tax provision. Significant judgment is required in determining uncertain tax positions. The Company has established accruals for uncertain tax positions using its judgment and adjusts these accruals, as warranted, due to changing facts and circumstances.

New Accounting Pronouncements

See Note 1 ''Significant Accounting Policies'' included in Item 8 of this 10-K for a description of new accounting pronouncements applicable to the Company.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk.

The Company's earnings and financial condition are exposed to interest rate risk, credit quality risk, market valuation risk, foreign currency risk, commodity risk and operational risk.

Evaluation of Interest Rate and Credit Quality Risk

The Company manages interest rate risk by seeking to maintain a tight match between the durations of assets and liabilities when appropriate. The Company manages credit quality risk by seeking to maintain high average credit quality ratings and diversified sector exposure within its debt securities portfolio. In connection with its investment and risk management objectives, the Company also uses derivative financial instruments whose market value is at least partially determined by, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets or credit ratings/spreads. The Company's use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps. These instruments, viewed separately, subject the Company to varying degrees of interest rate, equity price and credit risk. However, when used for hedging, the Company expects these instruments to reduce overall risk.

Investments
The Company's investment portfolio supported the following products at December 31, 2021 and 2020:

In millions	**2021**	**2020**
Experience-rated products	$ 957	$ 1,037
Remaining products	25,185	22,775
Total investments	$ 26,142	$ 23,812

Investment risks associated with experience-rated products generally do not impact the Company's operating results. The risks associated with investments supporting experience-rated pension and annuity products in the large case pensions business in the Company's Corporate/Other segment are assumed by the contract holders and not by the Company (subject to, among other things, certain minimum guarantees). Assets supporting experience-rated products may be subject to contract holder or participant withdrawals.

The debt securities in the Company's investment portfolio had an average credit quality rating of A at both December 31, 2021 and 2020, with a fair value of approximately $6.7 billion and $6.3 billion rated AAA at December 31, 2021 and 2020, respectively. The fair value of debt securities that were rated below investment grade (that is, having a credit quality rating below BBB-/Baa3) was $2.3 billion and $1.9 billion at December 31, 2021 and 2020, respectively (of which 2% at both December 31, 2021 and 2020 supported experience-rated products).

At December 31, 2021 and 2020, the Company held $305 million and $321 million, respectively, of municipal debt securities that were guaranteed by third parties, representing 1% of total investments at both December 31, 2021 and 2020. These securities had an average credit quality rating of AA at both December 31, 2021 and 2020 with the guarantee. These securities had an average credit quality rating of A at both December 31, 2021 and 2020, respectively, without the guarantee. The Company does not have any significant concentration of investments with third party guarantors (either direct or indirect).

The Company generally classifies debt securities as available for sale, and carries them at fair value on the consolidated balance sheets. At both December 31, 2021 and 2020, less than 1% of debt securities were valued using inputs that reflect the Company's assumptions (categorized as Level 3 inputs in accordance with accounting principles generally accepted in the United States of America). See Note 4 ''Fair Value'' included in Item 8 of this 10-K for additional information on the methodologies and key assumptions used to determine the fair value of investments. For additional information related to investments, see Note 3 ''Investments'' included in Item 8 of this 10-K.

The Company regularly reviews debt securities in its portfolio to determine whether a decline in fair value below the cost basis or carrying value has occurred. If a debt security is in an unrealized loss position and the Company has the intent to sell the security, or it is more likely than not that the Company will have to sell the security before recovery of its amortized cost basis, the amortized cost basis of the security is written down to its fair value and the difference is recognized in net income. If a debt security is in an unrealized loss position and the Company does not have the intent to sell and it is more likely than not that the Company will not have to sell such security before recovery of its amortized cost basis, the Company bifurcates the impairment into credit-related and non-credit related components. The amount of the credit-related component is recorded as an allowance

for credit losses and recognized in net income, and the amount of the non-credit related component is included in other comprehensive income. The impairment of debt securities is considered a critical accounting policy. See ‘‘Critical Accounting Policies - Impairments of Debt Securities” in the MD&A included in Item 7 of this 10-K for additional information.

Evaluation of Market Valuation Risks

The Company regularly evaluates its risk from market-sensitive instruments by examining, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets and/or credit ratings/spreads. The Company also regularly evaluates the appropriateness of investments relative to management-approved investment guidelines (and operates within those guidelines) and the business objectives of its portfolios.

On a quarterly basis, the Company reviews the impact of hypothetical net losses in its investment portfolio on the Company’s consolidated near-term financial condition, operating results and cash flows assuming the occurrence of certain reasonably possible changes in near-term market rates and prices. Interest rate changes (whether resulting from changes in treasury yields or credit spreads or other factors) represent the most material risk exposure category for the Company. The Company has estimated the impact on the fair value of market sensitive instruments based on the net present value of cash flows using a representative set of likely future interest rate scenarios. The assumptions used were as follows: an immediate increase of 100 basis points in interest rates (which the Company believes represents a moderately adverse scenario) for long-term debt issued by the Company, as well as its interest rate sensitive investments and an immediate decrease of 15% in prices for publicly traded domestic equity securities in the Company’s investment portfolio.

Assuming an immediate increase of 100 basis points in interest rates, the theoretical decline in the fair values of market sensitive instruments at December 31, 2021 is as follows:

- The fair value of long-term debt issued by the Company would decline by approximately $4.6 billion ($5.8 billion pretax). Changes in the fair value of long-term debt do not impact the Company’s operating results or financial condition.
- The theoretical reduction in the fair value of interest rate sensitive investments partially offset by the theoretical reduction in the fair value of interest rate sensitive liabilities would result in a net decline in fair value of approximately $680 million ($860 million pretax) related to continuing non-experience-rated products. Reductions in the fair value of investment securities would be reflected as an unrealized loss in equity, as the Company classifies these debt securities as available for sale. The Company does not record liabilities at fair value.

If the value of the Company’s publicly traded domestic equity securities held within its investment portfolio were to decline by 15%, this would result in a net decline in fair value of $14 million ($18 million pretax).

Based on overall exposure to interest rate risk and equity price risk, the Company believes that these changes in market rates and prices would not materially affect consolidated near-term financial condition, operating results or cash flows as of December 31, 2021.

Evaluation of Foreign Currency and Commodity Risk

At December 31, 2021 and 2020, the Company did not have any material foreign currency exchange rate or commodity derivative instruments in place and believes its exposure to foreign currency exchange rate risk is not material.

Evaluation of Operational Risks

The Company also faces certain operational risks. Those risks include risks related to the COVID-19 pandemic and risks related to information security, including cybersecurity.

The spread of COVID-19, or actions taken to mitigate its spread, could have material and adverse effects on our ability to operate our businesses effectively, including as a result of the complete or partial closure of facilities or labor shortages. Disruptions in our supply chains, our distribution chains and/or public and private infrastructure, including communications, financial services and supply chains, could materially and adversely impact our business operations. We have transitioned a significant subset of our colleagues to a remote work environment in an effort to mitigate the spread of COVID-19, as have a significant number of our third-party service providers, which may amplify certain risks to our businesses, including an increased demand for information technology resources, increased risk of phishing and other cyber attacks, increased risk of unauthorized dissemination of sensitive personal information or proprietary or confidential information about us or our medical members or other third-parties and increased risk of business interruptions.

The Company and its vendors have experienced diverse cyber attacks and expect to continue to experience cyber attacks going forward. As examples, the Company and its vendors have experienced attempts to gain access to systems, denial of service attacks, attempted malware infections, account takeovers, scanning activity and phishing emails. Attacks can originate from external criminals, terrorists, nation states or internal actors. The Company is dedicating and will continue to dedicate significant resources and incur significant expenses to maintain and update on an ongoing basis the systems and processes that are designed to mitigate the information security risks it faces and protect the security of its computer systems, software, networks and other technology assets against attempts by unauthorized parties to obtain access to confidential information, disrupt or degrade service or cause other damage. The impact of cyber attacks has not been material to the Company's operations or operating results through December 31, 2021. The Board and its Audit Committee and Nominating and Corporate Governance Committee are regularly informed regarding the Company's information security policies, practices and status.

Item 8. Financial Statements and Supplementary Data.

Index to Consolidated Financial Statements

Consolidated Statements of Operations

In millions, except per share amounts	For the Years Ended December 31, 2021	2020	2019
Revenues:			
Products	$ 203,738	$ 190,688	$ 185,236
Premiums	76,132	69,364	63,122
Services	11,042	7,856	7,407
Net investment income	1,199	798	1,011
Total revenues	292,111	268,706	256,776
Operating costs:			
Cost of products sold	175,803	163,981	158,719
Benefit costs	64,260	55,679	52,529
Store impairments	1,358	—	231
Goodwill impairment	431	—	—
Operating expenses	37,066	35,135	33,310
Total operating costs	278,918	254,795	244,789
Operating income	13,193	13,911	11,987
Interest expense	2,503	2,907	3,035
Loss on early extinguishment of debt	452	1,440	79
Other income	(182)	(206)	(124)
Income before income tax provision	10,420	9,770	8,997
Income tax provision	2,522	2,569	2,366
Income from continuing operations	7,898	7,201	6,631
Loss from discontinued operations, net of tax	—	(9)	—
Net income	7,898	7,192	6,631
Net (income) loss attributable to noncontrolling interests	12	(13)	3
Net income attributable to CVS Health	$ 7,910	$ 7,179	$ 6,634
Basic earnings per share:			
Income from continuing operations attributable to CVS Health	$ 6.00	$ 5.49	$ 5.10
Loss from discontinued operations attributable to CVS Health	$ —	$ (0.01)	$ —
Net income attributable to CVS Health	$ 6.00	$ 5.48	$ 5.10
Weighted average basic shares outstanding	1,319	1,309	1,301
Diluted earnings per share:			
Income from continuing operations attributable to CVS Health	$ 5.95	$ 5.47	$ 5.08
Loss from discontinued operations attributable to CVS Health	$ —	$ (0.01)	$ —
Net income attributable to CVS Health	$ 5.95	$ 5.46	$ 5.08
Weighted average diluted shares outstanding	1,329	1,314	1,305
Dividends declared per share	$ 2.00	$ 2.00	$ 2.00

See accompanying notes to consolidated financial statements.

Consolidated Statements of Comprehensive Income

In millions	For the Years Ended December 31, 2021	2020	2019
Net income	$ 7,898	$ 7,192	$ 6,631
Other comprehensive income (loss), net of tax:			
Net unrealized investment gains (losses)	(436)	440	677
Foreign currency translation adjustments	(7)	3	162
Net cash flow hedges	(26)	(31)	(33)
Pension and other postretirement benefits	20	(17)	111
Other comprehensive income (loss)	(449)	395	917
Comprehensive income	7,449	7,587	7,548
Comprehensive (income) loss attributable to noncontrolling interests	12	(13)	3
Comprehensive income attributable to CVS Health	$ 7,461	$ 7,574	$ 7,551

See accompanying notes to consolidated financial statements.

Consolidated Balance Sheets

In millions, except per share amounts	At December 31, 2021	2020
Assets:		
Cash and cash equivalents	$ 9,408	$ 7,854
Investments	3,117	3,000
Accounts receivable, net	24,431	21,742
Inventories	17,760	18,496
Other current assets	5,292	5,277
Total current assets	60,008	56,369
Long-term investments	23,025	20,812
Property and equipment, net	12,896	12,606
Operating lease right-of-use assets	19,122	20,729
Goodwill	79,121	79,552
Intangible assets, net	29,026	31,142
Separate accounts assets	5,087	4,881
Other assets	4,714	4,624
Total assets	$ 232,999	$ 230,715
Liabilities:		
Accounts payable	$ 12,544	$ 11,138
Pharmacy claims and discounts payable	17,330	15,795
Health care costs payable	8,808	7,936
Policyholders' funds	4,301	4,270
Accrued expenses	17,670	14,243
Other insurance liabilities	1,303	1,557
Current portion of operating lease liabilities	1,646	1,638
Current portion of long-term debt	4,205	5,440
Total current liabilities	67,807	62,017
Long-term operating lease liabilities	18,177	18,757
Long-term debt	51,971	59,207
Deferred income taxes	6,270	6,794
Separate accounts liabilities	5,087	4,881
Other long-term insurance liabilities	6,402	7,007
Other long-term liabilities	1,904	2,351
Total liabilities	157,618	161,014
Commitments and contingencies (Note 16)		
Shareholders' equity:		
Preferred stock, par value $0.01: 0.1 shares authorized; none issued or outstanding	—	—
Common stock, par value $0.01: 3,200 shares authorized; 1,744 shares issued and 1,322 shares outstanding at December 31, 2021 and 1,733 shares issued and 1,310 shares outstanding at December 31, 2020 and capital surplus	47,377	46,513
Treasury stock, at cost: 422 and 423 shares at December 31, 2021 and 2020	(28,173)	(28,178)
Retained earnings	54,906	49,640
Accumulated other comprehensive income	965	1,414
Total CVS Health shareholders' equity	75,075	69,389
Noncontrolling interests	306	312
Total shareholders' equity	75,381	69,701
Total liabilities and shareholders' equity	$ 232,999	$ 230,715

See accompanying notes to consolidated financial statements.

Consolidated Statements of Cash Flows

In millions	For the Years Ended December 31, 2021	2020	2019
Cash flows from operating activities:			
Cash receipts from customers	$ 284,219	$ 264,327	$ 248,393
Cash paid for inventory and prescriptions dispensed by retail network pharmacies	(165,783)	(158,636)	(149,655)
Insurance benefits paid	(63,598)	(55,124)	(52,242)
Cash paid to other suppliers and employees	(31,652)	(29,763)	(28,932)
Interest and investment income received	743	894	955
Interest paid	(2,469)	(2,904)	(2,954)
Income taxes paid	(3,195)	(2,929)	(2,717)
Net cash provided by operating activities	18,265	15,865	12,848
Cash flows from investing activities:			
Proceeds from sales and maturities of investments	7,246	6,467	7,049
Purchases of investments	(9,963)	(9,639)	(7,534)
Purchases of property and equipment	(2,520)	(2,437)	(2,457)
Proceeds from sale-leaseback transactions	—	101	5
Acquisitions (net of cash acquired)	(146)	(866)	(444)
Proceeds from sale of subsidiary	—	840	—
Other	122	—	42
Net cash used in investing activities	(5,261)	(5,534)	(3,339)
Cash flows from financing activities:			
Net repayments of short-term debt	—	—	(720)
Proceeds from issuance of long-term debt	987	9,958	3,736
Repayments of long-term debt	(10,254)	(15,631)	(8,336)
Derivative settlements	—	(7)	(25)
Dividends paid	(2,625)	(2,624)	(2,603)
Proceeds from exercise of stock options	549	264	210
Payments for taxes related to net share settlement of equity awards	(168)	(88)	(112)
Other	155	432	196
Net cash used in financing activities	(11,356)	(7,696)	(7,654)
Net increase in cash, cash equivalents and restricted cash	1,648	2,635	1,855
Cash, cash equivalents and restricted cash at the beginning of the period	11,043	8,408	6,553
Cash, cash equivalents and restricted cash at the end of the period	$ 12,691	$ 11,043	$ 8,408

In millions	For the Years Ended December 31, 2021	2020	2019
Reconciliation of net income to net cash provided by operating activities:			
Net income	$ 7,898	$ 7,192	$ 6,631
Adjustments required to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	4,512	4,441	4,371
Store impairments	1,358	—	231
Goodwill impairment	431	—	—
Stock-based compensation	484	400	453
(Gain) loss on sale of subsidiaries	—	(269)	205
Loss on early extinguishment of debt	452	1,440	79
Deferred income taxes	(428)	(570)	(654)
Other noncash items	(390)	72	33
Change in operating assets and liabilities, net of effects from acquisitions:			
Accounts receivable, net	(2,703)	(1,510)	(2,158)
Inventories	735	(973)	(1,075)
Other assets	(3)	364	(614)
Accounts payable and pharmacy claims and discounts payable	2,898	2,769	3,550
Health care costs payable and other insurance liabilities	169	(231)	320
Other liabilities	2,852	2,740	1,476
Net cash provided by operating activities	$ 18,265	$ 15,865	$ 12,848

See accompanying notes to consolidated financial statements.

Consolidated Statements of Shareholders' Equity

	Number of shares outstanding		Attributable to CVS Health						
In millions	Common Shares	Treasury Shares [1]	Common Stock and Capital Surplus [2]	Treasury Stock [1]	Retained Earnings	Accumulated Other Comprehensive Income	Total CVS Health Shareholders' Equity	Noncontrolling Interests	Total Shareholders' Equity
Balance at December 31, 2018	**1,720**	**(425)**	**$ 45,440**	**$ (28,228)**	**$ 40,911**	**$ 102**	**$ 58,225**	**$ 318**	**$ 58,543**
Adoption of new accounting standards [3]	—	—	—	—	178	—	178	—	178
Net income	—	—	—	—	6,634	—	6,634	(3)	6,631
Other comprehensive income (Note 13)	—	—	—	—	—	917	917	—	917
Stock option activity, stock awards and other	7	2	532	—	—	—	532	—	532
Purchase of treasury shares, net of ESPP issuances	—	(2)	—	(7)	—	—	(7)	—	(7)
Common stock dividends	—	—	—	—	(2,615)	—	(2,615)	—	(2,615)
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(9)	(9)
Balance at December 31, 2019	1,727	(425)	45,972	(28,235)	45,108	1,019	63,864	306	64,170
Adoption of new accounting standard [4]	—	—	—	—	(3)	—	(3)	—	(3)
Net income	—	—	—	—	7,179	—	7,179	13	7,192
Other comprehensive income (Note 13)	—	—	—	—	—	395	395	—	395
Stock option activity, stock awards and other	6	—	541	—	—	—	541	—	541
ESPP issuances, net of purchase of treasury shares	—	2	—	57	—	—	57	—	57
Common stock dividends	—	—	—	—	(2,644)	—	(2,644)	—	(2,644)
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(7)	(7)
Balance at December 31, 2020	1,733	(423)	46,513	(28,178)	49,640	1,414	69,389	312	69,701
Net income	—	—	—	—	7,910	—	7,910	(12)	7,898
Other comprehensive loss (Note 13)	—	—	—	—	—	(449)	(449)	—	(449)
Stock option activity, stock awards and other	11	—	864	—	—	—	864	—	864
ESPP issuances, net of purchase of treasury shares	—	1	—	5	—	—	5	—	5
Common stock dividends	—	—	—	—	(2,644)	—	(2,644)	—	(2,644)
Other increases in noncontrolling interests	—	—	—	—	—	—	—	6	6
Balance at December 31, 2021	**1,744**	**(422)**	**$ 47,377**	**$ (28,173)**	**$ 54,906**	**$ 965**	**$ 75,075**	**$ 306**	**$ 75,381**

(1) Treasury shares include 1 million shares held in trust for each of the years ended December 31, 2021, 2020 and 2019. Treasury stock includes $29 million related to shares held in trust for each of the years ended December 31, 2021, 2020 and 2019. See Note 1 ''Significant Accounting Policies'' for additional information.

(2) Common stock and capital surplus includes the par value of common stock of $17 million as of December 31, 2021, 2020 and 2019.

(3) Reflects the adoption of Accounting Standards Update ("ASU") 2016-02, *Leases* (Topic 842), which resulted in an increase to retained earnings of $178 million during the year ended December 31, 2019.

(4) Reflects the adoption of ASU 2016-13, *Financial Instruments - Credit Losses* (Topic 326), which resulted in a reduction to retained earnings of $3 million during the year ended December 31, 2020.

See accompanying notes to consolidated financial statements.

Notes to Consolidated Financial Statements

1. Significant Accounting Policies

Description of Business

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health" or the "Company"), has more than 9,900 retail locations, nearly 1,200 walk-in medical clinics, a leading pharmacy benefits manager with approximately 110 million plan members with expanding specialty pharmacy solutions and a dedicated senior pharmacy care business serving more than one million patients per year. The Company also serves an estimated 35 million people through traditional, voluntary and consumer-directed health insurance products and related services, including expanding Medicare Advantage offerings and a leading standalone Medicare Part D prescription drug plan ("PDP"). The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

The coronavirus disease 2019 ("COVID-19") and its emerging new variants continue to impact the economies of the U.S. and other countries around the world. The impact of COVID-19 on the Company's businesses, operating results, cash flows and financial condition in the years ended December 31, 2021 and 2020, as well as information regarding certain expected impacts of COVID-19 on the Company, is discussed throughout this Annual Report on Form 10-K.

The Company has four reportable segments: Health Care Benefits, Pharmacy Services, Retail/LTC and Corporate/Other, which are described below.

Health Care Benefits Segment
The Health Care Benefits segment operates as one of the nation's leading diversified health care benefits providers. The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make more informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental and behavioral health plans, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services and health information technology products and services. The Health Care Benefits segment also provided workers' compensation administrative services through its Coventry Health Care Workers' Compensation business ("Workers' Compensation business") prior to the sale of this business on July 31, 2020. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates. The Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk for medical and dental care costs) as "ASC." In addition, effective January 2022, the Company entered the individual public health insurance exchanges ("Public Exchanges") in eight states through which it sells Insured plans directly to individual consumers.

Pharmacy Services Segment
The Pharmacy Services segment provides a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services and mail order pharmacy. In addition, through the Pharmacy Services segment, the Company provides specialty pharmacy and infusion services, clinical services, disease management services, medical spend management and pharmacy and/or other administrative services for providers and federal 340B drug pricing program covered entities ("Covered Entities"). The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, PDPs, Medicaid managed care plans, plans offered on Public Exchanges and private health insurance exchanges, other sponsors of health benefit plans throughout the United States and Covered Entities. The Pharmacy Services segment operates retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services.

Retail/LTC Segment
The Retail/LTC segment sells prescription drugs and a wide assortment of health and wellness products and general merchandise, provides health care services through its MinuteClinic® walk-in medical clinics, provides medical diagnostic testing, administers vaccinations for illnesses such as influenza, COVID-19 and shingles and conducts long-term care pharmacy ("LTC") operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to long-term care facilities and other care settings. As of December 31, 2021, the Retail/LTC segment operated more than 9,900 retail locations, nearly 1,200 MinuteClinic locations as well as online retail pharmacy websites, LTC pharmacies and on-site pharmacies.

Corporate/Other Segment
The Company presents the remainder of its financial results in the Corporate/Other segment, which primarily consists of:

- Management and administrative expenses to support the Company's overall operations, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments, expenses associated with the Company's investments in its transformation and enterprise modernization programs and acquisition-related transaction and integration costs; and
- Products for which the Company no longer solicits or accepts new customers such as its large case pensions and long-term care insurance products.

Basis of Presentation

The accompanying consolidated financial statements of CVS Health and its subsidiaries have been prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP"). The consolidated financial statements include the accounts of the Company and its majority-owned subsidiaries and variable interest entities ("VIEs") for which the Company is the primary beneficiary. All material intercompany balances and transactions have been eliminated.

Reclassifications

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

Use of Estimates

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and temporary investments with maturities of three months or less when purchased. The Company invests in short-term money market funds, commercial paper and time deposits, as well as other debt securities that are classified as cash equivalents within the accompanying consolidated balance sheets, as these funds are highly liquid and readily convertible to known amounts of cash.

Restricted Cash

Restricted cash (included in other current assets) represents funds held on behalf of members, including health savings account ("HSA") funds associated with high deductible health plans. Beginning in 2021, the Company began presenting these funds held on behalf of members in restricted cash and, for statement of cash flow purposes, retrospectively adjusted the 2020 and 2019 balances by the amounts shown in the table below in the line item "restricted cash (included in other current assets)" to conform with the current year presentation. Restricted cash (included in other assets) represents amounts held in a trust in one of the Company's captive insurance companies to satisfy collateral requirements associated with the assignment of certain insurance policies. All restricted cash is invested in time deposits, money market funds or commercial paper.

The following is a reconciliation of cash and cash equivalents on the consolidated balance sheets to total cash, cash equivalents and restricted cash on the consolidated statements of cash flows as of December 31, 2021, 2020 and 2019:

In millions	**2021**	**2020**	**2019**
Cash and cash equivalents	$ 9,408	$ 7,854	$ 5,683
Restricted cash (included in other current assets)	3,065	2,913	2,454
Restricted cash (included in other assets)	218	276	271
Total cash, cash equivalents and restricted cash in the consolidated statements of cash flows	$ 12,691	$ 11,043	$ 8,408

Investments

Debt Securities
Debt securities consist primarily of U.S. Treasury and agency securities, mortgage-backed securities, corporate and foreign bonds and other debt securities. Debt securities are classified as either current or long-term investments based on their contractual maturities unless the Company intends to sell an investment within the next twelve months, in which case it is classified as current on the consolidated balance sheets. Debt securities are classified as available for sale and are carried at fair value. See Note 4 ‘‘Fair Value’’ for additional information on how the Company estimates the fair value of these investments.

If a debt security is in an unrealized loss position and the Company has the intent to sell the security, or it is more likely than not that the Company will have to sell the security before recovery of its amortized cost basis, the amortized cost basis of the security is written down to its fair value and the difference is recognized in net income. If a debt security is in an unrealized loss position and the Company does not have the intent to sell and it is more likely than not that the Company will not have to sell such security before recovery of its amortized cost basis, the Company bifurcates the impairment into credit-related and non-credit related components. In evaluating whether a credit related loss exists, the Company considers a variety of factors including: the extent to which the fair value is less than the amortized cost basis; adverse conditions specifically related to the issuer of a security, an industry or geographic area; the payment structure of the security; the failure of the issuer of the security to make scheduled interest or principal payments; and any changes to the rating of the security by a rating agency. The amount of the credit-related component is recorded as an allowance for credit losses and recognized in net income, and the amount of the non-credit related component is included in other comprehensive income. Interest is not accrued on debt securities when management believes the collection of interest is unlikely.

The credit-related component is determined by comparing the present value of cash flows expected to be collected from the security, considering all reasonably available information relevant to the collectability of the security, with the amortized cost basis of the security. If the present value of cash flows expected to be collected is less than the amortized cost basis of the security, the Company records an allowance for credit losses, which is limited by the amount that the fair value is less than amortized cost basis.

For mortgage-backed and other asset-backed securities, the Company recognizes 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 Company’s investment in the security is adjusted to the amount that would have existed had the new effective yield been applied since the acquisition of the security, with adjustments recognized in net income.

Equity Securities
Equity securities with readily available fair values are measured at fair value with changes in fair value recognized in net income (loss).

Mortgage Loans
Mortgage loan investments on the consolidated balance sheets are valued at the unpaid principal balance, net of an allowance for credit losses. Mortgage loans with a maturity date or a committed prepayment date within twelve months are classified as current on the consolidated balance sheets. The Company assesses whether its loans share similar risk characteristics and, if so, groups such loans in a risk pool when measuring expected credit losses. The Company considers the following characteristics when evaluating whether its loans share similar risk characteristics: loan-to-value ratios, property type (e.g., office, retail, apartment, industrial), geographic location, vacancy rates and property condition.

Credit loss reserves are determined using a loss rate method that multiplies the unpaid principal balance of each loan within a risk pool group by an estimated loss rate percentage. The loss rate percentage considers both the expected loan loss severity and the probability of loan default. For periods where the Company is able to make or obtain reasonable and supportable forecasts of expected economic conditions (e.g., gross domestic product, employment), the Company adjusts its expected loss rates to reflect these forecasted economic conditions. For periods beyond which the Company is able to make or obtain reasonable and supportable forecasts of expected economic conditions, the Company reverts to historical loss rates in determining expected credit losses.

Interest income on a potential problem loan (i.e., high probability of default) or restructured loan is accrued to the extent it is deemed to be collectible and the loan continues to perform under its original or restructured terms. Interest income on problem loans (i.e., more than 60 days delinquent, in bankruptcy or in process of foreclosure) is recognized on a cash basis. Cash payments on loans in the process of foreclosure are treated as a return of principal.

Other Investments
Other investments consist primarily of the following:

- Private equity and hedge fund limited partnerships, which are accounted for using the equity method of accounting. Under this method, the carrying value of the investment is based on the value of the Company's equity ownership of the underlying investment funds provided by the general partner or manager of the investments, the financial statements of which generally are audited. As a result of the timing of the receipt of the valuation information provided by the fund managers, these investments are generally reported on up to a three month lag. The Company reviews investments for impairment at least quarterly and monitors their performance throughout the year through discussions with the administrators, managers and/or general partners. If the Company becomes aware of an impairment of a limited partnership's investments through its review or prior to receiving the limited partnership's financial statements at the financial statement date, an impairment will be recognized by recording a reduction in the carrying value of the limited partnership with a corresponding charge to net investment income.
- Investment real estate, which is carried on the consolidated balance sheets at depreciated cost, including capital additions, net of write-downs for other-than-temporary declines in fair value. Depreciation is calculated using the straight-line method based on the estimated useful life of each asset. If any real estate investment is considered held-for-sale, it is carried at the lower of its carrying value or fair value less estimated selling costs. The Company generally estimates fair value using net operating income and applying a capitalization rate in conjunction with comparable sales information. At the time of the sale, the difference between the sales price and the carrying value is recorded as a realized capital gain or loss.
- Privately-placed equity securities, which are carried on the consolidated balance sheets at cost less impairments, plus or minus subsequent adjustments for observable price changes. Additionally, as a member of the Federal Home Loan Bank of Boston ("FHLBB"), a subsidiary of the Company is required to purchase and hold shares of the FHLBB. These shares are restricted and carried at cost.

Net Investment Income
Net investment income on the Company's investments is recorded when earned and is reflected in the Company's net income (other than net investment income on assets supporting experience-rated products). Experience-rated products are products in the large case pensions business where the contract holder, not the Company, assumes investment and other risks, subject to, among other things, minimum guarantees provided by the Company. The effect of investment performance on experience-rated products is allocated to contract holders' accounts daily, based on the underlying investment experience and, therefore, does not impact the Company's net income (as long as the contract's minimum guarantees are not triggered). Net investment income on assets supporting large case pensions' experience-rated products is included in net investment income in the consolidated statements of operations and is credited to contract holders' accounts through a charge to benefit costs. The contract holders' accounts are reflected in policyholders' funds on the consolidated balance sheets.

Realized capital gains and losses on investments (other than realized capital gains and losses on investments supporting experience-rated products) are included as a component of net investment income in the consolidated statements of operations. Realized capital gains and losses are determined on a specific identification basis. Purchases and sales of debt and equity securities and alternative investments are reflected on the trade date. Purchases and sales of mortgage loans and investment real estate are reflected on the closing date.

Realized capital gains and losses on investments supporting large case pensions' experience-rated products are not included in realized capital gains and losses in the consolidated statements of operations and instead are credited directly to contract holders' accounts. The contract holders' accounts are reflected in policyholders' funds on the consolidated balance sheets.

Unrealized capital gains and losses on investments (other than unrealized capital gains and losses on investments supporting experience-rated products) are reflected in shareholders' equity, net of tax, as a component of accumulated other comprehensive income. Unrealized capital gains and losses on investments supporting large case pensions' experience-rated products are credited directly to contract holders' accounts. The contract holders' accounts are reflected in policyholders' funds on the consolidated balance sheets.

Derivative Financial Instruments

The Company uses derivative financial instruments in order to manage interest rate and foreign exchange risk and credit exposure. The Company's use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps.

Accounts Receivable

Accounts receivable are stated net of allowances for credit losses, customer credit allowances, contractual allowances and estimated terminations. Accounts receivable, net is composed of the following at December 31, 2021 and 2020:

In millions	2021	2020
Trade receivables	$ 7,932	$ 7,101
Vendor and manufacturer receivables	10,573	9,815
Premium receivables	2,537	2,628
Other receivables	3,389	2,198
Total accounts receivable, net	$ 24,431	$ 21,742

The Company's allowance for credit losses was $339 million and $358 million as of December 31, 2021 and 2020, respectively. When developing an estimate of the Company's expected credit losses, the Company considers all available relevant information regarding the collectability of cash flows, including historical information, current conditions and reasonable and supportable forecasts of future economic conditions over the contractual life of the receivable. The Company's accounts receivable are short duration in nature and typically settle in less than 30 days.

Inventories

Inventories are valued at the lower of cost or net realizable value using the weighted average cost method. Physical inventory counts are taken on a regular basis in each retail store and LTC pharmacy, and a continuous cycle count process is the primary procedure used to validate the inventory balances on hand in each distribution center and mail facility to ensure that the amounts reflected in the consolidated financial statements are properly stated. During the interim period between physical inventory counts, the Company accrues for anticipated physical inventory losses on a location-by-location basis based on historical results and current physical inventory trends.

Reinsurance Recoverables

The Company utilizes reinsurance agreements primarily to: (a) reduce required capital and (b) facilitate the acquisition or disposition of certain insurance contracts. Ceded reinsurance agreements permit the Company to recover a portion of its losses from reinsurers, although they do not discharge the Company's primary liability as the direct insurer of the risks reinsured. Failure of reinsurers to indemnify the Company could result in losses; however, the Company does not expect charges for unrecoverable reinsurance to have a material effect on its consolidated operating results or financial condition. The Company evaluates the financial condition of its reinsurers and monitors concentrations of credit risk arising from similar geographic regions, activities or economic characteristics of its reinsurers. At December 31, 2021, the Company's reinsurance recoverables consisted primarily of amounts due from third parties that are rated consistent with companies that are considered to have the ability to meet their obligations. Reinsurance recoverables are recorded as other current assets or other assets on the consolidated balance sheets.

Health Care Contract Acquisition Costs

Insurance products included in the Health Care Benefits segment are cancellable by either the customer or the member monthly upon written notice. Acquisition costs related to prepaid health care and health indemnity contracts are generally expensed as incurred. Acquisition costs for certain long-duration insurance contracts are deferred and are recorded as other current assets or other assets on the consolidated balance sheets and are amortized over the estimated life of the contracts. The amortization of deferred acquisition costs is recorded in operating expenses in the consolidated statements of operations. At December 31, 2021 and 2020, the balance of deferred acquisition costs was $895 million and $546 million, respectively, comprised primarily of commissions paid on Medicare Supplement products within the Health Care Benefits segment.

Property and Equipment

Property and equipment is reported at historical cost, net of accumulated depreciation. Property, equipment and improvements to leased premises are depreciated using the straight-line method over the estimated useful lives of the assets, or when applicable, the term of the lease, whichever is shorter. Estimated useful lives generally range from 1 to 40 years for buildings, building improvements and leasehold improvements and 3 to 10 years for fixtures, equipment and internally developed software. Repair and maintenance costs are charged directly to expense as incurred. Major renewals or replacements that

substantially extend the useful life of an asset are capitalized and depreciated. Application development stage costs for significant internally developed software projects are capitalized and depreciated.

Property and equipment consists of the following at December 31, 2021 and 2020:

In millions	**2021**	**2020**
Land	$ 2,038	$ 2,134
Building and improvements	4,225	3,950
Fixtures and equipment	13,619	13,125
Leasehold improvements	6,242	6,077
Software	7,426	6,020
Total property and equipment	33,550	31,306
Accumulated depreciation and amortization	(20,654)	(18,700)
Property and equipment, net	$ 12,896	$ 12,606

Depreciation expense (which includes the amortization of property and equipment under finance or capital leases) totaled $2.3 billion, $2.1 billion and $1.9 billion for the years ended December 31, 2021, 2020 and 2019, respectively. During the year ended December 31, 2021, the Company recorded an impairment on property and equipment of $261 million in connection with the planned closure of certain retail stores. See Note 6 ‘‘Leases’’ for additional information about this impairment charge as well as the Company’s finance leases.

Right-of-Use Assets and Lease Liabilities

The Company determines if an arrangement contains a lease at the inception of a contract. Right-of-use assets represent the Company’s right to use an underlying asset for the lease term and lease liabilities represent the Company’s obligation to make lease payments arising from the lease. Right-of-use assets and lease liabilities are recognized at the commencement date of the lease, renewal date of the lease or significant remodeling of the lease space based on the present value of the remaining future minimum lease payments. As the interest rate implicit in the Company’s leases is not readily determinable, the Company utilizes its incremental borrowing rate, determined by class of underlying asset, to discount the lease payments. The operating lease right-of-use assets also include lease payments made before commencement and are reduced by lease incentives.

The Company’s real estate leases typically contain options that permit renewals for additional periods of up to five years each. For real estate leases, the options to extend are not considered reasonably certain at lease commencement because the Company reevaluates each lease on a regular basis to consider the economic and strategic incentives of exercising the renewal options and regularly opens or closes stores to align with its operating strategy. Generally, the renewal option periods are not included within the lease term and the associated payments are not included in the measurement of the right-of-use asset and lease liability. Similarly, renewal options are not included in the lease term for non-real estate leases because they are not considered reasonably certain of being exercised at lease commencement. Leases with an initial term of 12 months or less are not recorded on the balance sheets, and lease expense is recognized on a straight-line basis over the term of the short-term lease.

For real estate leases, the Company accounts for lease components and nonlease components as a single lease component. Certain real estate leases require additional payments based on sales volume, as well as reimbursement for real estate taxes, common area maintenance and insurance, which are expensed as incurred as variable lease costs. Other real estate leases contain one fixed lease payment that includes real estate taxes, common area maintenance and insurance. These fixed payments are considered part of the lease payment and included in the right-of-use assets and lease liabilities.

See Note 6 ‘‘Leases’’ for additional information about right-of-use assets and lease liabilities.

Goodwill

The Company accounts for business combinations using the acquisition method of accounting, which requires the excess cost of an acquisition over the fair value of net assets acquired and identifiable intangible assets to be recorded as goodwill. Goodwill is not amortized, but is subject to impairment reviews annually, or more frequently if necessary, as further described in “Long-Lived Asset Impairment” below. See Note 5 ‘‘Goodwill and Other Intangibles’’ for additional information about goodwill.

Intangible Assets

The Company's identifiable intangible assets consist primarily of trademarks, trade names, customer contracts/relationships, covenants not to compete, technology, provider networks and value of business acquired ("VOBA"). These intangible assets arise primarily from the determination of their respective fair market values at the date of acquisition. Amounts assigned to identifiable intangible assets, and their related useful lives, are derived from established valuation techniques and management estimates.

The Company's definite-lived intangible assets are amortized over their estimated useful lives based upon the pattern of future cash flows attributable to the asset. Other than VOBA, definite-lived intangible assets are amortized using the straight-line method. VOBA is amortized over the expected life of the acquired contracts in proportion to estimated premiums. Indefinite-lived intangible assets are not amortized but are tested for impairment annually, or more frequently if necessary, as further described in "Long-Lived Asset Impairment" below.

See Note 5 ''Goodwill and Other Intangibles'' for additional information about intangible assets.

Long-Lived Asset Impairment

The Company evaluates the recoverability of long-lived assets, excluding goodwill and indefinite-lived intangible assets, which are tested for impairment using separate tests described below, whenever events or changes in circumstances indicate that the carrying value of such asset may not be recoverable. The Company groups and evaluates these long-lived assets for impairment at the lowest level at which individual cash flows can be identified. If indicators of impairment are present, the Company first compares the carrying amount of the asset group to the estimated future cash flows associated with the asset group (undiscounted). If the estimated future cash flows used in this analysis are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to the asset group's estimated future cash flows (discounted). If required, an impairment loss is recorded for the portion of the asset group's carrying value that exceeds the asset group's estimated future cash flows (discounted). During the year ended December 31, 2021, the Company recorded a store impairment charge of approximately $1.4 billion primarily related to the write down of operating lease right-of-use assets and property and equipment in connection with the planned closure of approximately 900 retail stores between 2022 and 2024. There were no material impairment charges recognized on long-lived assets in the year ended 2020. During the year ended December 31, 2019 the Company recorded a store impairment charge of $231 million primarily related to operating lease right-of-use assets. See Note 6 ''Leases'' for additional information about the right-of-use asset impairment charges.

When evaluating goodwill for potential impairment, the Company compares the fair value of its reporting units to their respective carrying amounts. The Company estimates the fair value of its reporting units using a combination of a discounted cash flow method and a market multiple method. If the carrying amount of a reporting unit exceeds its estimated fair value, an impairment loss is recognized in an amount equal to that excess. During the third quarter of 2021, the Company performed its required annual impairment tests of goodwill, the results of which indicated an impairment of the goodwill associated with the LTC reporting unit. Accordingly, during the third quarter of 2021, the Company recorded a $431 million goodwill impairment charge. The results of the impairment tests indicated that there was no impairment of goodwill of the remaining reporting units as of the testing date or during the year ended December 31, 2021. During the third quarter of both 2020 and 2019, the Company performed its required annual goodwill impairment tests and concluded there were no goodwill impairments as of the testing dates or during the years ended December 31, 2020 and 2019. See Note 5 ''Goodwill and Other Intangibles'' for additional information about the goodwill impairment charge recorded during the year ended December 31, 2021.

Indefinite-lived intangible assets are tested for impairment by comparing the estimated fair value of the asset to its carrying value. The Company estimates the fair value of its indefinite-lived trademarks using the relief from royalty method under the income approach. If the carrying value of the asset exceeds its estimated fair value, an impairment loss is recognized, and the asset is written down to its estimated fair value. There were no impairment losses recognized on indefinite-lived intangible assets in any of the years ended December 31, 2021, 2020 or 2019.

Separate Accounts

Separate Accounts assets and liabilities related to large case pensions products represent funds maintained to meet specific objectives of contract holders who bear the investment risk. These assets and liabilities are carried at fair value. Net investment income (including net realized capital gains and losses) accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from the Company's other businesses. Deposits, withdrawals and net

investment income (including net realized and net unrealized capital gains and losses) on Separate Accounts assets are not reflected in the consolidated statements of operations or cash flows. Management fees charged to contract holders are included in services revenue and recognized over the period earned.

Health Care Costs Payable

Health care costs payable consist principally of unpaid fee-for-service medical, dental and pharmacy claims, capitation costs, other amounts due to providers pursuant to risk-sharing arrangements related to the Health Care Benefits segment's Insured Commercial, Medicare and Medicaid products and accruals for state assessments. Unpaid health care claims include an estimate of payments the Company will make for (i) services rendered to the Company's Insured members but not yet reported to the Company and (ii) claims which have been reported to the Company but not yet paid, each as of the financial statement date (collectively, "IBNR"). Health care costs payable also include an estimate of the cost of services that will continue to be rendered after the financial statement date if the Company is obligated to pay for such services in accordance with contractual or regulatory requirements. Such estimates are developed using actuarial principles and assumptions which consider, among other things, historical and projected claim submission and processing patterns, assumed and historical medical cost trends, historical utilization of medical services, claim inventory levels, changes in Insured membership and product mix, seasonality and other relevant factors. The Company reflects changes in these estimates in benefit costs in the Company's consolidated operating results in the period they are determined. Capitation costs represent contractual monthly fees paid to participating physicians and other medical providers for providing medical care, regardless of the volume of medical services provided to the Insured member. Amounts due under risk-sharing arrangements are based on the terms of the underlying contracts with the providers and consider claims experience under the contracts through the financial statement date.

The Company develops its estimate of IBNR using actuarial principles and assumptions that consider numerous factors. Of those factors, the Company considers the analysis of historical and projected claim payment patterns (including claims submission and processing patterns) and the assumed health care cost trend rate (the year-over-year change in per member per month health care costs) to be the most critical assumptions. In developing its IBNR estimate, the Company consistently applies these actuarial principles and assumptions each period, with consideration to the variability of related factors. There have been no significant changes to the methodologies or assumptions used to develop the Company's estimate of IBNR in 2021.

The Company analyzes historical claim payment patterns by comparing claim incurred dates (i.e., the date services were provided) to claim payment dates to estimate "completion factors." The Company uses completion factors predominantly to estimate the ultimate cost of claims incurred more than three months before the financial statement date. The Company estimates completion factors by aggregating claim data based on the month of service and month of claim payment and estimating the percentage of claims incurred for a given month that are complete by each month thereafter. For any given month, substantially all claims are paid within six months of the date of service, but it can take up to 48 months or longer after the date of service before all of the claims are completely resolved and paid. These historically-derived completion factors are then applied to claims paid through the financial statement date to estimate the ultimate claim cost for a given month's incurred claim activity. The difference between the estimated ultimate claim cost and the claims paid through the financial statement date represents the Company's estimate of claims remaining to be paid as of the financial statement date and is included in the Company's health care costs payable. The completion factors the Company uses reflect judgments and possible adjustments based on data such as claim inventory levels, claim submission and processing patterns and, to a lesser extent, other factors such as changes in health care cost trend rates, changes in Insured membership and changes in product mix. If claims are submitted or processed on a faster (slower) pace than prior periods, the actual claims may be more (less) complete than originally estimated using the Company's completion factors, which may result in reserves that are higher (lower) than the ultimate cost of claims.

Because claims incurred within three months before the financial statement date are less mature, the Company uses a combination of historically-derived completion factors and the assumed health care cost trend rate to estimate the ultimate cost of claims incurred for these months. The Company applies its actuarial judgment and places a greater emphasis on the assumed health care cost trend rate for the most recent claim incurred dates as these months may be influenced by seasonal patterns and changes in membership and product mix.

The Company's health care cost trend rate is affected by changes in per member utilization of medical services as well as changes in the unit cost of such services. Many factors influence the health care cost trend rate, including the Company's ability to manage benefit costs through product design, negotiation of favorable provider contracts and medical management programs, as well as the mix of the Company's business. The health status of the Company's Insured members, aging of the population and other demographic characteristics, advances in medical technology and other factors continue to contribute to rising per member utilization and unit costs. Changes in health care practices, inflation, new technologies, increases in the cost of

prescription drugs (including specialty pharmacy drugs), direct-to-consumer marketing by pharmaceutical companies, clusters of high-cost cases, claim intensity, changes in the regulatory environment, health care provider or member fraud and numerous other factors also contribute to the cost of health care and the Company's health care cost trend rate.

For each reporting period, the Company uses an extensive degree of judgment in the process of estimating its health care costs payable. As a result, considerable variability and uncertainty is inherent in such estimates, particularly with respect to claims with claim incurred dates of three months or less before the financial statement date; and the adequacy of such estimates is highly sensitive to changes in assumed completion factors and the assumed health care cost trend rates. For each reporting period the Company recognizes the actuarial best estimate of health care costs payable considering the potential volatility in assumed completion factors and health care cost trend rates, as well as other factors. The Company believes its estimate of health care costs payable is reasonable and adequate to cover its obligations at December 31, 2021; however, actual claim payments may differ from the Company's estimates. A worsening (or improvement) of the Company's health care cost trend rates or changes in completion factors from those that the Company assumed in estimating health care costs payable at December 31, 2021 would cause these estimates to change in the near term, and such a change could be material.

Each quarter, the Company re-examines previously established health care costs payable estimates based on actual claim payments for prior periods and other changes in facts and circumstances. Given the extensive degree of judgment in this estimate, it is possible that the Company's estimates of health care costs payable could develop either favorably (that is, its actual benefit costs for the period were less than estimated) or unfavorably. The changes in the Company's estimate of health care costs payable may relate to a prior quarter, prior year or earlier periods. For a roll forward of the Company's health care costs payable, see Note 7 ''Health Care Costs Payable.'' The Company's reserving practice is to consistently recognize the actuarial best estimate of its ultimate liability for health care costs payable.

Other Insurance Liabilities

Unpaid Claims
Unpaid claims consist primarily of reserves associated with certain short-duration group disability and term life insurance contracts, including an estimate for IBNR as of the financial statement date. Reserves associated with certain short-duration group disability and term life insurance contracts are based upon the Company's estimate of the present value of future benefits, which is based on assumed investment yields and assumptions regarding mortality, morbidity and recoveries from the U.S. Social Security Administration. The Company develops its estimate of IBNR using actuarial principles and assumptions which consider, among other things, contractual requirements, claim incidence rates, claim recovery rates, seasonality and other relevant factors. The Company discounts certain claim liabilities related to group long-term disability and life insurance waiver of premium contracts. The discount rates generally reflect the Company's expected investment returns for the investments supporting all incurral years of these liabilities. The discount rates for retrospectively-rated contracts are set at contractually specified levels. The Company's estimates of unpaid claims are subject to change due to changes in the underlying experience of the insurance contracts, changes in investment yields or other factors, and these changes are recorded in current and future benefits in the consolidated statements of operations in the period they are determined. The Company estimates its reserve for claims IBNR for life products largely based on completion factors. The completion factors used are based on the Company's historical experience and reflect judgments and possible adjustments based on data such as claim inventory levels, claim payment patterns, changes in business volume and other factors. If claims are submitted or processed on a faster (slower) pace than historical periods, the actual claims may be more (less) complete than originally estimated using completion factors, which may result in reserves that are higher (lower) than required to cover future life benefit payments. There have been no significant changes to the methodologies or assumptions used to develop the Company's estimate of unpaid claims IBNR in 2021. As of December 31, 2021, unpaid claims balances of $324 million and $1.3 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively. As of December 31, 2020, unpaid claims balances of $532 million and $1.5 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively.

Substantially all life and disability insurance liabilities have been fully ceded to unrelated third parties through indemnity reinsurance agreements; however, the Company remains directly obligated to the policyholders.

Future Policy Benefits
Future policy benefits consist primarily of reserves for limited payment pension and annuity contracts and long-term care insurance contracts. Reserves for limited payment pension and annuity contracts are computed using actuarial principles that consider, among other things, assumptions reflecting anticipated mortality, retirement, expense and interest rate experience. Such assumptions generally vary by plan, year of issue and policy duration. Assumed interest rates on such contracts ranged from 3.0% to 11.3% in the year ended December 31, 2021 and from 3.3% to 11.3% in the year ended December 31, 2020. The Company periodically reviews mortality assumptions against both industry standards and its experience. Reserves for long-

duration long-term care contracts represent the Company's estimate of the present value of future benefits and essential maintenance expenses to be paid to or on behalf of policyholders less the present value of future gross premiums. The assumed interest rate on such contracts was 5.1% in both the years ended December 31, 2021 and 2020. The Company's estimate of the present value of future benefits under such contracts is based upon mortality, morbidity and interest rate assumptions. As of December 31, 2021, future policy benefits balances of $416 million and $5.1 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively. As of December 31, 2020, future policy benefits balances of $462 million and $5.5 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively.

Premium Deficiency Reserves

The Company evaluates its insurance contracts to determine if it is probable that a loss will be incurred. A premium deficiency loss is recognized when it is probable that expected future claims, including maintenance costs (for example, direct costs such as claim processing costs), will exceed existing reserves plus anticipated future premiums and reinsurance recoveries. Anticipated investment income is not considered in the calculation of premium deficiency losses for short-duration contracts. For purposes of determining premium deficiency losses, contracts are grouped consistent with the Company's method of acquiring, servicing and measuring the profitability of such contracts. As of December 31, 2021 and 2020, the Company established a premium deficiency reserve of $16 million and $11 million, respectively, related to Medicaid products in the Health Care Benefits segment.

Policyholders' Funds

Policyholders' funds consist primarily of reserves for pension and annuity investment contracts and customer funds associated with certain health contracts. Reserves for such contracts are equal to cumulative deposits less withdrawals and charges plus interest credited thereon, net of experience-rated adjustments. In 2021, interest rates for pension and annuity investment contracts ranged from 3.5% to 4.8%. In 2020, interest rates for pension and annuity investment contracts ranged from 4.1% to 5.1%. Reserves for contracts subject to experience rating reflect the Company's rights as well as the rights of policyholders and plan participants. The Company also holds funds for HSAs on behalf of members associated with high deductible health plans. These amounts are held to pay for qualified health care expenses incurred by these members. The HSA balances were approximately $2.9 billion and $2.7 billion at December 31, 2021 and 2020, respectively, and are reflected in other current assets with a corresponding liability in policyholders' funds. These assets are considered restricted cash for cash flow statement purposes.

Policyholders' funds liabilities that are expected to be paid within twelve months from the balance sheet date are classified as current on the consolidated balance sheets. Policyholders' funds liabilities that are expected to be paid greater than twelve months from the balance sheet date are included in other long-term liabilities on the consolidated balance sheets.

Self-Insurance Liabilities

The Company is self-insured for certain losses related to general liability, workers' compensation and auto liability. The Company obtains third party insurance coverage to limit exposure from these claims. The Company is also self-insured for certain losses related to health and medical liabilities. The Company's self-insurance accruals, which include reported claims and claims incurred but not reported, are calculated using standard insurance industry actuarial assumptions and the Company's historical claims experience. At December 31, 2021 and 2020, self-insurance liabilities totaled $1.1 billion and $927 million, respectively, and were recorded as accrued expenses on the consolidated balance sheets.

Foreign Currency Translation and Transactions

For non-U.S. dollar functional currency locations, (i) assets and liabilities are translated at end-of-period exchange rates, (ii) revenues and expenses are translated at average exchange rates in effect during the period and (iii) equity is translated at historical exchange rates. The resulting cumulative translation adjustments are included as a component of accumulated other comprehensive income.

For U.S. dollar functional currency locations, foreign currency assets and liabilities are remeasured into U.S. dollars at end-of-period exchange rates, except for nonmonetary balance sheet accounts which are remeasured at historical exchange rates. Revenues and expenses are remeasured at average exchange rates in effect during each period, except for those expenses related to the nonmonetary balance sheet amounts which are remeasured at historical exchange rates. Gains or losses from foreign currency remeasurement are included in net income.

Gains and losses from foreign currency transactions and the effects of foreign currency remeasurements were not material in the years ended December 31, 2021 or 2020. On July 1, 2019, the Company sold its Brazilian subsidiary, Drogaria Onofre Ltda. ("Onofre") for an immaterial amount. The Company recorded a loss on the divestiture, which included the elimination of the subsidiary's $154 million cumulative translation adjustment from accumulated other comprehensive income during the year ended December 31, 2019.

Revenue Recognition

Health Care Benefits Segment
Health Care Benefits revenue is principally derived from insurance premiums and fees billed to customers. Revenue is recognized based on customer billings, which, in the Company's Commercial business, reflect contracted rates per member and the number of covered members recorded in the Company's records at the time the billings are prepared. Billings are generally sent monthly for coverage during the following month. Revenue related to the Company's Government business is collected monthly from the U.S. federal government and various government agencies based on fixed payment rates and member eligibility.

The Company's billings may be subsequently adjusted to reflect enrollment changes due to member terminations or other factors. These adjustments are known as retroactivity adjustments. In each period, the Company estimates the amount of future retroactivity and adjusts the recorded revenue accordingly. As information regarding actual retroactivity amounts becomes known, the Company refines its estimates and records any required adjustments to revenues in the period in which they arise.

Premium Revenue
Premiums are recognized as revenue in the month in which the enrollee is entitled to receive health care services. Premiums are reported net of an allowance for estimated terminations and uncollectible amounts. Additionally, premium revenue subject to the minimum medical loss ratio ("MLR") rebate requirements of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (as amended, collectively, the "ACA") is recorded net of the estimated minimum MLR rebates for the current calendar year. Premiums related to unexpired contractual coverage periods (unearned premiums) are reported as other insurance liabilities on the consolidated balance sheets and recognized as revenue when earned.

Some of the Company's contracts allow for premiums to be adjusted to reflect actual experience or the relative health status of Insured members. Such adjustments are reasonably estimable at the outset of the contract, and adjustments to those estimates are made based on actual experience of the customer emerging under the contract and the terms of the underlying contract.

Services Revenue
Services revenue relates to contracts that can include various combinations of services or series of services which generally are capable of being distinct and accounted for as separate performance obligations. The Health Care Benefits segment's services revenue primarily consists of ASC fees received in exchange for performing certain claim processing and member services for ASC members. ASC fee revenue is recognized over the period the service is provided. Some of the Company's administrative services contracts include guarantees with respect to certain functions, such as customer service response time, claim processing accuracy and claim processing turnaround time, as well as certain guarantees that a plan sponsor's benefit claim experience will fall within a certain range. With any of these guarantees, the Company is financially at risk if the conditions of the arrangements are not met, although the maximum amount at risk typically is limited to a percentage of the fees otherwise payable to the Company by the customer involved. Each period the Company estimates its obligations under the terms of these guarantees and records its estimate as an offset to services revenues.

Accounting for Medicare Part D
Revenues include insurance premiums earned by the Company's PDPs, which are determined based on the PDP's annual bid and related contractual arrangements with the U.S. Centers for Medicare & Medicaid Services ("CMS"). The insurance premiums include a beneficiary premium, which is the responsibility of the PDP member, and can be subsidized by CMS in the case of low-income members, and a direct premium paid by CMS. Premiums collected in advance are initially recorded within other insurance liabilities and are then recognized ratably as revenue over the period in which members are entitled to receive benefits.

Revenues also include a risk-sharing feature of the Medicare Part D program design referred to as the risk corridor. The Company estimates variable consideration in the form of amounts payable to, or receivable from, CMS under the risk corridor, and adjusts revenue based on calculations of additional subsidies to be received from or owed to CMS at the end of the reporting year.

In addition to Medicare Part D premiums, the Company receives additional payments each month from CMS related to catastrophic reinsurance, low-income cost-sharing subsidies and coverage gap benefits. If the subsidies received differ from the amounts earned from actual prescriptions transferred, the difference is recorded in either accounts receivable, net or accrued expenses.

Pharmacy Services Segment
The Pharmacy Services segment sells prescription drugs directly through its mail service dispensing pharmacies and indirectly through the Company's retail pharmacy network. The Company's pharmacy benefit arrangements are accounted for in a manner consistent with a master supply arrangement as there are no contractual minimum volumes and each prescription is considered a separate purchasing decision and distinct performance obligation transferred at a point in time. PBM services performed in connection with each prescription claim are considered part of a single performance obligation which culminates in the dispensing of prescription drugs.

The Company recognizes revenue using the gross method at the contract price negotiated with its clients when the Company has concluded it controls the prescription drug before it is transferred to the client plan members. The Company controls prescriptions dispensed indirectly through its retail pharmacy network because it has separate contractual arrangements with those pharmacies, has discretion in setting the price for the transaction and assumes primary responsibility for fulfilling the promise to provide prescription drugs to its client plan members while also performing the related PBM services.

Revenues include (i) the portion of the price the client pays directly to the Company, net of any discounts earned on brand name drugs or other discounts and refunds paid back to the client (see "Drug Discounts" and "Guarantees" below), (ii) the price paid to the Company by client plan members for mail order prescriptions and the price paid to retail network pharmacies by client plan members for retail prescriptions ("retail co-payments"), and (iii) claims based administrative fees for retail pharmacy network contracts. Sales taxes are not included in revenues.

The Company recognizes revenue when control of the prescription drugs is transferred to customers, in an amount that reflects the consideration the Company expects to be entitled to receive in exchange for those prescription drugs. The Company has established the following revenue recognition policies for the Pharmacy Services segment:

- Revenues generated from prescription drugs sold by mail service dispensing pharmacies are recognized when the prescription drug is delivered to the client plan member. At the time of delivery, the Company has performed substantially all of its performance obligations under its client contracts and does not experience a significant level of returns or reshipments.
- Revenues generated from prescription drugs sold by third party pharmacies in the Company's retail pharmacy network and associated administrative fees are recognized at the Company's point-of-sale, which is when the claim is adjudicated by the Company's online claims processing system and the Company has transferred control of the prescription drug and completed all of its performance obligations.

For contracts under which the Company acts as an agent or does not control the prescription drugs prior to transfer to the client plan member, revenue is recognized using the net method.

Drug Discounts
The Company records revenue net of manufacturers' rebates earned by its clients based on their plan members' utilization of brand-name formulary drugs. The Company estimates these rebates at period-end based on actual and estimated claims data and its estimates of the manufacturers' rebates earned by its clients. The estimates are based on the best available data at period-end and recent history for the various factors that can affect the amount of rebates due to the client. The Company adjusts its rebates payable to clients to the actual amounts paid when these rebates are paid or as significant events occur. Any cumulative effect of these adjustments is recorded against revenues at the time it is identified. Adjustments generally result from contract changes with clients or manufacturers that have retroactive rebate adjustments, differences between the estimated and actual product mix subject to rebates, or whether the brand name drug was included in the applicable formulary. The effect of adjustments between estimated and actual manufacturers' rebate amounts has not been material to the Company's operating results or financial condition.

Guarantees
The Company also adjusts revenues for refunds owed to clients resulting from pricing guarantees and performance against defined service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's operating results or financial condition.

Retail/LTC Segment

Retail Pharmacy

The Company's retail drugstores recognize revenue at the time the customer takes possession of the merchandise. For pharmacy sales, each prescription claim is its own arrangement with the customer and is a performance obligation, separate and distinct from other prescription claims under other retail network arrangements. Revenues are adjusted for refunds owed to third party payers resulting from pricing guarantees and performance against defined value-based service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's operating results or financial condition.

Revenue from Company gift cards purchased by customers is deferred as a contract liability until goods or services are transferred. Any amounts not expected to be redeemed by customers (i.e., breakage) are recognized based on historical redemption patterns.

Customer returns are not material to the Company's operating results or financial condition. Sales taxes are not included in revenues.

Loyalty and Other Programs

The Company's customer loyalty program, ExtraCare®, consists of two components, ExtraSavings™ and ExtraBucks® Rewards. ExtraSavings are coupons that are recorded as a reduction of revenue when redeemed as the Company concluded that they do not represent a promise to the customer to deliver additional goods or services at the time of issuance because they are not tied to a specific transaction or spending level.

ExtraBucks Rewards are accumulated by customers based on their historical spending levels. Thus, the Company has determined that there is an additional performance obligation to those customers at the time of the initial transaction. The Company allocates the transaction price to the initial transaction and the ExtraBucks Rewards transaction based upon the relative standalone selling price, which considers historical redemption patterns for the rewards. Revenue allocated to ExtraBucks Rewards is recognized as those rewards are redeemed. At the end of each period, unredeemed ExtraBucks Rewards are reflected as a contract liability.

The Company also offers a subscription-based membership program, CarePass®, under which members are entitled to a suite of benefits delivered over the course of the subscription period, as well as a promotional reward that can be redeemed for future goods and services. Subscriptions are paid for on a monthly or annual basis at the time of or in advance of the Company delivering the goods and services. Revenue from these arrangements is recognized as the performance obligations are satisfied.

Long-term Care

Revenue is recognized when control of the promised goods or services is transferred to customers in an amount that reflects the consideration the Company expects to be entitled to receive in exchange for those goods or services. Each prescription claim represents a separate performance obligation of the Company, separate and distinct from other prescription claims under customer arrangements. A significant portion of long-term care revenue from sales of pharmaceutical and medical products is reimbursed by the federal Medicare Part D program and, to a lesser extent, state Medicaid programs. The Company monitors its revenues and receivables from these reimbursement sources, as well as long-term care facilities and other third party insurance payors, and reduces revenue at the revenue recognition date to properly account for the variable consideration due to anticipated differences between billed and reimbursed amounts. Accordingly, the total revenues and receivables reported in the Company's consolidated financial statements are recorded at the amount expected to be ultimately received from these payors.

Patient co-payments associated with Medicare Part D, certain state Medicaid programs, Medicare Part B and certain third party payors typically are not collected at the time products are delivered or services are rendered, but are billed to the individuals as part of normal billing procedures and subject to normal accounts receivable collections procedures.

Walk-In Medical Clinics

For services provided by the Company's walk-in medical clinics, revenue recognition occurs for completed services provided to patients, with adjustments taken for third party payor contractual obligations and patient direct bill historical collection rates.

Disaggregation of Revenue

The following table disaggregates the Company's revenue by major source in each segment for the years ended December 31, 2021, 2020 and 2019:

In millions	**Health Care Benefits**	**Pharmacy Services**	**Retail/ LTC**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
2021						
Major goods/services lines:						
Pharmacy	$ —	$ 152,262	$ 76,121	$ —	$ (43,765)	$ 184,618
Front Store	—	—	21,315	—	—	21,315
Premiums	76,064	—	—	68	—	76,132
Net investment income	586	—	17	596	—	1,199
Other	5,536	760	2,652	57	(158)	8,847
Total	$ 82,186	$ 153,022	$ 100,105	$ 721	$ (43,923)	$ 292,111
Pharmacy Services distribution channel:						
Pharmacy network [1]		$ 91,715				
Mail choice [2]		60,547				
Other		760				
Total		$ 153,022				
2020						
Major goods/services lines:						
Pharmacy	$ —	$ 141,116	$ 70,176	$ —	$ (40,003)	$ 171,289
Front Store	—	—	19,655	—	—	19,655
Premiums	69,301	—	—	63	—	69,364
Net investment income	483	—	—	315	—	798
Other	5,683	822	1,367	48	(320)	7,600
Total	$ 75,467	$ 141,938	$ 91,198	$ 426	$ (40,323)	$ 268,706
Pharmacy Services distribution channel:						
Pharmacy network [1]		$ 85,045				
Mail choice [2]		56,071				
Other		822				
Total		$ 141,938				
2019						
Major goods/services lines:						
Pharmacy	$ —	$ 140,896	$ 66,442	$ —	$ (41,413)	$ 165,925
Front Store	—	—	19,422	—	—	19,422
Premiums	63,031	—	—	91	—	63,122
Net investment income	599	—	—	412	—	1,011
Other	5,974	595	744	9	(26)	7,296
Total	$ 69,604	$ 141,491	$ 86,608	$ 512	$ (41,439)	$ 256,776
Pharmacy Services distribution channel:						
Pharmacy network [1]		$ 88,755				
Mail choice [2]		52,141				
Other		595				
Total		$ 141,491				

(1) Pharmacy Services pharmacy network is defined as claims filled at retail and specialty retail pharmacies, including the Company's retail pharmacies and LTC pharmacies, but excluding Maintenance Choice® activity, which is included within the mail choice category. Maintenance Choice permits eligible client plan members to fill their maintenance prescriptions through mail order delivery or at a CVS Pharmacy retail store for the same price as mail order.

(2) Pharmacy Services mail choice is defined as claims filled at a Pharmacy Services mail order facility, which includes specialty mail claims inclusive of Specialty Connect® claims picked up at a retail pharmacy, as well as prescriptions filled at the Company's retail pharmacies under the Maintenance Choice program.

Contract Balances

Contract liabilities primarily represent the Company's obligation to transfer additional goods or services to a customer for which the Company has received consideration, and include ExtraBucks Rewards and unredeemed Company gift cards. The consideration received remains a contract liability until goods or services have been provided to the customer. In addition, the Company recognizes breakage on Company gift cards based on historical redemption patterns.

The following table provides information about receivables and contract liabilities from contracts with customers as of December 31, 2021 and 2020:

In millions	**2021**	**2020**
Trade receivables (included in accounts receivable, net)	$ 7,932	$ 7,101
Contract liabilities (included in accrued expenses)	87	71

During the years ended December 31, 2021 and 2020, the contract liabilities balance includes increases related to customers' earnings in ExtraBucks Rewards or issuances of Company gift cards and decreases for revenues recognized during the period as a result of the redemption of ExtraBucks Rewards or Company gift cards and breakage of Company gift cards. Below is a summary of such changes:

In millions	**2021**	**2020**
Contract liabilities, beginning of period	$ 71	$ 73
Rewards earnings and gift card issuances	387	357
Redemption and breakage	(371)	(359)
Contract liabilities, end of period	$ 87	$ 71

Cost of Products Sold

The Company accounts for cost of products sold as follows:

Pharmacy Services Segment

Cost of products sold includes: (i) the cost of prescription drugs sold during the reporting period directly through the Company's mail service dispensing pharmacies and indirectly through the Company's retail pharmacy network, (ii) shipping and handling costs, and (iii) the operating costs of the Company's mail service dispensing pharmacies and client service operations and related information technology support costs including depreciation and amortization. The cost of prescription drugs sold component of cost of products sold includes: (i) the cost of the prescription drugs purchased from manufacturers or distributors and shipped to members in clients' benefit plans from the Company's mail service dispensing pharmacies, net of any volume-related or other discounts (see "Vendor Allowances and Purchase Discounts" below) and (ii) the cost of prescription drugs sold (including retail co-payments) through the Company's retail pharmacy network under contracts where the Company is the principal, net of any volume-related or other discounts.

Retail/LTC Segment

Cost of products sold includes: the cost of merchandise sold during the reporting period, including prescription drug costs, and the related purchasing costs, warehousing and delivery costs (including depreciation and amortization) and actual and estimated inventory losses.

Vendor Allowances and Purchase Discounts

The Company accounts for vendor allowances and purchase discounts as follows:

Pharmacy Services Segment

The Pharmacy Services segment receives purchase discounts on products purchased. Contractual arrangements with vendors, including manufacturers, wholesalers and retail pharmacies, normally provide for the Pharmacy Services segment to receive

purchase discounts from established list prices in one, or a combination, of the following forms: (i) a direct discount at the time of purchase, (ii) a discount for the prompt payment of invoices or (iii) when products are purchased indirectly from a manufacturer (e.g., through a wholesaler or retail pharmacy), a discount (or rebate) paid subsequent to dispensing. These rebates are recognized when prescriptions are dispensed and are generally calculated and billed to manufacturers within 30 days of the end of each completed quarter. Historically, the effect of adjustments resulting from the reconciliation of rebates recognized to the amounts billed and collected has not been material to the Company's operating results or financial condition. The Company accounts for the effect of any such differences as a change in accounting estimate in the period the reconciliation is completed. The Pharmacy Services segment also receives additional discounts under its wholesaler contracts if it exceeds contractually defined purchase volumes. In addition, the Pharmacy Services segment receives fees from pharmaceutical manufacturers for administrative services. Purchase discounts and administrative service fees are recorded as a reduction of cost of products sold.

Retail/LTC Segment
Vendor allowances received by the Retail/LTC segment reduce the carrying cost of inventory and are recognized in cost of products sold when the related inventory is sold, unless they are specifically identified as a reimbursement of incremental costs for promotional programs and/or other services provided. Amounts that are directly linked to advertising commitments are recognized as a reduction of advertising expense (included in operating expenses) when the related advertising commitment is satisfied. Any amounts received in excess of the actual cost incurred also reduce the carrying cost of inventory. The total value of any upfront payments received from vendors that are linked to purchase commitments is initially deferred. The deferred amounts are then amortized to reduce cost of products sold over the life of the contract based upon sales volume. The total value of any upfront payments received from vendors that are not linked to purchase commitments is also initially deferred. The deferred amounts are then amortized to reduce cost of products sold on a straight-line basis over the life of the related contract. The total amortization of these upfront payments was not material to the Company's consolidated financial statements in any of the periods presented.

Health Care Reform

Health Insurer Fee
Since January 1, 2014, the ACA has imposed an annual premium-based health insurer fee ("HIF") for each calendar year, payable in September, which was not deductible for tax purposes. The Company has been required to estimate a liability for the HIF at the beginning of the calendar year in which the fee was payable with a corresponding deferred asset that was amortized ratably to operating expenses over the calendar year. The Company recorded the liability for the HIF in accrued expenses and recorded the deferred asset in other current assets. In December 2019, the HIF was repealed for calendar years after 2020, therefore there was no expense related to the HIF in the year ended December 31, 2021. In the year ended December 31, 2020, operating expenses included $1.0 billion related to the Company's share of the HIF. There was no expense related to the HIF in 2019, since there was a one-year suspension of the HIF for 2019.

Risk Adjustment
The ACA established a permanent risk adjustment program to transfer funds from qualified individual and small group insurance plans with below average risk scores to plans with above average risk scores. Based on the risk of the Company's qualified plan members relative to the average risk of members of other qualified plans in comparable markets, as defined by the ACA, the Company estimates its ultimate risk adjustment receivable (recorded in accounts receivable) or payable (recorded in accrued expenses) for the current calendar year and reflects the pro-rata year-to-date impact as an adjustment to premium revenue.

Risk Corridor
The ACA established a temporary risk corridor program, which expired at the end of 2016, for qualified individual and small group health insurance plans. Under this program, health insurance companies were to make payments to, or receive payments from, the U.S. Department of Health and Human Services ("HHS") based on their ratio of allowable costs to target costs (as defined by the ACA).

The Company filed a lawsuit in August 2019 to recover the $313 million it was owed under the ACA's risk corridor program, which had been stayed pending the Supreme Court decision. In April 2020, the U.S. Supreme Court ruled that health insurance companies may sue the federal government for amounts owed as calculated under the ACA's temporary risk corridor program.

In October 2020, the Company received the $313 million it was owed under the ACA's risk corridor program. The Company recorded the risk corridor payment as an increase to premium revenue in the year ended December 31, 2020. After considering

offsetting items such as the ACA's minimum MLR rebate requirements and premium taxes, the Company recorded pre-tax income of $307 million and after-tax income of $223 million during the year ended December 31, 2020.

Advertising Costs

Advertising costs, which are reduced by the portion funded by vendors, are expensed when the related advertising takes place. Net advertising costs, which are included in operating expenses, were $523 million, $461 million and $396 million in 2021, 2020 and 2019, respectively.

Stock-Based Compensation

Stock-based compensation is measured at the grant date based on the fair value of the award and is recognized as expense over the requisite service period of the stock award (generally three to five years) using the straight-line method.

Income Taxes

The Company accounts for income taxes under the asset and liability method, which requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of events that have been included in the consolidated financial statements. Under this method, deferred tax assets and liabilities are determined on the basis of the differences between the consolidated financial statements and tax basis of assets and liabilities using enacted tax rates in effect for the year or years in which the differences are expected to reverse. The effect of a change in the tax rates on deferred tax assets and liabilities is recognized in income in the period that includes the enactment date of such change.

The Company recognizes deferred tax assets to the extent that it believes these assets are more likely than not to be realized. In making such a determination, the Company considers all available positive and negative evidence, including future reversals of existing taxable temporary differences, projected future taxable income, tax planning strategies, and the Company's recent operating results. The Company establishes a valuation allowance when it does not consider it more likely than not that a deferred tax asset will be recovered.

The Company records uncertain tax positions on the basis of a two-step process whereby (1) the Company determines whether it is more likely than not that the tax positions will be sustained on the basis of the technical merits of the position and (2) for those tax positions that meet the more-likely-than-not recognition threshold, the Company recognizes the largest amount of tax benefit that is more than 50% likely to be realized upon ultimate settlement with the related tax authority.

Interest and/or penalties related to uncertain tax positions are recognized in the income tax provision.

Measurement of Defined Benefit Pension and Other Postretirement Employee Benefit Plans

The Company sponsors defined benefit pension plans ("pension plans") and other postretirement employee benefit plans ("OPEB plans") for its employees and retirees. The Company recognizes the funded status of its pension and OPEB plans on the consolidated balance sheets based on the year-end measurements of plan assets and benefit obligations. When the fair value of plan assets are in excess of the plan benefit obligations, the amounts are reported in other current assets and other assets. When the fair value of plan benefit obligations are in excess of plan assets, the amounts are reported in accrued expenses and other long-term 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. The net periodic benefit cost (income) for the Company's pension and OPEB plans do not contain a service cost component as these plans have been frozen for an extended period of time. Non-service cost components of pension and postretirement net periodic benefit cost (income) are included in other income in the consolidated statements of operations.

Earnings per Share

Earnings per share is computed using the two-class method. The Company calculates basic earnings per share based on the weighted average number of common shares outstanding for the period. See Note 14 ''Earnings Per Share'' for additional information.

Shares Held in Trust

The Company maintains grantor trusts, which held approximately one million shares of its common stock at both December 31, 2021 and 2020. These shares are designated for use under various employee compensation plans. Since the Company holds these shares, they are excluded from the computation of basic and diluted shares outstanding.

Variable Interest Entities

The Company has investments in (i) a generic pharmaceutical sourcing entity, (ii) certain hedge fund and private equity investments and (iii) certain real estate partnerships that are considered VIEs. The Company does not have a future obligation to fund losses or debts on behalf of these investments; however, it may voluntarily contribute funds. In evaluating whether the Company is the primary beneficiary of a VIE, the Company considers several factors, including whether the Company has (a) the power to direct the activities that most significantly impact the VIE's economic performance and (b) the obligation to absorb losses and the right to receive benefits that could potentially be significant to the VIE.

Variable Interest Entities - Primary Beneficiary
In 2014, the Company and Cardinal Health, Inc. ("Cardinal") established Red Oak Sourcing, LLC ("Red Oak"), a generic pharmaceutical sourcing entity in which the Company and Cardinal each own 50%. The Red Oak arrangement had an initial term of ten years. In 2021, the Red Oak arrangement was amended to extend the initial term an additional five years, for a total term of 15 years. Under this arrangement, the Company and Cardinal contributed their sourcing and supply chain expertise to Red Oak and agreed to source and negotiate generic pharmaceutical supply contracts for both companies through Red Oak; however, Red Oak does not own or hold inventory on behalf of either company. No physical assets (e.g., property and equipment) were contributed to Red Oak by either company, and minimal funding was provided to capitalize Red Oak. The Company has determined that it is the primary beneficiary of this VIE because it has the ability to direct the activities of Red Oak. Consequently, the Company consolidates Red Oak in its consolidated financial statements within the Retail/LTC segment.

Cardinal is required to pay the Company quarterly payments, which began in October 2014 and will extend through June 2029. As milestones are met, the quarterly payments increase. The Company received $183 million from Cardinal during each of the years ended December 31, 2021, 2020 and 2019. The payments reduce the Company's carrying value of inventory and are recognized in cost of products sold when the related inventory is sold. Amounts reimbursed by Cardinal for the years ended December 31, 2021, 2020 and 2019, and amounts due to or due from Cardinal at December 31, 2021 and 2020 were immaterial.

Variable Interest Entities - Other Variable Interest Holder
The Company has invested in certain VIEs for which it has determined that it is not the primary beneficiary, consisting of the following:

- *Hedge fund and private equity investments* - The Company invests in hedge fund and private equity investments in order to generate investment returns for its investment portfolio supporting its insurance businesses.
- *Real estate partnerships* - The Company invests in various real estate partnerships, including those that construct, own and manage low-income housing developments. For the low income housing development investments, substantially all of the projected benefits to the Company are from tax credits and other tax benefits.

The Company is not the primary beneficiary of these VIEs because the nature of the Company's involvement with the activities of these VIEs does not give the Company the power to direct the activities that most significantly impact their economic performance. The Company records the amount of its investment in these VIEs as long-term investments on the consolidated balance sheets and recognizes its share of each VIE's income or losses in net income (loss). The Company's maximum exposure to loss from these VIEs is limited to its investment balances as disclosed below and the risk of recapture of previously recognized tax credits related to the real estate partnerships, which the Company does not consider significant.

The total amount of other variable interest holder VIE assets included in long-term investments on the consolidated balance sheets at December 31, 2021 and 2020 was as follows:

In millions	**2021**	**2020**
Hedge fund investments	$ 463	$ 342
Private equity investments	601	547
Real estate partnerships	225	200
Total	$ 1,289	$ 1,089

Related Party Transactions

The Company has an equity method investment in SureScripts, LLC ("SureScripts"), which operates a clinical health information network. The Company utilizes this clinical health information network in providing services to its client plan members and retail customers. The Company expensed fees for the use of this network of $52 million, $56 million and $32 million in the years ended December 31, 2021, 2020 and 2019, respectively. The Company's investment in and equity in the earnings of SureScripts for all periods presented is immaterial.

The Company has an equity method investment in Heartland Healthcare Services, LLC ("Heartland"). Heartland operates several LTC pharmacies in four states. Heartland paid the Company $79 million, $77 million and $96 million for pharmaceutical inventory purchases during the years ended December 31, 2021, 2020 and 2019, respectively. Additionally, the Company performs certain collection functions for Heartland and then transfers those customer cash collections to Heartland. The Company's investment in and equity in the earnings of Heartland for all periods presented is immaterial.

During the years ended December 31, 2021, 2020 and 2019, the Company made charitable contributions of $50 million, $50 million and $30 million, respectively, to the CVS Health Foundation, a non-profit entity that focuses on health, education and community involvement programs. The charitable contributions were recorded as operating expenses in the consolidated statements of operations within the Corporate/Other segment for the years ended December 31, 2021, 2020 and 2019.

Discontinued Operations

In connection with certain business dispositions completed between 1995 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Linens 'n Things and Bob's Stores, each of which subsequently filed for bankruptcy. The Company's loss from discontinued operations includes lease-related costs that the Company believes it will likely be required to satisfy pursuant to these lease guarantees. See "Lease Guarantees" in Note 16 ''Commitments and Contingencies'' for additional information.

Below is a summary of the results of discontinued operations for the year ended December 31, 2020.

In millions	**2020**
Loss from discontinued operations	$ (12)
Income tax benefit	3
Loss from discontinued operations, net of tax	$ (9)

Results from discontinued operations were immaterial for the years ended December 31, 2021 and 2019.

New Accounting Pronouncements Recently Adopted

Simplifying the Accounting for Income Taxes
In December 2019, the Financial Accounting Standards Board ("FASB") issued ASU 2019-12, *Simplifying the Accounting for Income Taxes* (Topic 740). This standard simplifies the accounting for income taxes by eliminating certain exceptions to the guidance in Accounting Standards Codification 740 related to the approach for intraperiod tax allocation, the methodology for calculating income taxes in an interim period and the recognition of deferred tax liabilities for outside basis differences. The standard also simplifies aspects of the accounting for franchise taxes and enacted changes in tax laws or rates and clarifies the accounting for transactions that result in a step-up in the tax basis of goodwill. The Company adopted this new accounting standard on January 1, 2021. The adoption of this standard did not have a material impact on the Company's consolidated operating results, cash flows, financial condition or related disclosures.

New Accounting Pronouncements Not Yet Adopted

Targeted Improvements to the Accounting for Long-Duration Insurance Contracts
In August 2018, the FASB issued ASU 2018-12, *Targeted Improvements to the Accounting for Long-Duration Contracts* (Topic 944). 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 liability 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 and requires additional disclosures regarding the long duration insurance contract liabilities in the Company's interim and annual financial statements. The standard is effective for public companies for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2022. The Company will adopt the new standard on January 1, 2023, using the modified retrospective transition method as of the earliest period presented for changes to the liability for future policy benefits and deferred acquisition costs. While the Company is still evaluating the impact of the new standard on its financial statements, the Company anticipates an increase to its liability for future policy benefits with a corresponding change in accumulated other comprehensive income as a result of updating the rate used to discount the liabilities to reflect the yield for an upper-medium grade fixed-income instrument compared to the Company's expected investment yield under the existing guidance.

2. Divestitures

Divestiture of Workers' Compensation Business

On July 31, 2020, the Company sold its Workers' Compensation business for approximately $850 million. The results of this business were reported within the Health Care Benefits segment. The Company recorded a pre-tax gain on the divestiture of $269 million in the year ended December 31, 2020, which is reflected as a reduction in operating expenses in the Company's consolidated statement of operations within the Health Care Benefits segment.

Divestiture of Brazilian Subsidiary

On July 1, 2019, the Company sold its Brazilian subsidiary, Onofre, for an immaterial amount. Onofre operated 50 retail pharmacy stores, the results of which historically had been reported within the Retail/LTC segment. The Company recorded a pre-tax loss on the divestiture of $205 million in the year ended December 31, 2019, which primarily relates to the elimination of the cumulative translation adjustment from accumulated other comprehensive income and is reflected in operating expenses in the Company's consolidated statement of operations within the Retail/LTC segment.

3. Investments

Total investments at December 31, 2021 and 2020 were as follows:

	2021			2020		
In millions	**Current**	**Long-term**	**Total**	**Current**	**Long-term**	**Total**
Debt securities available for sale	$ 3,009	$ 20,231	$ 23,240	$ 2,774	$ 18,414	$ 21,188
Mortgage loans	58	844	902	226	821	1,047
Other investments	50	1,950	2,000	—	1,577	1,577
Total investments	$ 3,117	$ 23,025	$ 26,142	$ 3,000	$ 20,812	$ 23,812

At December 31, 2021 and 2020, the Company held investments of $450 million and $524 million, respectively, related to the 2012 conversion of an existing group annuity contract from a participating to a non-participating contract. These investments are included in the total investments of large case pensions supporting non-experience-rated products. Although these investments are not accounted for as Separate Accounts assets, they are legally segregated and are not subject to claims that arise out of the Company's business and only support future policy benefits obligations under that group annuity contract.

Debt Securities

Debt securities available for sale at December 31, 2021 and 2020 were as follows:

In millions	Amortized Cost [1]	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2021				
Debt securities:				
U.S. government securities	$ 2,349	$ 70	$ (3)	$ 2,416
States, municipalities and political subdivisions	2,947	148	(4)	3,091
U.S. corporate securities	9,093	682	(40)	9,735
Foreign securities	2,821	196	(24)	2,993
Residential mortgage-backed securities	870	15	(10)	875
Commercial mortgage-backed securities	1,278	44	(12)	1,310
Other asset-backed securities	2,791	14	(13)	2,792
Redeemable preferred securities	25	3	—	28
Total debt securities [2]	$ 22,174	$ 1,172	$ (106)	$ 23,240
December 31, 2020				
Debt securities:				
U.S. government securities	$ 2,341	$ 128	$ —	$ 2,469
States, municipalities and political subdivisions	2,556	172	—	2,728
U.S. corporate securities	7,879	1,023	(8)	8,894
Foreign securities	2,595	324	(1)	2,918
Residential mortgage-backed securities	673	32	—	705
Commercial mortgage-backed securities	962	84	—	1,046
Other asset-backed securities	2,369	36	(2)	2,403
Redeemable preferred securities	21	4	—	25
Total debt securities [2]	$ 19,396	$ 1,803	$ (11)	$ 21,188

(1) There was no allowance for expected credit losses recorded on available-for-sale debt securities at December 31, 2021 or 2020.

(2) Investment risks associated with the Company's experience-rated products generally do not impact the Company's consolidated operating results. At December 31, 2021, debt securities with a fair value of $864 million, gross unrealized capital gains of $94 million and gross unrealized capital losses of $2 million and at December 31, 2020, debt securities with a fair value of $919 million, gross unrealized capital gains of $135 million and no gross unrealized capital losses were included in total debt securities, but support experience-rated products. Changes in net unrealized capital gains (losses) on these securities are not reflected in accumulated other comprehensive income.

The amortized cost and fair value of debt securities at December 31, 2021 are shown below by contractual maturity. Actual maturities may differ from contractual maturities because securities may be restructured, called or prepaid, or the Company intends to sell a security prior to maturity.

In millions	Amortized Cost	Fair Value
Due to mature:		
Less than one year	$ 1,205	$ 1,218
One year through five years	6,965	7,142
After five years through ten years	4,733	4,910
Greater than ten years	4,332	4,993
Residential mortgage-backed securities	870	875
Commercial mortgage-backed securities	1,278	1,310
Other asset-backed securities	2,791	2,792
Total	$ 22,174	$ 23,240

Mortgage-Backed and Other Asset-Backed Securities
All of the Company's residential mortgage-backed securities at December 31, 2021 were issued by the Government National Mortgage Association, the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation and carry agency guarantees and explicit or implicit guarantees by the U.S. Government. At December 31, 2021, the Company's residential mortgage-backed securities had an average credit quality rating of AAA and a weighted average duration of 4.7 years.

The Company's commercial mortgage-backed securities have underlying loans that are dispersed throughout the United States. Significant market observable inputs used to value these securities include loss severity and probability of default. At December 31, 2021, these securities had an average credit quality rating of AAA and a weighted average duration of 6.1 years.

The Company's other asset-backed securities have a variety of underlying collateral (e.g., automobile loans, credit card receivables, home equity loans and commercial loans). Significant market observable inputs used to value these securities include the unemployment rate, loss severity and probability of default. At December 31, 2021, these securities had an average credit quality rating of AA and a weighted average duration of 1.0 year.

Summarized below are the debt securities the Company held at December 31, 2021 and 2020 that were in an unrealized capital loss position, aggregated by the length of time the investments have been in that position:

	Less than 12 months			Greater than 12 months			Total		
In millions, except number of securities	**Number of Securities**	**Fair Value**	**Unrealized Losses**	**Number of Securities**	**Fair Value**	**Unrealized Losses**	**Number of Securities**	**Fair Value**	**Unrealized Losses**
December 31, 2021									
Debt securities:									
U.S. government securities	43	$ 242	$ 2	10	$ 40	$ 1	53	$ 282	$ 3
States, municipalities and political subdivisions	233	428	3	13	33	1	246	461	4
U.S. corporate securities	1,610	2,296	31	165	238	9	1,775	2,534	40
Foreign securities	449	747	20	57	91	4	506	838	24
Residential mortgage-backed securities	165	593	9	10	36	1	175	629	10
Commercial mortgage-backed securities	188	462	7	35	112	5	223	574	12
Other asset-backed securities	1,011	2,030	12	26	31	1	1,037	2,061	13
Redeemable preferred securities	1	2	—	1	3	—	2	5	—
Total debt securities	3,700	$ 6,800	$ 84	317	$ 584	$ 22	4,017	$ 7,384	$ 106
December 31, 2020									
Debt securities:									
U.S. government securities	32	$ 205	$ —	—	$ —	$ —	32	$ 205	$ —
States, municipalities and political subdivisions	49	83	—	—	—	—	49	83	—
U.S. corporate securities	145	155	8	2	—	—	147	155	8
Foreign securities	41	69	1	5	5	—	46	74	1
Residential mortgage-backed securities	23	26	—	3	—	—	26	26	—
Commercial mortgage-backed securities	22	75	—	—	—	—	22	75	—
Other asset-backed securities	156	256	1	49	41	1	205	297	2
Total debt securities	468	$ 869	$ 10	59	$ 46	$ 1	527	$ 915	$ 11

The Company reviewed the securities in the table above and concluded that they are performing assets generating investment income to support the needs of the Company's business. In performing this review, the Company considered factors such as the quality of the investment security based on research performed by the Company's internal credit analysts and external rating agencies and the prospects of realizing the carrying value of the security based on the investment's current prospects for recovery. Unrealized capital losses at December 31, 2021 were generally caused by interest rate increases and not by unfavorable changes in the credit quality associated with these securities. As of December 31, 2021, the Company did not intend to sell these securities, and did not believe it was more likely than not that it would be required to sell these securities prior to the anticipated recovery of their amortized cost basis.

The maturity dates for debt securities in an unrealized capital loss position at December 31, 2021 were as follows:

	Supporting experience-rated products		Supporting remaining products		Total	
In millions	**Fair Value**	**Unrealized Losses**	**Fair Value**	**Unrealized Losses**	**Fair Value**	**Unrealized Losses**
Due to mature:						
Less than one year	$ 2	$ —	$ 49	$ 1	$ 51	$ 1
One year through five years	13	1	2,229	32	2,242	33
After five years through ten years	33	1	1,332	26	1,365	27
Greater than ten years	17	—	445	10	462	10
Residential mortgage-backed securities	4	—	625	10	629	10
Commercial mortgage-backed securities	6	—	568	12	574	12
Other asset-backed securities	4	—	2,057	13	2,061	13
Total	$ 79	$ 2	$ 7,305	$ 104	$ 7,384	$ 106

Mortgage Loans

The Company's mortgage loans are collateralized by commercial real estate. During the years ended December 31, 2021 and 2020, the Company had the following activity in its mortgage loan portfolio:

In millions	**2021**	**2020**
New mortgage loans	$ 262	$ 63
Mortgage loans fully repaid	373	187
Mortgage loans foreclosed	—	—

The Company assesses mortgage loans on a regular basis for credit impairments, and assigns a credit quality indicator to each loan. The Company's credit quality indicator is internally developed and categorizes each loan in its portfolio on a scale from 1 to 7. These indicators are based upon several factors, including current loan-to-value ratios, current and future property cash flow, property condition, market trends, creditworthiness of the borrower and deal structure.

- *Category 1* - Represents loans of superior quality.
- *Categories 2 to 4* - Represent loans where credit risk is minimal to acceptable; however, these loans may display some susceptibility to economic changes.
- *Categories 5 and 6* - Represent loans where credit risk is not substantial, but these loans warrant management's close attention.
- *Category 7* - Represents loans where collections are potentially at risk; if necessary, an impairment is recorded.

Based upon the Company's assessments at December 31, 2021 and 2020, the amortized cost basis of the Company's mortgage loans within each credit quality indicator by year of origination was as follows:

	Amortized Cost Basis by Year of Origination						
In millions, except credit quality indicator	**2021**	**2020**	**2019**	**2018**	**2017**	**Prior**	**Total**
December 31, 2021							
1	$ —	$ —	$ —	$ —	$ —	$ 28	$ 28
2 to 4	255	48	40	72	97	349	861
5 and 6	—	—	—	3	4	6	13
7	—	—	—	—	—	—	—
Total	$ 255	$ 48	$ 40	$ 75	$ 101	$ 383	$ 902
December 31, 2020							
1		$ —	$ —	$ —	$ 22	$ 37	$ 59
2 to 4		46	96	91	124	595	952
5 and 6		—	—	3	4	29	36
7		—	—	—	—	—	—
Total		$ 46	$ 96	$ 94	$ 150	$ 661	$ 1,047

At December 31, 2021 scheduled mortgage loan principal repayments were as follows:

In millions	
2022	$ 58
2023	100
2024	210
2025	76
2026	177
Thereafter	281
Total	$ 902

Net Investment Income

Sources of net investment income for the years ended December 31, 2021, 2020 and 2019 were as follows:

In millions	**2021**	**2020**	**2019**
Debt securities	$ 634	$ 598	$ 589
Mortgage loans	55	60	71
Other investments	381	123	194
Gross investment income	1,070	781	854
Investment expenses	(47)	(35)	(42)
Net investment income (excluding net realized capital gains or losses)	1,023	746	812
Net realized capital gains [(1)]	176	52	199
Net investment income [(2)]	$ 1,199	$ 798	$ 1,011

(1) Net realized capital gains are net of yield-related impairment losses on debt securities of $42 million and $49 million for the years ended December 31, 2021 and 2020, respectively. There were no credit-related losses on debt securities in the years ended December 31, 2021 and 2020. Net realized capital gains are net of other-than-temporary impairment ("OTTI") losses on debt securities of $24 million for the year ended December 31, 2019.

(2) Net investment income includes $38 million, $42 million and $44 million for the years ended December 31, 2021, 2020 and 2019, respectively, related to investments supporting experience-rated products.

Capital gains and losses recognized during the year ended December 31, 2021 related to investments in equity securities held as of December 31, 2021 were not material.

Excluding amounts related to experience-rated products, proceeds from the sale of available-for-sale debt securities and the related gross realized capital gains and losses in the years ended December 31, 2021, 2020 and 2019 were as follows:

In millions	**2021**	**2020**	**2019**
Proceeds from sales	$ 3,572	$ 3,913	$ 4,773
Gross realized capital gains	72	80	146
Gross realized capital losses	14	62	17

4. Fair Value

The preparation of the Company's consolidated financial statements in accordance with GAAP requires certain assets and liabilities to be reflected at their fair value and others to be reflected on another basis, such as an adjusted historical cost basis. In this note, the Company provides details on the fair value of financial assets and liabilities and how it determines those fair values. The Company presents this information for those financial instruments that are measured at fair value for which the change in fair value impacts net income attributable to CVS Health or other comprehensive income separately from other financial assets and liabilities.

Financial Instruments Measured at Fair Value on the Consolidated Balance Sheets

Certain of the Company's financial instruments are measured at fair value on the consolidated balance sheets. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by GAAP. The following are the levels of the hierarchy and a brief description of the type of valuation information ("valuation inputs") that qualifies a financial asset or liability for each level:

- Level 1 – Unadjusted quoted prices for identical assets or liabilities in active markets.
- Level 2 – Valuation inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, valuation inputs that are observable that are not prices (such as interest rates and credit risks) and valuation inputs that are derived from or corroborated by observable markets.
- Level 3 – Developed from unobservable data, reflecting the Company's assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, the Company uses these quoted market prices to determine the fair value of financial assets and liabilities and classifies these assets and liabilities in Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, the Company estimates fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities are classified in Level 2. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

The following is a description of the valuation methodologies used for the Company's financial assets and liabilities that are measured at fair value, including the general classification of such assets and liabilities pursuant to the valuation hierarchy.

Cash and Cash Equivalents – The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. When quoted prices are available in an active market, cash equivalents are classified in Level 1 of the fair value hierarchy. Fair values of cash equivalent instruments that do not trade on a regular basis in active markets are classified as Level 2.

Debt Securities – Where quoted prices are available in an active market, debt securities are classified in Level 1 of the fair value hierarchy. The Company's Level 1 debt securities consist primarily of U.S. Treasury securities.

The fair values of the Company's Level 2 debt securities are obtained using models, such as matrix pricing, which use quoted market prices of debt securities with similar characteristics or discounted cash flows to estimate fair value. The

Company reviews these prices to ensure they are based on observable market inputs that include quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets and inputs that are observable that are not prices (such as interest rates and credit risks). The Company also reviews the methodologies and the assumptions used to calculate prices from these observable inputs. On a quarterly basis, the Company selects a sample of its Level 2 debt securities' prices and compares them to prices provided by a secondary source. Variances over a specified threshold are identified and reviewed to confirm the price provided by the primary source represents an appropriate estimate of fair value. In addition, the Company's internal investment team consistently compares the prices obtained for select Level 2 debt securities to the team's own independent estimates of fair value for those securities. The Company obtained one price for each of its Level 2 debt securities and did not adjust any of those prices at December 31, 2021 or 2020.

The Company also values certain debt securities using Level 3 inputs. For Level 3 debt securities, fair values are determined by outside brokers or, in the case of certain private placement securities, are priced internally. Outside brokers determine the value of these debt securities through a combination of their knowledge of the current pricing environment and market flows. The Company did not have any broker quoted debt securities for the years ended December 31, 2021 and 2020. For some private placement securities, the Company's internal staff determines the value of these debt securities by analyzing spreads of corporate and sector indices as well as interest spreads of comparable public bonds. Examples of these private placement Level 3 debt securities include certain U.S. and foreign securities and certain tax-exempt municipal securities.

Equity Securities – The Company currently has two classifications of equity securities: those that are publicly traded and those that are privately placed. Publicly-traded equity securities are classified in Level 1 because quoted prices are available for these securities in an active market. For privately placed equity securities, there is no active market; therefore, these securities are classified in Level 3 because the Company prices these securities through an internal analysis of each investment's financial statements and cash flow projections. Significant unobservable inputs consist of earnings and revenue multiples, discount for lack of marketability and comparability adjustments. An increase or decrease in any of these unobservable inputs would have resulted in a change in the fair value measurement.

There were no financial liabilities measured at fair value on a recurring basis on the consolidated balance sheets at December 31, 2021 or 2020. Financial assets measured at fair value on a recurring basis on the consolidated balance sheets at December 31, 2021 and 2020 were as follows:

In millions	**Level 1**	**Level 2**	**Level 3**	**Total**
December 31, 2021				
Cash and cash equivalents	$ 4,954	$ 4,454	$ —	$ 9,408
Debt securities:				
U.S. government securities	2,372	44	—	2,416
States, municipalities and political subdivisions	—	3,086	5	3,091
U.S. corporate securities	—	9,697	38	9,735
Foreign securities	—	2,983	10	2,993
Residential mortgage-backed securities	—	875	—	875
Commercial mortgage-backed securities	—	1,310	—	1,310
Other asset-backed securities	—	2,789	3	2,792
Redeemable preferred securities	—	28	—	28
Total debt securities	2,372	20,812	56	23,240
Equity securities	114	—	55	169
Total	$ 7,440	$ 25,266	$ 111	$ 32,817
December 31, 2020				
Cash and cash equivalents	$ 3,985	$ 3,869	$ —	$ 7,854
Debt securities:				
U.S. government securities	2,370	99	—	2,469
States, municipalities and political subdivisions	—	2,727	1	2,728
U.S. corporate securities	—	8,842	52	8,894
Foreign securities	—	2,918	—	2,918
Residential mortgage-backed securities	—	705	—	705
Commercial mortgage-backed securities	—	1,046	—	1,046
Other asset-backed securities	—	2,403	—	2,403
Redeemable preferred securities	—	24	1	25
Total debt securities	2,370	18,764	54	21,188
Equity securities	17	—	30	47
Total	$ 6,372	$ 22,633	$ 84	$ 29,089

The changes in the balances of Level 3 financial assets during the year ended December 31, 2021 were as follows:

In millions	States, municipalities and political subdivisions	U.S. corporate securities	Foreign securities	Other asset-backed securities	Redeemable preferred securities	Equity securities	Total
Beginning balance	$ 1	$ 52	$ —	$ —	$ 1	$ 30	$ 84
Net realized and unrealized capital gains (losses):							
Included in earnings	—	(10)	—	—	2	13	5
Included in other comprehensive income	—	(3)	—	—	(1)	—	(4)
Purchases	—	1	—	3	—	13	17
Sales	(1)	(1)	—	—	(2)	(1)	(5)
Settlements	—	(1)	—	—	—	—	(1)
Transfers into Level 3, net	5	—	10	—	—	—	15
Ending balance	$ 5	$ 38	$ 10	$ 3	$ —	$ 55	$ 111

The change in unrealized capital losses included in other comprehensive income associated with Level 3 financial assets which were held as of December 31, 2021 was $4 million during the year ended December 31, 2021.

The changes in the balances of Level 3 financial assets during the year ended December 31, 2020 were as follows:

In millions	States, municipalities and political subdivisions	U.S. corporate securities	Redeemable preferred securities	Equity securities	Total
Beginning balance	$ —	$ 37	$ 12	$ 39	$ 88
Net realized and unrealized capital gains (losses):					
Included in earnings	—	(11)	18	(3)	4
Included in other comprehensive income	—	—	(5)	—	(5)
Purchases	—	27	—	3	30
Sales	—	—	(24)	(9)	(33)
Settlements	—	(1)	—	—	(1)
Transfers into Level 3, net	1	—	—	—	1
Ending balance	$ 1	$ 52	$ 1	$ 30	$ 84

The change in unrealized capital losses included in other comprehensive income associated with Level 3 financial assets which were held as of December 31, 2020 was $4 million during the year ended December 31, 2020.

The total gross transfers into (out of) Level 3 during the years ended December 31, 2021 and 2020 were as follows:

In millions	2021	2020
Gross transfers into Level 3	$ 15	$ 1
Gross transfers out of Level 3	—	—
Net transfers into Level 3	$ 15	$ 1

Financial Instruments Not Measured at Fair Value on the Consolidated Balance Sheets

The carrying value and estimated fair value classified by level of fair value hierarchy for financial instruments carried on the consolidated balance sheets at adjusted cost or contract value at December 31, 2021 and 2020 were as follows:

	Carrying	Estimated Fair Value			
In millions	**Value**	**Level 1**	**Level 2**	**Level 3**	**Total**
December 31, 2021					
Assets:					
Mortgage loans	$ 902	$ —	$ —	$ 907	$ 907
Equity securities [1]	126	N/A	N/A	N/A	N/A
Liabilities:					
Investment contract liabilities:					
With a fixed maturity	5	—	—	5	5
Without a fixed maturity	336	—	—	373	373
Long-term debt	56,176	64,157	—	—	64,157
December 31, 2020					
Assets:					
Mortgage loans	$ 1,047	$ —	$ —	$ 1,070	$ 1,070
Equity securities [1]	145	N/A	N/A	N/A	N/A
Liabilities:					
Investment contract liabilities:					
With a fixed maturity	5	—	—	5	5
Without a fixed maturity	322	—	—	371	371
Long-term debt	64,647	75,940	—	—	75,940

(1) It was not practical to estimate the fair value of these cost-method investments as it represents shares of unlisted companies. See Note 1 ‘‘Significant Accounting Policies’’ for additional information regarding the valuation of cost method investments.

Separate Accounts Measured at Fair Value on the Consolidated Balance Sheets

Separate Accounts assets relate to the Company’s large case pensions products which represent funds maintained to meet specific objectives of contract holders. Since contract holders bear the investment risk of these assets, a corresponding Separate Accounts liability has been established equal to the assets. These assets and liabilities are carried at fair value. Net investment income and capital gains and losses on Separate Accounts assets accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from the Company’s other businesses. Deposits, withdrawals, net investment income and realized and unrealized capital gains and losses on Separate Accounts assets are not reflected in the consolidated statements of operations, shareholders’ equity or cash flows.

Separate Accounts assets include debt and equity securities. The valuation methodologies used for these assets are similar to the methodologies described above in this Note 4 ‘‘Fair Value.’’ Separate Accounts assets also include investments in common/collective trusts that are carried at fair value. Common/collective trusts invest in other investment funds otherwise known as the underlying funds. The Separate Accounts’ interests in the common/collective trust funds are based on the fair values of the investments of the underlying funds and therefore are classified in Level 2. The assets in the underlying funds primarily consist of equity securities. Investments in common/collective trust funds are valued at their respective net asset value (“NAV”) per share/unit on the valuation date.

Separate Accounts financial assets at December 31, 2021 and 2020 were as follows:

	December 31, 2021				December 31, 2020			
In millions	**Level 1**	**Level 2**	**Level 3**	**Total**	**Level 1**	**Level 2**	**Level 3**	**Total**
Cash and cash equivalents	$ 2	$ 186	$ —	$ 188	$ 2	$ 186	$ —	$ 188
Debt securities	1,233	3,048	—	4,281	1,465	2,634	—	4,099
Equity securities	—	1	—	1	—	2	—	2
Common/collective trusts	—	547	—	547	—	563	—	563
Total [1]	$ 1,235	$ 3,782	$ —	$ 5,017	$ 1,467	$ 3,385	$ —	$ 4,852

(1) Excludes $70 million and $29 million of other receivables at December 31, 2021 and 2020, respectively.

During the years ended December 31, 2021 and 2020, the Company had no gross transfers of Separate Accounts financial assets into or out of Level 3.

5. Goodwill and Other Intangibles

Goodwill

Below is a summary of the changes in the carrying amount of goodwill by segment for the years ended December 31, 2021 and 2020:

In millions	**Health Care Benefits**	**Pharmacy Services**	**Retail/ LTC**	**Total**
Balance at December 31, 2019	$ 45,361	$ 23,581	$ 10,807	$ 79,749
Acquisitions	274	34	—	308
Divestiture of Workers' Compensation business	(505)	—	—	(505)
Balance at December 31, 2020	45,130	23,615	10,807	79,552
Impairment	—	—	(431)	(431)
Balance at December 31, 2021	$ 45,130	$ 23,615	$ 10,376	$ 79,121

During the year ended December 31, 2021, the decrease in the carrying amount of goodwill was primarily driven by a goodwill impairment charge related to the LTC reporting unit within the Retail/LTC segment. During the year ended December 31, 2020, the decrease in the carrying amount of goodwill was primarily driven by the divestiture of the Workers' Compensation business, partially offset by goodwill associated with immaterial acquisitions. See Note 2 ''Divestitures'' for further discussion regarding the Workers' Compensation business divestiture.

During the third quarter of 2021, the Company performed its required annual impairment tests of goodwill. The results of the impairment tests indicated an impairment of the goodwill associated with the LTC reporting unit, as the reporting unit's carrying value exceeded its fair value as of the testing date. The results of the impairment tests of the remaining reporting units indicated that there was no impairment of goodwill as of the testing date.

During 2021, the LTC reporting unit has continued to face challenges that have impacted the Company's ability to grow the LTC reporting unit's business at the rate estimated when its 2020 goodwill impairment test was performed. These challenges include lower net facility admissions, net long-term care facility customer losses and the prolonged adverse impact of the COVID-19 pandemic and the emerging new variants, which resulted in more significant declines in occupancy rates experienced by the Company's long-term care facility customers than previously anticipated. During the third quarter of 2021, LTC management updated their 2021 annual forecast and submitted their long-term plan which showed deterioration in the financial results for the remainder of 2021 and beyond. The Company utilized these updated projections in performing its annual impairment test, which indicated that the fair value of the LTC reporting unit was lower than its carrying value, resulting in a $431 million goodwill impairment charge in the third quarter of 2021. The fair value of the LTC reporting unit was determined using a combination of a discounted cash flow method and a market multiple method. As of December 31, 2021, there was no remaining goodwill balance in the LTC reporting unit. During the third quarter of 2021, the Company also performed an impairment test of the intangible assets of the LTC reporting unit and concluded these assets were not impaired. As of December 31, 2021, there was $2.7 billion of intangible assets related to customer lists in the LTC reporting unit.

During the third quarter of 2020, the Company performed its required annual impairment tests of goodwill. The results of the impairment tests indicated that there was no impairment of goodwill.

At December 31, 2021 and 2020, cumulative goodwill impairments were $6.6 billion and $6.1 billion, respectively.

Intangible Assets

The following table is a summary of the Company's intangible assets as of December 31, 2021 and 2020:

In millions, except weighted average life	**Gross Carrying Amount**	**Accumulated Amortization**	**Net Carrying Amount**	**Weighted Average Life (years)**
2021				
Trademarks (indefinite-lived)	$ 10,498	$ —	$ 10,498	N/A
Customer contracts/relationships and covenants not to compete	25,084	(10,564)	14,520	15.0
Technology	1,060	(1,060)	—	3.0
Provider networks	4,203	(651)	3,552	20.0
Value of Business Acquired	590	(173)	417	20.0
Other	318	(279)	39	8.4
Total	$ 41,753	$ (12,727)	$ 29,026	15.3
2020				
Trademarks (indefinite-lived)	$ 10,498	$ —	$ 10,498	N/A
Customer contracts/relationships and covenants not to compete	24,952	(8,923)	16,029	14.9
Technology	1,060	(739)	321	3.0
Provider networks	4,203	(440)	3,763	20.0
Value of Business Acquired	590	(119)	471	20.0
Other	320	(260)	60	7.7
Total	$ 41,623	$ (10,481)	$ 31,142	15.2

Amortization expense for intangible assets totaled $2.3 billion, $2.3 billion and $2.4 billion for the years ended December 31, 2021, 2020 and 2019, respectively. The projected annual amortization expense for the Company's intangible assets for the next five years is as follows:

In millions	
2022	$ 1,858
2023	1,826
2024	1,785
2025	1,734
2026	1,494

6. Leases

The Company leases most of its retail stores and mail order facilities and certain distribution centers and corporate offices under operating or finance leases, typically with initial terms of 15 to 25 years. The Company also leases certain equipment and other assets under operating or finance leases, typically with initial terms of 3 to 10 years.

In addition, the Company leases pharmacy space at the stores of another retail chain for which the noncancelable contractual term of the pharmacy lease arrangement exceeds the remaining estimated economic life of the buildings. For these pharmacy lease arrangements, the Company concluded that for accounting purposes the lease term was the remaining estimated economic life of the buildings. Consequently, most of these individual pharmacy leases are finance leases.

The following table is a summary of the components of net lease cost for the years ended December 31, 2021, 2020 and 2019:

In millions	**2021**	**2020**	**2019**
Operating lease cost	$ 2,633	$ 2,670	$ 2,720
Finance lease cost:			
Amortization of right-of-use assets	62	56	38
Interest on lease liabilities	62	58	44
Total finance lease costs	124	114	82
Short-term lease costs	25	22	24
Variable lease costs	604	599	581
Less: sublease income	59	55	50
Net lease cost	$ 3,327	$ 3,350	$ 3,357

Supplemental cash flow information related to leases for the years ended December 31, 2021, 2020 and 2019 is as follows:

In millions	**2021**	**2020**	**2019**
Cash paid for amounts included in the measurement of lease liabilities:			
Operating cash flows paid for operating leases	$ 2,714	$ 2,724	$ 2,701
Operating cash flows paid for interest portion of finance leases	62	58	44
Financing cash flows paid for principal portion of finance leases	50	34	26
Right-of-use assets obtained in exchange for lease obligations:			
Operating leases	1,254	1,679	1,824
Finance leases	278	313	283

Supplemental balance sheet information related to leases as of December 31, 2021 and 2020 is as follows:

In millions, except remaining lease term and discount rate	2021	2020
Operating leases:		
Operating lease right-of-use assets	$ 19,122	$ 20,729
Current portion of operating lease liabilities	$ 1,646	$ 1,638
Long-term operating lease liabilities	18,177	18,757
Total operating lease liabilities	$ 19,823	$ 20,395
Finance leases:		
Property and equipment, gross	$ 1,375	$ 1,107
Accumulated depreciation	(188)	(106)
Property and equipment, net	$ 1,187	$ 1,001
Current portion of long-term debt	$ 50	$ 33
Long-term debt	1,250	1,050
Total finance lease liabilities	$ 1,300	$ 1,083
Weighted average remaining lease term *(in years)*		
Operating leases	12.8	13.3
Finance leases	20.0	20.3
Weighted average discount rate		
Operating leases	4.4 %	4.5 %
Finance leases	5.0 %	5.6 %

The following table summarizes the maturity of lease liabilities under finance and operating leases as of December 31, 2021:

In millions	Finance Leases	Operating Leases [1]	Total
2022	$ 122	$ 2,685	$ 2,807
2023	121	2,613	2,734
2024	111	2,398	2,509
2025	110	2,217	2,327
2026	109	2,054	2,163
Thereafter	1,495	14,103	15,598
Total lease payments [2]	2,068	26,070	28,138
Less: imputed interest	(768)	(6,247)	(7,015)
Total lease liabilities	$ 1,300	$ 19,823	$ 21,123

(1) Future operating lease payments have not been reduced by minimum sublease rentals of $311 million due in the future under noncancelable subleases.
(2) The Company leases pharmacy and clinic space from Target Corporation. Amounts related to such finance and operating leases are reflected above. Pharmacy lease amounts due in excess of the remaining estimated economic life of the buildings of approximately $2.4 billion are not reflected in this table since the estimated economic life of the buildings is shorter than the contractual term of the pharmacy lease arrangement.

Sale-Leaseback Transactions

The Company finances a portion of its store development program through sale-leaseback transactions. The properties are generally sold at net book value, which generally approximates fair value, and the resulting leases generally qualify and are accounted for as operating leases. The operating leases that resulted from these transactions are included in the tables above. The Company does not have any retained or contingent interests in the stores and does not provide any guarantees, other than a

guarantee of lease payments, in connection with the sale-leaseback transactions. There were no sale-leaseback transactions in 2021. Proceeds from sale-leaseback transactions totaled $101 million and $5 million in the years ended December 31, 2020 and 2019, respectively. Gains from sale-leaseback transactions totaled $3 million in the year ended December 31, 2020. There were no material gains from sale-leaseback transactions in the year ended December 31, 2019.

Store Impairment Charges
The Company evaluates its retail store right-of-use and property and equipment assets for impairment at the retail store level, which is the lowest level at which cash flows can be identified. For retail stores where there is an indicator of impairment present, the Company first compares the carrying amount of the asset group to the estimated future cash flows associated with the asset group (undiscounted). If the estimated undiscounted future cash flows used in the analysis are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to its estimated fair value which is the greater of the asset group's estimated future cash flows (discounted), or the consideration of what a market participant would pay to lease the assets, net of leasing costs. The Company's estimate of fair value considers historical results, current operating trends, consolidated sales, profitability and cash flow results and forecasts. For assets which the Company has determined it will be able to sublease, the estimated future cash flows include the estimated sublease income, net of estimated leasing costs.

When the carrying value of an asset group exceeds its estimated fair value, an impairment loss is recorded to reduce the value of the asset group to its estimated fair value. As the impaired assets are measured at fair value on a nonrecurring basis primarily using unobservable inputs as of the measurement date, the assets are classified in Level 3 of the fair value hierarchy.

During the fourth quarter of 2021, the Company completed a strategic review of its retail business and announced the creation of new formats for its stores to continue to drive higher engagement with customers. As part of this review, the Company evaluated changes in population, consumer buying patterns and future health needs to ensure it has the right kinds of stores in the right locations for consumers and for the business. In connection with this initiative, on November 17, 2021, the Board of Directors of CVS Health Corporation (the "Board") authorized the closing of approximately 900 retail stores over the next three years. The Company expects to close approximately 300 stores each year between 2022 and 2024. As a result, management determined that there were indicators of impairment with respect to the impacted stores' asset groups, including the associated operating lease right-of-use assets and property and equipment. A long-lived asset impairment test was performed during the fourth quarter of 2021 and the results of the impairment test indicated that the fair value of certain retail store asset groups was lower than their respective carrying values. Accordingly, in the three months ended December 31, 2021, the Company recorded a store impairment charge of approximately $1.4 billion, consisting of a write down of approximately $1.1 billion related to operating lease right-of-use assets and $261 million related to property and equipment, within the Retail/LTC segment. Subsequent to the impairment loss, the fair value of the associated operating lease right-of use assets and property and equipment were $356 million and $185 million, respectively.

During 2019, the Company performed reviews of its retail stores and determined it would close 68 underperforming retail pharmacy stores. As a result, management determined that there were indicators of impairment with respect to the impacted stores, including the associated operating lease right-of-use assets. Long-lived asset impairment tests were performed and the results indicated that the fair value of those underperforming retail stores were lower than their respective carrying values. Accordingly, the Company recorded store impairment charges of $231 million during the year ended December 31, 2019, primarily related to these operating lease right-of-use asset impairment charges, within the Retail/LTC segment.

7. Health Care Costs Payable

The following is information about incurred and cumulative paid health care claims development as of December 31, 2021, net of reinsurance, and the total IBNR liabilities plus expected development on reported claims included within the net incurred claims amounts. See Note 1 ‘‘Significant Accounting Policies’’ for information on how the Company estimates IBNR reserves and health care costs payable as well as changes to those methodologies, if any. The Company’s estimate of IBNR liabilities is primarily based on trend and completion factors. Claim frequency is not used in the calculation of the Company’s liability. In addition, it is impracticable to disclose claim frequency information for health care claims due to the Company’s inability to gather consistent claim frequency information across its multiple claims processing systems. Any claim frequency count disclosure would not be comparable across the Company’s different claim processing systems and would not be consistent from period to period based on the volume of claims processed through each system. As a result, health care claim count frequency is not included in the disclosures below.

The information about incurred and paid health care claims development for the year ended December 31, 2020 is presented as required unaudited supplemental information.

In millions	**Incurred Health Care Claims, Net of Reinsurance For the Years Ended December 31,**	
Date of Service	**2020**	**2021**
	(Unaudited)	
2020	$ 54,529	$ 53,804
2021		62,830
	Total	$ 116,634

In millions	**Cumulative Paid Health Care Claims, Net of Reinsurance For the Years Ended December 31,**	
Date of Service	**2020**	**2021**
	(Unaudited)	
2020	$ 47,567	$ 53,590
2021		54,600
	Total	$ 108,190
All outstanding liabilities for health care costs payable prior to 2020, net of reinsurance		130
Total outstanding liabilities for health care costs payable, net of reinsurance		$ 8,574

At December 31, 2021, the Company’s liabilities for IBNR plus expected development on reported claims totaled approximately $6.6 billion. Substantially all of the Company’s liabilities for IBNR plus expected development on reported claims at December 31, 2021 related to the current calendar year.

The reconciliation of the December 31, 2021 health care net incurred and paid claims development tables to the health care costs payable liability on the consolidated balance sheet is as follows:

In millions	**December 31, 2021**
Short-duration health care costs payable, net of reinsurance	$ 8,574
Reinsurance recoverables	8
Premium deficiency reserve	16
Insurance lines other than short duration	210
Total health care costs payable	$ 8,808

The following table shows the components of the change in health care costs payable during the years ended December 31, 2021, 2020 and 2019:

In millions	**2021**	**2020**	**2019**
Health care costs payable, beginning of period	$ 7,936	$ 6,879	$ 6,147
Less: Reinsurance recoverables	10	5	4
Health care costs payable, beginning of period, net	7,926	6,874	6,143
Acquisitions, net	—	414	—
Add: Components of incurred health care costs			
Current year	64,761	55,835	52,723
Prior years	(788)	(429)	(524)
Total incurred health care costs [1]	63,973	55,406	52,199
Less: Claims paid			
Current year	56,323	48,770	46,158
Prior years	6,792	6,009	5,314
Total claims paid	63,115	54,779	51,472
Add: Premium deficiency reserve	16	11	4
Health care costs payable, end of period, net	8,800	7,926	6,874
Add: Reinsurance recoverables	8	10	5
Health care costs payable, end of period	$ 8,808	$ 7,936	$ 6,879

(1) Total incurred health care costs for the years ended December 31, 2021, 2020 and 2019 in the table above exclude (i) $16 million, $11 million and $4 million, respectively, for a premium deficiency reserve related to the Company's Medicaid products, (ii) $59 million, $41 million and $41 million, respectively, of benefit costs recorded in the Health Care Benefits segment that are included in other insurance liabilities on the consolidated balance sheets and (iii) $212 million, $221 million and $285 million, respectively, of benefit costs recorded in the Corporate/Other segment that are included in other insurance liabilities on the consolidated balance sheets.

The Company's estimates of prior years' health care costs payable decreased by $788 million, $429 million and $524 million in 2021, 2020 and 2019, respectively, because claims were settled for amounts less than originally estimated (i.e., the amount of claims incurred was lower than originally estimated), primarily due to lower health care cost trends as well as the actual claim submission time being faster than originally assumed (i.e., the Company's completion factors were higher than originally assumed) in estimating health care costs payable at the end of the prior year. This development does not directly correspond to an increase in the Company's operating results as these reductions were offset by estimated current period health care costs when the Company established the estimate of the current year health care costs payable.

8. Borrowings and Credit Agreements

The following table is a summary of the Company's borrowings as of December 31, 2021 and 2020:

In millions	2021	2020
Long-term debt		
3.35% senior notes due March 2021	$ —	$ 2,038
Floating rate notes due March 2021 (0.950% at December 31, 2020)	—	1,000
4.125% senior notes due May 2021	—	222
2.125% senior notes due June 2021	—	1,750
4.125% senior notes due June 2021	—	203
5.45% senior notes due June 2021	—	187
3.5% senior notes due July 2022	1,500	1,500
2.75% senior notes due November 2022	1,000	1,000
2.75% senior notes due December 2022	1,250	1,250
4.75% senior notes due December 2022	399	399
3.7% senior notes due March 2023	—	2,336
2.8% senior notes due June 2023	1,300	1,300
4% senior notes due December 2023	414	414
3.375% senior notes due August 2024	650	650
2.625% senior notes due August 2024	1,000	1,000
3.5% senior notes due November 2024	750	750
5% senior notes due December 2024	299	299
4.1% senior notes due March 2025	950	950
3.875% senior notes due July 2025	2,828	2,828
2.875% senior notes due June 2026	1,750	1,750
3% senior notes due August 2026	750	750
3.625% senior notes due April 2027	750	750
6.25% senior notes due June 2027	372	372
1.3% senior notes due August 2027	2,250	2,250
4.3% senior notes due March 2028	5,000	7,050
3.25% senior notes due August 2029	1,750	1,750
3.75% senior notes due April 2030	1,500	1,500
1.75% senior notes due August 2030	1,250	1,250
1.875% senior notes due February 2031	1,250	1,250
2.125% senior notes due September 2031	1,000	—
4.875% senior notes due July 2035	652	652
6.625% senior notes due June 2036	771	771
6.75% senior notes due December 2037	533	533
4.78% senior notes due March 2038	5,000	5,000
6.125% senior notes due September 2039	447	447
4.125% senior notes due April 2040	1,000	1,000
2.7% senior notes due August 2040	1,250	1,250
5.75% senior notes due May 2041	133	133
4.5% senior notes due May 2042	500	500
4.125% senior notes due November 2042	500	500
5.3% senior notes due December 2043	750	750
4.75% senior notes due March 2044	375	375
5.125% senior notes due July 2045	3,500	3,500
3.875% senior notes due August 2047	1,000	1,000
5.05% senior notes due March 2048	8,000	8,000
4.25% senior notes due April 2050	750	750
Finance lease liabilities	1,300	1,083
Other	320	326
Total debt principal	56,743	65,318
Debt premiums	219	238
Debt discounts and deferred financing costs	(786)	(909)
	56,176	64,647
Less:		
Current portion of long-term debt	(4,205)	(5,440)
Long-term debt	$ 51,971	$ 59,207

The following is a summary of the Company's required repayments of debt principal due during each of the next five years and thereafter, as of December 31, 2021:

In millions		
2022	$	4,154
2023		1,719
2024		2,706
2025		3,785
2026		2,507
Thereafter		40,572
Subtotal		55,443
Finance lease liabilities [(1)]		1,300
Total debt principal	$	56,743

(1) See Note 6 ''Leases'' for a summary of maturities of the Company's finance lease liabilities.

Short-term Borrowings

Commercial Paper and Back-up Credit Facilities
The Company did not have any commercial paper outstanding as of December 31, 2021 or 2020. In connection with its commercial paper program, the Company maintains a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 17, 2023, a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 16, 2024, and a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 11, 2026. The credit facilities allow for borrowings at various rates that are dependent, in part, on the Company's public debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately 0.03%, regardless of usage. As of December 31, 2021 and 2020, there were no borrowings outstanding under any of the Company's back-up credit facilities.

Federal Home Loan Bank of Boston ("FHLBB")
A subsidiary of the Company is a member of the FHLBB. As a member, the subsidiary has the ability to obtain cash advances, subject to certain minimum collateral requirements. The maximum borrowing capacity available from the FHLBB as of December 31, 2021 was approximately $995 million. At both December 31, 2021 and 2020, there were no outstanding advances from the FHLBB.

Long-term Borrowings

2021 Notes
On August 18, 2021, the Company issued $1.0 billion aggregate principal amount of 2.125% unsecured senior notes due September 15, 2031 for total proceeds of $987 million, net of discounts, underwriting fees and offering expenses. The net proceeds of this offering were used for the purchase of senior notes in connection with the Company's cash tender offer in August 2021 as described below.

2020 Notes
On December 16, 2020, the Company issued $750 million aggregate principal amount of 1.3% unsecured senior notes due August 21, 2027 and $1.25 billion aggregate principal amount of 1.875% unsecured senior notes due February 28, 2031 for total proceeds of approximately $1.99 billion, net of discounts and underwriting fees. The $750 million aggregate principal amount of 1.3% unsecured senior notes represent a further issuance of the Company's 1.3% unsecured senior notes due August 21, 2027 initially issued in an aggregate principal amount of $1.5 billion on August 21, 2020.

On August 21, 2020, the Company issued $1.5 billion aggregate principal amount of 1.3% unsecured senior notes due August 21, 2027, $1.25 billion aggregate principal amount of 1.75% unsecured senior notes due August 21, 2030 and $1.25 billion aggregate principal amount of 2.7% unsecured senior notes due August 21, 2040 (collectively, the "August 2020 Notes") for total proceeds of approximately $3.97 billion, net of discounts and underwriting fees.

On March 31, 2020, the Company issued $750 million aggregate principal amount of 3.625% unsecured senior notes due April 1, 2027, $1.5 billion aggregate principal amount of 3.75% unsecured senior notes due April 1, 2030, $1.0 billion aggregate principal amount of 4.125% unsecured senior notes due April 1, 2040 and $750 million aggregate principal amount of 4.25%

unsecured senior notes due April 1, 2050 (collectively, the “March 2020 Notes”) for total proceeds of approximately $3.95 billion, net of discounts and underwriting fees.

The net proceeds of these offerings were used for general corporate purposes, which may include working capital, capital expenditures, as well as the repurchase and/or repayment of indebtedness.

During March 2020, the Company entered into several interest rate swap transactions to manage interest rate risk. These agreements were designated as cash flow hedges and were used to hedge the exposure to variability in future cash flows resulting from changes in interest rates related to the anticipated issuance of the March 2020 Notes. In connection with the issuance of the March 2020 Notes, the Company terminated all outstanding cash flow hedges. The Company paid a net amount of $7 million to the hedge counterparties upon termination, which was recorded as a loss, net of tax, of $5 million in accumulated other comprehensive income and will be reclassified as interest expense over the life of the March 2020 Notes. See Note 13 ‘‘Other Comprehensive Income’’ for additional information.

Early Extinguishments of Debt
In December 2021, the Company redeemed for cash the remaining $2.3 billion of its outstanding 3.7% senior notes due 2023. In connection with the early redemption of such senior notes, the Company paid a make-whole premium of $80 million in excess of the aggregate principal amount of the senior notes that were redeemed, wrote-off $8 million of unamortized deferred financing costs and incurred $1 million in fees, for a total loss on early extinguishment of debt of $89 million.

In August 2021, the Company purchased approximately $2.0 billion of its outstanding 4.3% senior notes due 2028 through a cash tender offer. In connection with the purchase of such senior notes, the Company paid a premium of $332 million in excess of the aggregate principal amount of the senior notes that were purchased, wrote-off $26 million of unamortized deferred financing costs and incurred $5 million in fees, for a total loss on early extinguishment of debt of $363 million.

In December 2020, the Company purchased $4.5 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $113 million of its 4.0% senior notes due 2023, $1.4 billion of its 3.7% senior notes due 2023, $1.0 billion of its 4.1% senior notes due 2025 and $2.0 billion of its 4.3% senior notes due 2028. In connection with the purchase of such senior notes, the Company paid a premium of $619 million in excess of the aggregate principal amount of the senior notes that were purchased, wrote-off $45 million of unamortized deferred financing costs and incurred $10 million in fees, for a total loss on early extinguishment of debt of $674 million.

In August 2020, the Company purchased $6.0 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $723 million of its 4.0% senior notes due 2023, $2.3 billion of its 3.7% senior notes due 2023 and $3.0 billion of its 4.1% senior notes due 2025. In connection with the purchase of such senior notes, the Company paid a premium of $706 million in excess of the aggregate principal amount of the senior notes that were purchased, wrote-off $47 million of unamortized deferred financing costs and incurred $13 million in fees, for a total loss on early extinguishment of debt of $766 million.

In August 2019, the Company purchased $4.0 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $1.3 billion of its 3.125% senior notes due 2020, $723 million of its floating rate notes due 2020, $328 million of its 4.125% senior notes due 2021, $297 million of 4.125% senior notes due 2021 issued by Aetna Inc. (“Aetna”), $413 million of 5.45% senior notes due 2021 issued by Coventry Health Care, Inc., a wholly-owned subsidiary of Aetna, and $962 million of its 3.35% senior notes due 2021. In connection with the purchase of such senior notes, the Company paid a premium of $76 million in excess of the aggregate principal amount of the senior notes that were purchased, incurred $8 million in fees and recognized a net gain of $5 million on the write-off of net unamortized deferred financing premiums, for a net loss on early extinguishment of debt of $79 million.

Debt Covenants

The Company’s back-up revolving credit facilities, unsecured senior notes and unsecured floating rate notes contain customary restrictive financial and operating covenants. These covenants do not include an acceleration of the Company’s debt maturities in the event of a downgrade in the Company’s credit ratings. The Company does not believe the restrictions contained in these covenants materially affect its financial or operating flexibility. As of December 31, 2021, the Company was in compliance with all of its debt covenants.

9. Pension Plans and Other Postretirement Benefits

Defined Contribution Plans

As of December 31, 2021, the Company sponsors several active 401(k) savings plans that cover all employees who meet plan eligibility requirements.

The Company makes matching contributions consistent with the provisions of the respective plans. At the participant's option, account balances, including the Company's matching contribution, can be invested among various investment options under each plan. The CVS Health Future Fund 401(k) Plan offers CVS Health Corporation's common stock fund as an investment option. The Company also maintains nonqualified, unfunded deferred compensation plans for certain key employees. The plans provide participants the opportunity to defer portions of their eligible compensation and for certain nonqualified plans, participants receive matching contributions equivalent to what they could have received under the CVS Health Future Fund 401(k) Plan absent certain restrictions and limitations under the Internal Revenue Code. The Company's contributions under its defined contribution plans were $552 million, $520 million and $550 million in the years ended December 31, 2021, 2020 and 2019, respectively. The Company's contributions for the year ended December 31, 2019 include contributions to the Aetna 401(k) Plan, which was merged into the CVS Health Future Fund 401(k) Plan on January 1, 2020.

Defined Benefit Pension Plans

The Company sponsors a tax-qualified defined benefit pension plan that was frozen in 2010 and a nonqualified supplemental pension plan that was frozen in 2007. The Company also sponsors several other defined benefit pension plans that are unfunded nonqualified supplemental retirement plans.

Pension Benefit Obligation and Plan Assets
The following tables outline the change in pension benefit obligation and plan assets over the specified periods:

In millions	2021	2020
Change in benefit obligation:		
Benefit obligation, beginning of year	$ 6,462	$ 6,239
Interest cost	110	168
Actuarial (gain) loss	(102)	413
Benefit payments	(408)	(358)
Settlements	(53)	—
Benefit obligation, end of year	6,009	6,462
Change in plan assets:		
Fair value of plan assets, beginning of year	6,845	6,395
Actual return on plan assets	215	783
Employer contributions	78	25
Benefit payments	(408)	(358)
Settlements	(53)	—
Fair value of plan assets, end of year	6,677	6,845
Funded status	$ 668	$ 383

The change in the pension benefit obligation during the years ended December 31, 2021 and 2020 was primarily driven by the change in the discount rate during each respective period.

The assets (liabilities) recognized on the consolidated balance sheets at December 31, 2021 and 2020 for the defined benefit pension plans consisted of the following:

In millions	**2021**	**2020**
Noncurrent assets reflected in other assets	$ 946	$ 744
Current liabilities reflected in accrued expenses	(28)	(76)
Noncurrent liabilities reflected in other long-term liabilities	(250)	(285)
Net assets	$ 668	$ 383

Net Periodic Benefit Cost (Income)
The components of net periodic benefit cost (income) for the years ended December 31, 2021, 2020 and 2019 are shown below:

In millions	**2021**	**2020**	**2019**
Components of net periodic benefit cost (income):			
Interest cost	$ 110	$ 168	$ 225
Expected return on plan assets	(317)	(388)	(357)
Amortization of net actuarial loss	5	2	1
Settlement losses	16	—	—
Net periodic benefit cost (income)	$ (186)	$ (218)	$ (131)

Pension Plan Assumptions
The Company uses a series of actuarial assumptions to determine its benefit obligation and net periodic benefit cost (income), the most significant of which include discount rates and expected return on plan assets assumptions.

Discount Rates - The discount rate is determined using a yield curve as of the annual measurement date. The yield curve consists of a series of individual discount rates, with each discount rate corresponding to a single point in time, based on high-quality bonds. Projected benefit payments are discounted to the measurement date using the corresponding rate from the yield curve that is consistent with the maturity profile of the expected liability cash flows.

Expected Return on Plan Assets - The expected long-term rate of return on plan assets is determined by using the plan's target allocation and return expectations based on many factors including forecasted long-term capital market real returns and the inflationary outlook on a plan by plan basis. See "Pension Plan Assets" below for additional details regarding the pension plan assets as of December 31, 2021 and 2020.

The Company also considers other assumptions including mortality, interest crediting rate, termination and retirement rates and cost of living adjustments.

The Company determined its benefit obligation based on the following weighted average assumptions as of December 31, 2021 and 2020:

	2021	**2020**
Discount rate	2.8 %	2.5 %

The Company determined its net periodic benefit cost (income) based on the following weighted average assumptions for the years ended December 31, 2021, 2020 and 2019:

	2021	**2020**	**2019**
Discount rate	1.8 %	2.9 %	4.0 %
Expected long-term rate of return on plan assets	4.8 %	6.3 %	6.5 %

Pension Plan Assets

The Company's pension plan assets primarily include debt and equity securities held in separate accounts, common/collective trusts and real estate investments. The valuation methodologies used to value these debt and equity securities and common/collective trusts are similar to the methodologies described in Note 4 "Fair Value." Pension plan assets also include investments in other assets that are carried at fair value. The following is a description of the valuation methodologies used to value real estate investments and these additional investments, including the general classification pursuant to the fair value hierarchy.

Real Estate - Real estate investments are valued by independent third party appraisers. The appraisals comply with the Uniform Standards of Professional Appraisal Practice, which include, among other things, the income, cost, and sales comparison approaches to estimating property value. Therefore, these investments are classified in Level 3.

Private equity and hedge fund limited partnerships - Private equity and hedge fund limited partnerships are carried at fair value which is estimated using the NAV per unit as reported by the administrator of the underlying investment fund as a practical expedient to fair value. Therefore, these investments have been excluded from the fair value table below.

Pension plan assets with changes in fair value measured on a recurring basis at December 31, 2021 were as follows:

In millions	**Level 1**	**Level 2**	**Level 3**	**Total**
Cash and cash equivalents	$ 60	$ 97	$ —	$ 157
Debt securities:				
U.S. government securities	1,223	1	—	1,224
States, municipalities and political subdivisions	—	150	—	150
U.S. corporate securities	—	2,458	—	2,458
Foreign securities	—	202	—	202
Residential mortgage-backed securities	—	277	—	277
Commercial mortgage-backed securities	—	76	—	76
Other asset-backed securities	—	162	—	162
Redeemable preferred securities	—	4	—	4
Total debt securities	1,223	3,330	—	4,553
Equity securities:				
U.S. domestic	201	—	—	201
International	81	—	—	81
Domestic real estate	1	—	—	1
Total equity securities	283	—	—	283
Other investments:				
Real estate	—	—	378	378
Common/collective trusts [(1)]	—	410	—	410
Total other investments	—	410	378	788
Total pension investments [(2)]	$ 1,566	$ 3,837	$ 378	$ 5,781

(1) The assets in the underlying funds of common/collective trusts consist of $261 million of equity securities and $149 million of debt securities.

(2) Excludes $76 million of other receivables as well as $583 million of private equity limited partnership investments and $237 million of hedge fund limited partnership investments as these amounts are measured at NAV per share or an equivalent and are not subject to leveling within the fair value hierarchy.

Pension plan assets with changes in fair value measured on a recurring basis at December 31, 2020 were as follows:

In millions	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 118	$ 81	$ —	$ 199
Debt securities:				
U.S. government securities	575	36	—	611
States, municipalities and political subdivisions	—	170	—	170
U.S. corporate securities	—	2,006	—	2,006
Foreign securities	—	167	—	167
Residential mortgage-backed securities	—	287	—	287
Commercial mortgage-backed securities	—	83	—	83
Other asset-backed securities	—	133	—	133
Redeemable preferred securities	—	5	—	5
Total debt securities	575	2,887	—	3,462
Equity securities:				
U.S. domestic	1,046	—	—	1,046
International	537	—	—	537
Domestic real estate	15	—	—	15
Total equity securities	1,598	—	—	1,598
Other investments:				
Real estate	—	—	343	343
Common/collective trusts [1]	—	266	—	266
Derivatives	—	(3)	—	(3)
Total other investments	—	263	343	606
Total pension investments [2]	$ 2,291	$ 3,231	$ 343	$ 5,865

(1) The assets in the underlying funds of common/collective trusts consist of $84 million of equity securities and $182 million of debt securities.
(2) Excludes $142 million of other receivables as well as $624 million of private equity limited partnership investments and $214 million of hedge fund limited partnership investments as these amounts are measured at NAV per share or an equivalent and are not subject to leveling within the fair value hierarchy.

The changes in the balances of Level 3 pension plan assets during the year ended December 31, 2021 were as follows:

In millions	Real estate	Total
Beginning balance	$ 343	$ 343
Actual return on plan assets	43	43
Purchases, sales and settlements	(8)	(8)
Transfers out of Level 3	—	—
Ending balance	$ 378	$ 378

The changes in the balances of Level 3 pension plan assets during the year ended December 31, 2020 were as follows:

In millions	Real estate	U.S. corporate securities	Total
Beginning balance	$ 353	$ 1	$ 354
Actual return on plan assets	(2)	—	(2)
Purchases, sales and settlements	(8)	—	(8)
Transfers out of Level 3	—	(1)	(1)
Ending balance	$ 343	$ —	$ 343

The Company's pension plan invests in a diversified mix of assets designed to generate returns that will enable the plan to meet its future benefit obligations. The risk of unexpected investment and actuarial outcomes is regularly evaluated. This evaluation is performed through forecasting and assessing ranges of investment outcomes over short- and long-term horizons and by assessing the pension plan's liability characteristics. Complementary investment styles and strategies are utilized by professional investment management firms to further improve portfolio and operational risk characteristics. Public and private equity investments are used primarily to increase overall plan returns. Real estate investments are viewed favorably for their diversification benefits and above-average dividend generation. Fixed income investments provide diversification benefits and liability hedging attributes that are desirable, especially in falling interest rate environments.

At December 31, 2021, target investment allocations for the Company's pension plan were: 12% in equity securities, 77% in fixed income and debt securities, 5% in real estate, 3% in private equity limited partnerships and 3% in hedge funds. Actual asset allocations may differ from target allocations due to tactical decisions to overweight or underweight certain assets or as a result of normal fluctuations in asset values. Asset allocations are consistent with stated investment policies and, as a general rule, periodically rebalanced back to target asset allocations. Asset allocations and investment performance are formally reviewed periodically throughout the year by the pension plan's Investment Subcommittee. Forecasting of asset and liability growth is performed at least annually.

Cash Flows
The Company generally contributes to its tax-qualified pension plan based on minimum funding requirements determined under applicable federal laws and regulations. Employer contributions related to the nonqualified supplemental pension plans generally represent payments to retirees for current benefits. The Company contributed $78 million, $25 million and $25 million to its pension plans during 2021, 2020 and 2019, respectively. No contributions are required for the tax-qualified pension plan in 2022. The Company expects to make an immaterial amount of contributions for all other pension plans in 2022.

The Company estimates the following future benefit payments, which are calculated using the same actuarial assumptions used to measure the pension benefit obligation as of December 31, 2021:

In millions		
2022	$	371
2023		371
2024		371
2025		371
2026		368
2027-2031		1,776

Multiemployer Pension Plans
The Company also contributes to a number of multiemployer pension plans under the terms of collective-bargaining agreements that cover its union-represented employees. The risks of participating in these multiemployer plans are different from single-employer pension plans in the following respects: (i) assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers, (ii) if a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers, and (iii) if the Company chooses to stop participating in some of its multiemployer plans, the Company may be required to pay those plans an amount based on the underfunded status of the applicable plan, which is referred to as a withdrawal liability.

None of the multiemployer pension plans in which the Company participates are individually significant to the Company. The Company's contributions to multiemployer pension plans were $19 million, $19 million and $18 million in 2021, 2020 and 2019, respectively.

Other Postretirement Benefits

The Company provides postretirement health care and life insurance benefits to certain retirees who meet eligibility requirements. The Company's funding policy is generally to pay covered expenses as they are incurred. For retiree medical plan accounting, the Company reviews external data and its own historical trends for health care costs to determine the health care cost trend rates. As of December 31, 2021 and 2020, the Company's other postretirement benefits had an accumulated postretirement benefit obligation of $207 million and $226 million, respectively. Net periodic benefit costs related to these other postretirement benefits were $4 million, $12 million and $7 million in 2021, 2020 and 2019, respectively.

The Company estimates the following future benefit payments, which are calculated using the same actuarial assumptions used to measure the accumulated other postretirement benefit obligation as of December 31, 2021:

In millions	
2022	$ 12
2023	12
2024	12
2025	12
2026	12
2027-2031	60

Pursuant to various collective bargaining agreements, the Company also contributes to multiemployer health and welfare plans that cover certain union-represented employees. The plans provide postretirement health care and life insurance benefits to certain employees who meet eligibility requirements. The Company's contributions to multiemployer health and welfare plans totaled $60 million, $54 million and $57 million in 2021, 2020 and 2019, respectively.

10. Income Taxes

The income tax provision for continuing operations consisted of the following for the years ended December 31, 2021, 2020 and 2019:

In millions	**2021**	**2020**	**2019**
Current:			
Federal	$ 2,285	$ 2,615	$ 2,450
State	665	518	565
	2,950	3,133	3,015
Deferred:			
Federal	(306)	(450)	(535)
State	(122)	(114)	(114)
	(428)	(564)	(649)
Total	$ 2,522	$ 2,569	$ 2,366

The following table is a reconciliation of the statutory income tax rate to the Company's effective income tax rate for continuing operations for the years ended December 31, 2021, 2020 and 2019:

	2021	**2020**	**2019**
Statutory income tax rate	21.0 %	21.0 %	21.0 %
State income taxes, net of federal tax benefit	4.1	3.2	4.0
Health insurer fee	—	2.2	—
Basis difference upon disposition of subsidiary	—	(1.2)	—
Prior year refund claim	(1.2)	—	—
Other	0.3	1.1	1.3
Effective income tax rate	24.2 %	26.3 %	26.3 %

The following table is a summary of the components of the Company's deferred income tax assets and liabilities as of December 31, 2021 and 2020:

In millions	**2021**	**2020**
Deferred income tax assets:		
Lease and rents	$ 5,563	$ 5,742
Inventory	99	80
Employee benefits	193	238
Bad debts and other allowances	489	395
Net operating loss and capital loss carryforwards	416	568
Deferred income	78	43
Insurance reserves	501	489
Payroll tax deferral	87	173
Other	396	500
Valuation allowance	(325)	(454)
Total deferred income tax assets	7,497	7,774
Deferred income tax liabilities:		
Retirement benefits	(105)	(29)
Investments	(334)	(421)
Lease and rents	(4,947)	(5,368)
Depreciation and amortization	(8,381)	(8,750)
Total deferred income tax liabilities	(13,767)	(14,568)
Net deferred income tax liabilities	$ (6,270)	$ (6,794)

As of December 31, 2021, the Company had net operating and capital loss carryovers of $416 million, which expire between 2022 and 2041. The Company considers all available positive and negative evidence, including future reversals of existing taxable temporary differences, projected future taxable income, tax planning strategies and the Company's recent operating results. The Company established a valuation allowance of $325 million as of December 31, 2021 because it does not consider it more likely than not that these deferred tax assets will be recovered.

A reconciliation of the beginning and ending balance of unrecognized tax benefits in 2021, 2020 and 2019 is as follows:

In millions	**2021**	**2020**	**2019**
Beginning balance	$ 768	$ 655	$ 661
Additions based on tax positions related to the current year	3	3	4
Additions based on tax positions related to prior years	52	182	115
Reductions for tax positions of prior years	(33)	(56)	(111)
Expiration of statutes of limitation	(1)	(2)	(7)
Settlements	(7)	(14)	(7)
Ending balance	$ 782	$ 768	$ 655

CVS Health Corporation and most of its subsidiaries are subject to U.S. federal income tax as well as income tax of numerous state and local jurisdictions. CVS Health Corporation participated in the Compliance Assurance Process through 2019, which is a program made available by the U.S. Internal Revenue Service ("IRS") to certain qualifying large taxpayers, under which participants work collaboratively with the IRS to identify and resolve potential tax issues through open, cooperative and transparent interaction prior to the annual filing of their federal income tax returns. The IRS has completed its examinations of the Company's consolidated U.S. federal income tax returns for tax years through and including 2013 and 2018. The IRS has substantially completed its examinations of the Company's consolidated U.S. federal income tax returns for tax years 2014 through 2017 and 2019.

CVS Health Corporation and its subsidiaries are also currently under income tax examinations by a number of state and local tax authorities. As of December 31, 2021, no examination has resulted in any proposed adjustments that would result in a material change to the Company's operating results, financial condition or liquidity.

Substantially all material state and local income tax matters have been concluded for fiscal years through 2014. Certain state exams are likely to be concluded and certain state statutes of limitations will lapse in 2022, but the change in the balance of the Company's uncertain tax positions is projected to be immaterial. In addition, it is reasonably possible that the Company's unrecognized tax benefits could change within the next twelve months due to the anticipated conclusion of various examinations with the IRS for various years. An estimate of the range of the possible change cannot be made at this time.

The Company records interest expense related to unrecognized tax benefits and penalties in the income tax provision. The Company accrued interest expense of approximately $40 million, $34 million and $49 million in 2021, 2020 and 2019, respectively. The Company had approximately $151 million and $121 million accrued for interest and penalties as of December 31, 2021 and 2020, respectively.

As of December 31, 2021, the total amount of unrecognized tax benefits that, if recognized, would affect the Company's effective income tax rate is approximately $669 million, after considering the federal benefit of state income taxes.

11. Stock Incentive Plans

The terms of the CVS Health 2017 Incentive Compensation Plan ("ICP") provide for grants of annual incentive and long-term performance awards to executive officers and other officers and employees of the Company or any subsidiary of the Company, as well as equity compensation to outside directors of CVS Health Corporation. Payment of such annual incentive and long-term performance awards will be in cash, stock, other awards or other property, at the discretion of the Management Planning and Development Committee (the "MP&D Committee") of the Board. The ICP allows for a maximum of 58 million shares of CVS Health Corporation common stock to be reserved and available for grants. As of December 31, 2021, there were approximately 30 million shares of CVS Health Corporation common stock available for future grants under the ICP.

Upon the acquisition of Aetna (the "Aetna Acquisition") on November 28, 2018, approximately 22 million shares of Aetna common stock subject to awards outstanding under the Amended Aetna Inc. 2010 Stock Incentive Plan ("SIP") were assumed by CVS Health Corporation. In addition, in accordance with the merger agreement, shares which were available for future issuance under the SIP were converted into approximately 32 million shares of CVS Health Corporation common stock reserved and available for issuance pursuant to future awards. Subsequent to the expiration of the SIP on May 21, 2020, the ICP is the only compensation plan under which the Company grants stock options, restricted stock and other stock-based awards to its employees.

Stock-Based Compensation Expense

Stock-based compensation is measured at the grant date based on the fair value of the award and is recognized as expense over the requisite service period of the stock award (generally three to five years) using the straight-line method. The following table is a summary of stock-based compensation for the years ended December 31, 2021, 2020 and 2019:

In millions	**2021**	**2020**	**2019**
Stock options and stock appreciation rights ("SARs") [1]	$ 80	$ 71	$ 76
Restricted stock units and performance stock units	404	329	377
Total stock-based compensation	$ 484	$ 400	$ 453

(1) Includes the ESPP.

ESPP

The Company's Employee Stock Purchase Plan ("ESPP") provides for the purchase of up to 60 million shares of CVS Health Corporation common stock. Under the ESPP, eligible employees may purchase common stock at the end of each six month offering period at a purchase price equal to 90% of the lower of the fair market value on the first day or the last day of the offering period. During 2021, approximately 3 million shares of common stock were purchased under the provisions of the ESPP at an average price of $60.51 per share. As of December 31, 2021, approximately 31 million shares of common stock were available for issuance under the ESPP.

The fair value of stock-based compensation associated with the ESPP is estimated on the date of grant (the first day of the six month offering period) using the Black-Scholes option pricing model.

The following table is a summary of the assumptions used to value the ESPP awards for the years ended December 31, 2021, 2020 and 2019:

	2021	2020	2019
Dividend yield [1]	1.34 %	1.46 %	1.70 %
Expected volatility [2]	25.27 %	37.21 %	27.96 %
Risk-free interest rate [3]	0.08 %	0.81 %	2.27 %
Expected life (in years) [4]	0.5	0.5	0.5
Weighted-average grant date fair value	$ 12.55	$ 13.85	$ 10.51

(1) The dividend yield is calculated based on semi-annual dividends paid and the fair market value of CVS Health Corporation stock at the grant date.
(2) The expected volatility is estimated based on the historical volatility of CVS Health Corporation's daily stock price over the previous six month period.
(3) The risk-free interest rate is selected based on the Treasury constant maturity interest rate whose term is consistent with the expected term of ESPP purchases (i.e., six months).
(4) The expected life is based on the semi-annual purchase period.

Restricted Stock Units and Performance Stock Units

The Company's restricted stock units and performance stock units are considered nonvested share awards and require no payment from the employee. The fair value of the restricted stock units is based on the market price of CVS Health Corporation common stock on the grant date and is recognized on a straight-line basis over the vesting period. For each restricted stock unit granted, employees receive one share of common stock, net of taxes, at the end of the vesting period.

The Company's performance stock units contain performance vesting conditions in addition to a service vesting condition. Vesting of the Company's performance stock units is dependent upon the degree to which the Company achieves its performance goals, which are generally set for a three-year performance period and are approved at the time of grant by the MP&D Committee.

The fair value of performance stock units granted with service and performance vesting conditions is based on the market price of CVS Health Corporation common stock on the grant date and is recognized over the vesting period. Certain of the performance stock units also contain a market vesting condition based on the performance of CVS Health Corporation common stock relative to a comparator group. The fair value of these performance stock units is determined using a Monte Carlo simulation as of the grant date and is recognized over the vesting period.

As of December 31, 2021, there was $529 million of total unrecognized compensation cost related to the Company's restricted stock units and performance stock units that are expected to vest. These costs are expected to be recognized over a weighted-average period of 2.1 years. The total fair value of restricted stock units vested during 2021, 2020 and 2019 was $406 million, $229 million and $265 million, respectively.

The following table is a summary of the restricted stock unit and performance stock unit activity for the year ended December 31, 2021:

In thousands, except weighted average grant date fair value	Units	Weighted Average Grant Date Fair Value
Outstanding at beginning of year, nonvested	14,824	$ 58.12
Granted	6,190	$ 74.39
Vested	(5,448)	$ 74.47
Forfeited	(1,236)	$ 63.40
Outstanding at end of year, nonvested	14,330	$ 63.02

Stock Options and SARs

All stock option grants are awarded at fair value on the date of grant. The fair value of stock options is estimated using the Black-Scholes option pricing model, and stock-based compensation is recognized on a straight-line basis over the requisite

service period. Stock options granted generally become exercisable over a four-year period from the grant date. Stock options granted through 2018 generally expire seven years after the grant date. Stock options granted subsequent to 2018 generally expire ten years after the grant date.

All unvested Aetna SARs outstanding upon the acquisition of Aetna were converted into replacement CVS Health Corporation SARs. The replacement SARs granted are settled in CVS Health Corporation common stock, net of taxes, based on the appreciation of the stock price on the exercise date over the market price on the date of grant. The fair value of SARs is estimated using the Black-Scholes option pricing model, and stock-based compensation is recognized on a straight-line basis over the requisite service period. SARs generally become exercisable over a three-year period from the grant date. SARs generally expire ten years after the grant date. No SARs have been granted subsequent to the Aetna Acquisition.

The following table is a summary of stock option and SAR activity that occurred for the years ended December 31, 2021, 2020 and 2019:

In millions	**2021**	**2020**	**2019**
Cash received from stock options exercised (including ESPP)	$ 549	$ 264	$ 210
Payments for taxes for net share settlement of equity awards	168	88	112
Intrinsic value of stock options and SARs exercised	105	24	30
Fair value of stock options and SARs vested	224	252	467

The fair value of each stock option is estimated using the Black-Scholes option pricing model based on the following assumptions at the time of grant:

	2021	**2020**	**2019**
Dividend yield [1]	2.68 %	3.42 %	3.68 %
Expected volatility [2]	27.10 %	25.22 %	21.76 %
Risk-free interest rate [3]	1.13 %	0.61 %	0.56 %
Expected life (in years) [4]	6.3	6.3	6.3
Weighted-average grant date fair value	$ 14.57	$ 8.78	$ 6.27

(1) The dividend yield is based on annual dividends paid and the fair market value of CVS Health Corporation stock at the grant date.
(2) The expected volatility is estimated based on the historical volatility of CVS Health Corporation's daily stock price over a period equal to the expected life of each option grant after adjustments for infrequent events such as stock splits.
(3) The risk-free interest rate is selected based on yields from U.S. Treasury zero-coupon issues with a remaining term equal to the expected term of the options being valued.
(4) The expected life represents the number of years the options are expected to be outstanding from grant date based on historical option or SAR holder exercise experience.

As of December 31, 2021, unrecognized compensation expense related to unvested stock options totaled $38 million, which the Company expects to be recognized over a weighted-average period of 2.0 years. After considering anticipated forfeitures, the Company expects approximately 9 million of the unvested stock options to vest over the requisite service period.

The following table is a summary of the Company's stock option and SAR activity for the year ended December 31, 2021:

In thousands, except weighted average exercise price and remaining contractual term	Shares	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term	Aggregate Intrinsic Value
Outstanding at beginning of year	23,955	$ 69.62		
Granted	3,322	$ 74.66		
Exercised	(6,366)	$ 63.41		
Forfeited	(694)	$ 62.66		
Expired	(1,156)	$ 87.42		
Outstanding at end of year	19,061	$ 71.74	4.75	$ 603,137
Exercisable at end of year	9,704	$ 79.99	2.61	229,034
Vested at end of year and expected to vest in the future	18,709	$ 71.82	4.69	590,514

12. Shareholders' Equity

Share Repurchases

The following share repurchase programs have been authorized by the Board:

In billions Authorization Date	Authorized	Remaining as of December 31, 2021
December 9, 2021 ("2021 Repurchase Program")	$ 10.0	$ 10.0
November 2, 2016 ("2016 Repurchase Program")	15.0	—

Each of the share Repurchase Programs was effective immediately. The 2016 Repurchase program was terminated effective December 9, 2021. The 2021 Repurchase Program permits the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase ("ASR") transactions, and/or other derivative transactions. The 2021 Repurchase Program can be modified or terminated by the Board at any time.

During the years ended December 31, 2021, 2020 and 2019, the Company did not repurchase any shares of common stock pursuant to the 2016 or 2021 Repurchase Programs.

Pursuant to the authorization under the 2021 Repurchase Program, the Company entered into a $1.5 billion fixed dollar ASR with Barclays Bank PLC ("Barclays"). Upon payment of the $1.5 billion purchase price on January 4, 2022, the Company received a number of shares of CVS Health Corporation's common stock equal to 80% of the $1.5 billion notional amount of the ASR or approximately 11.6 million shares at a price of $103.34 per share, which were placed into treasury stock in January 2022. At the conclusion of the ASR, the Company may receive additional shares equal to the remaining 20% of the $1.5 billion notional amount. The ultimate number of shares the Company may receive will depend on the daily volume-weighted average price of the Company's stock over an averaging period, less a discount. It is also possible, depending on such weighted average price, that the Company will have an obligation to Barclays which, at the Company's option, could be settled in additional cash or by issuing shares. Under the terms of the ASR, the maximum number of shares that could be delivered to the Company is 29.0 million.

Dividends

The quarterly cash dividend declared by the Board was $0.50 per share in 2021 and 2020. In December 2021, the Board authorized a 10% increase in the quarterly cash dividend to $0.55 per share effective in 2022. CVS Health Corporation has paid cash dividends every quarter since becoming a public company. Future dividend payments will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

Regulatory Requirements

The Company's insurance business operations are conducted through subsidiaries that principally consist of health maintenance organizations ("HMOs") and insurance companies. The Company's HMO and insurance subsidiaries report their financial

statements in accordance with accounting practices prescribed by state regulatory authorities which may differ from GAAP. The combined statutory net income for the years ended and estimated combined statutory and capital surplus at December 31, 2021, 2020 and 2019 for the Company's insurance and HMO subsidiaries were as follows:

In millions	**2021**	**2020**	**2019**
Statutory net income	$ 3,302	$ 3,667	$ 2,842
Estimated statutory capital and surplus	14,879	13,238	10,975

The Company's insurance and HMO subsidiaries paid $1.6 billion of gross dividends to the Company for the year ended December 31, 2021.

In addition to general state law restrictions on payments of dividends and other distributions to stockholders applicable to all corporations, HMOs and insurance companies are subject to further regulations that, among other things, may require those companies to maintain certain levels of equity and restrict the amount of dividends and other distributions that may be paid to their equity holders. In addition, in connection with the Aetna Acquisition, the Company made certain undertakings that require prior regulatory approval of dividends by certain of its HMOs and insurance companies. At December 31, 2021, these amounts were as follows:

In millions	
Estimated minimum statutory surplus required by regulators	$ 7,261
Investments on deposit with regulatory bodies	794
Estimated maximum dividend distributions permitted in 2022 without prior regulatory approval	2,939

Noncontrolling Interests

At December 31, 2021 and 2020, noncontrolling interests were $306 million and $312 million, respectively, primarily related to third party interests in the Company's operating entities. The noncontrolling entities' share is included in total shareholders' equity on the consolidated balance sheets.

13. Other Comprehensive Income

Shareholders' equity included the following activity in accumulated other comprehensive income in 2021, 2020 and 2019:

	At December 31,		
In millions	**2021**	**2020**	**2019**
Net unrealized investment gains (losses):			
Beginning of year balance	$ 1,214	$ 774	$ 97
Other comprehensive income (loss) before reclassifications *($(489), $497 and $927 pretax)*	(410)	415	763
Amounts reclassified from accumulated other comprehensive income *($(32), $31 and $(105) pretax)* [1]	(26)	25	(86)
Other comprehensive income (loss)	(436)	440	677
End of year balance	778	1,214	774
Foreign currency translation adjustments:			
Beginning of year balance	7	4	(158)
Other comprehensive income (loss) before reclassifications	(7)	3	8
Amounts reclassified from accumulated other comprehensive income (loss) [2]	—	—	154
Other comprehensive income (loss)	(7)	3	162
End of year balance	—	7	4
Net cash flow hedges:			
Beginning of year balance	248	279	312
Other comprehensive loss before reclassifications *($0, $(7) and $(25) pretax)*	—	(5)	(18)
Amounts reclassified from accumulated other comprehensive income *($(34), $(35) and $(20) pretax)* [3]	(26)	(26)	(15)
Other comprehensive loss	(26)	(31)	(33)
End of year balance	222	248	279
Pension and other postretirement benefits:			
Beginning of year balance	(55)	(38)	(149)
Other comprehensive income (loss) before reclassifications *($20, $(30) and $162 pretax)*	15	(22)	120
Amounts reclassified from accumulated other comprehensive loss *($6, $7 and $(12) pretax)* [4]	5	5	(9)
Other comprehensive income (loss)	20	(17)	111
End of year balance	(35)	(55)	(38)
Total beginning of year accumulated other comprehensive income	1,414	1,019	102
Total other comprehensive income (loss)	(449)	395	917
Total end of year accumulated other comprehensive income	$ 965	$ 1,414	$ 1,019

(1) Amounts reclassified from accumulated other comprehensive income for specifically identified debt securities are included in net investment income in the consolidated statements of operations.

(2) Amounts reclassified from accumulated other comprehensive income (loss) represent the elimination of the cumulative translation adjustment associated with the sale of Onofre, which was sold on July 1, 2019. The loss on the divestiture of Onofre is reflected in operating expenses in the consolidated statements of operations.

(3) Amounts reclassified from accumulated other comprehensive income for specifically identified cash flow hedges are included within interest expense in the consolidated statements of operations. The Company expects to reclassify approximately $11 million, net of tax, in net gains associated with its cash flow hedges into net income within the next 12 months.

(4) Amounts reclassified from accumulated other comprehensive loss for specifically identified pension and other postretirement benefits are included in other income in the consolidated statements of operations.

14. Earnings Per Share

Earnings per share is computed using the two-class method. SARs and options to purchase 7 million, 15 million, and 17 million shares of common stock were outstanding, but were excluded from the calculation of diluted earnings per share for the years ended December 31, 2021, 2020 and 2019, respectively, because their exercise prices were greater than the average market price of the common shares and, therefore, the effect would be antidilutive.

The following is a reconciliation of basic and diluted earnings per share from continuing operations for the years ended December 31, 2021, 2020 and 2019:

In millions, except per share amounts	**2021**	**2020**	**2019**
Numerator for earnings per share calculation:			
Income from continuing operations	$ 7,898	$ 7,201	$ 6,631
Income allocated to participating securities	—	—	(5)
Net (income) loss attributable to noncontrolling interests	12	(13)	3
Income from continuing operations attributable to CVS Health	$ 7,910	$ 7,188	$ 6,629
Denominator for earnings per share calculation:			
Weighted average shares, basic	1,319	1,309	1,301
Effect of dilutive securities	10	5	4
Weighted average shares, diluted	1,329	1,314	1,305
Earnings per share from continuing operations:			
Basic	$ 6.00	$ 5.49	$ 5.10
Diluted	$ 5.95	$ 5.47	$ 5.08

15. Reinsurance

The Company utilizes reinsurance agreements primarily to: (a) reduce required capital and (b) facilitate the acquisition or disposition of certain insurance contracts. Ceded reinsurance agreements permit the Company to recover a portion of its losses from reinsurers, although they do not discharge the Company's primary liability as the direct insurer of the risks reinsured.

On November 30, 2018, the Company completed the sale of Aetna's standalone Medicare Part D prescription drug plans to a subsidiary of WellCare Health Plans, Inc. ("WellCare"), effective December 31, 2018. In connection with that sale, subsidiaries of WellCare and Aetna entered into reinsurance agreements under which WellCare ceded to Aetna 100% of the insurance risk related to the divested standalone Medicare Part D prescription drug plans for the 2019 PDP plan year.

In January 2022, the Company entered into two four-year reinsurance agreements with an unrelated reinsurer that allow it to reduce required capital and provide collateralized excess of loss reinsurance coverage on a portion of the Health Care Benefits segment's group Commercial Insured business.

Reinsurance recoverables (recorded as other current assets or other assets on the consolidated balance sheets) at December 31, 2021 and 2020 were as follows:

In millions	**2021**	**2020**
Reinsurer		
Hartford Life and Accident Insurance Company	$ 1,887	$ 2,364
Lincoln Life & Annuity Company of New York	395	406
VOYA Retirement Insurance and Annuity Company	167	170
All Other	100	115
Total	$ 2,549	$ 3,055

Direct, assumed and ceded premiums earned for the years ended December 31, 2021, 2020 and 2019 were as follows:

In millions	**2021**	**2020**	**2019**
Direct	$ 76,320	$ 69,711	$ 62,968
Assumed	492	478	2,108
Ceded	(680)	(825)	(1,954)
Net premiums	$ 76,132	$ 69,364	$ 63,122

The impact of reinsurance on benefit costs for the years ended December 31, 2021, 2020 and 2019 were as follows:

In millions	**2021**	**2020**	**2019**
Direct	$ 64,414	$ 56,077	$ 52,592
Assumed	398	329	1,562
Ceded	(552)	(727)	(1,625)
Net benefit costs	$ 64,260	$ 55,679	$ 52,529

There is not a material difference between premiums on a written basis versus an earned basis.

The Company also has various agreements with unrelated reinsurers that do not qualify for reinsurance accounting under GAAP, and consequently are accounted for using deposit accounting. The Company entered into these contracts to reduce the risk of catastrophic loss which in turn reduces the Company's capital and surplus requirements. Total deposit assets and liabilities related to reinsurance agreements that do not qualify for reinsurance accounting under GAAP were not material as of December 31, 2021 or 2020.

16. Commitments and Contingencies

COVID-19

The COVID-19 pandemic continues to evolve. The Company believes COVID-19's impact on its businesses, operating results, cash flows and/or financial condition primarily will be driven by the geographies impacted and the severity and duration of the pandemic; the pandemic's impact on the U.S. and global economies and consumer behavior and health care utilization patterns; and the timing, scope and impact of stimulus legislation as well as other federal, state and local governmental responses to the pandemic. Those primary drivers are beyond the Company's knowledge and control. As a result, the impact COVID-19 will have on the Company's businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be adverse and material. COVID-19 also may result in legal and regulatory proceedings, investigations and claims against the Company.

Guarantees

The Company has the following significant guarantee arrangements at December 31, 2021:

- ASC Claim Funding Accounts - The Company has arrangements with certain banks for the processing of claim payments for its ASC customers. The banks maintain accounts to fund claims of the Company's ASC customers. The customer is responsible for funding the amount paid by the bank each day. In these arrangements, the Company guarantees that the banks will not sustain losses if the responsible ASC customer does not properly fund its account. The aggregate maximum exposure under these arrangements is generally limited to $250 million. The Company can limit its exposure to these guarantees by suspending the payment of claims for ASC customers that have not adequately funded the amount paid by the bank.
- Separate Accounts Assets - Certain Separate Accounts assets associated with the large case pensions business in the Corporate/Other segment represent funds maintained as a contractual requirement to fund specific pension annuities that the Company has guaranteed. Minimum contractual obligations underlying the guaranteed benefits in these Separate Accounts were approximately $1.3 billion and $1.4 billion at December 31, 2021 and 2020, respectively. See Note 1 ''Significant Accounting Policies'' for additional information on Separate Accounts. Contract holders assume all investment and mortality risk and are required to maintain Separate Accounts balances at or above a specified level. The level of required funds is a function of the risk underlying the Separate Account's investment strategy. If contract holders do not maintain the required level of Separate Accounts assets to meet the annuity guarantees, the Company would

establish an additional liability. Contract holders' balances in the Separate Accounts at December 31, 2021 exceeded the value of the guaranteed benefit obligation. As a result, the Company was not required to maintain any additional liability for its related guarantees at December 31, 2021.

Lease Guarantees

Between 1995 and 1997, the Company sold or spun off a number of subsidiaries, including Bob's Stores and Linens 'n Things, each of which subsequently filed for bankruptcy, and Marshalls. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the former subsidiary's lease obligations for the initial lease term and any extension thereof pursuant to a renewal option provided for in the lease prior to the time of the disposition. When the subsidiaries were disposed of and accounted for as discontinued operations, the Company's guarantees remained in place, although each initial purchaser agreed to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries fail to make the required payments under a store lease, the Company could be required to satisfy those obligations, and any significant adverse impact of COVID-19 on such purchasers and/or former subsidiaries increases the risk that the Company will be required to satisfy those obligations. As of December 31, 2021, the Company guaranteed 72 such store leases (excluding the lease guarantees related to Linens 'n Things, which have been recorded as a liability on the consolidated balance sheets), with the maximum remaining lease term extending through 2030.

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers and life insurers as well as health insurers. The Company's assessments generally are based on a formula relating to the Company's health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

In 2009, the Pennsylvania Insurance Commissioner placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. Penn Treaty was placed in liquidation in March 2017. The Company has recorded a liability for its estimated share of future assessments by applicable life and health insurance guaranty associations. It is reasonably possible that in the future the Company may record a liability and expense relating to other insolvencies which could have a material adverse effect on the Company's operating results, financial condition and cash flows, and the risk is heightened by any significant adverse impact of the COVID-19 pandemic on the solvency of other insurers, including long-term care and life insurers. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that limit future offsets.

HMOs in certain states in which the Company does business are subject to assessments, including market stabilization and other risk-sharing pools, for which the Company is assessed charges based on incurred claims, demographic membership mix and other factors. The Company establishes liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments the Company pays are dependent upon the Company's experience relative to other entities subject to the assessment, and the ultimate liability is not known at the financial statement date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, the Company believes it has adequate reserves to cover such assessments.

The Company's total guaranty fund assessments liability was immaterial at both December 31, 2021 and 2020.

Litigation and Regulatory Proceedings

The Company has been involved or is currently involved in numerous legal proceedings, including litigation, arbitration, government investigations, audits, reviews and claims. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, the U.S. Department of Justice (the "DOJ"), state attorneys general, the U.S. Drug Enforcement Administration (the "DEA") and other governmental authorities.

Legal proceedings, in general, and securities, class action and multi-district litigation, in particular, and governmental special investigations, audits and reviews can be expensive and disruptive. Some of the litigation matters may purport or be determined

to be class actions and/or involve parties seeking large and/or indeterminate amounts, including punitive or exemplary damages, and may remain unresolved for several years. The Company also may be named from time to time in *qui tam* actions initiated by private third parties that could also be separately pursued by a governmental body. The results of legal proceedings, including government investigations, are often uncertain and difficult to predict, and the costs incurred in these matters can be substantial, regardless of the outcome.

The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and reasonably estimable, the Company does not establish an accrued liability. None of the Company's accruals for outstanding legal matters are material individually or in the aggregate to the Company's financial condition.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and the Company is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters. The Company believes that its defenses and assertions in pending legal proceedings have merit and does not believe that any of these pending matters, after consideration of applicable reserves and rights to indemnification, will have a material adverse effect on the Company's financial position. Substantial unanticipated verdicts, fines and rulings, however, do sometimes occur, which could result in judgments against the Company, entry into settlements or a revision to its expectations regarding the outcome of certain matters, and such developments could have a material adverse effect on its results of operations. In addition, as a result of governmental investigations or proceedings, the Company may be subject to damages, civil or criminal fines or penalties, or other sanctions including possible suspension or loss of licensure and/or exclusion from participating in government programs. The outcome of such governmental investigations of proceedings could be material to the Company.

Usual and Customary Pricing Litigation

The Company and certain current and former directors and officers are named as a defendant in a number of lawsuits that allege that the Company's retail pharmacies overcharged for prescription drugs by not submitting the correct usual and customary price during the claims adjudication process. These actions are brought by a number of different types of plaintiffs, including plan members, private payors, government payors, and shareholders based on different legal theories. Some of these cases are brought as putative class actions, and in some instances, classes have been certified. The Company is defending itself against these claims.

PBM Litigation and Investigations

The Company is named as a defendant in a number of lawsuits and is subject to a number of investigations concerning its PBM practices.

The Company is facing multiple lawsuits, including by a State Attorney General, governmental subdivisions and several putative class actions, regarding drug pricing and its rebate arrangements with drug manufacturers. These complaints, brought by a number of different types of plaintiffs under a variety of legal theories, generally allege that rebate agreements between the drug manufacturers and PBMs caused inflated prices for certain drug products. The Company is defending itself against these claims. The Company has also received subpoenas, civil investigative demands ("CIDs") and other requests for documents and information from, and is being investigated by, Attorneys General of multiple states and the District of Columbia regarding its PBM practices, including pricing and rebates. The Company has been providing documents and information in response to these subpoenas, CIDs and requests for information.

United States ex rel. Behnke v. CVS Caremark Corporation, et al. (U.S. District Court for the Eastern District of Pennsylvania). In April 2018, the Court unsealed a complaint filed in February 2014. The government has declined to intervene in this case. The relator alleges that the Company submitted, or caused to be submitted, to Part D of the Medicare program Prescription Drug Event data and/or Direct and Indirect Remuneration reports that misrepresented true prices paid by the Company's PBM to pharmacies for drugs dispensed to Part D beneficiaries with prescription benefits administered by the Company's PBM. The Company is defending itself against these claims.

Controlled Substances Litigation, Audits and Subpoenas

In December 2017, the U.S. Judicial Panel on Multidistrict Litigation consolidated numerous cases filed against various defendants by plaintiffs such as counties, cities, hospitals, Indian tribes and third-party payors, alleging claims generally concerning the impacts of widespread prescription opioid abuse. The consolidated multidistrict litigation captioned In re National Prescription Opiate Litigation (MDL No. 2804) is pending in the U.S. District Court for the Northern District of Ohio. This multidistrict litigation presumptively includes hundreds of relevant federal court cases that name the Company as a defendant. A significant number of similar cases that name the Company as a defendant in some capacity are pending in state courts. In addition, the Company has been named as a defendant in similar cases brought by certain state Attorneys General. The Company is defending itself against all such claims. Additionally, the Company has received subpoenas, CIDs and/or other requests for information regarding opioids from state Attorneys General and insurance and other regulators of several U.S. jurisdictions. The Company has been cooperating with the government with respect to these subpoenas, CIDs and other requests for information. In November 2021, the Company was among the chain pharmacies found liable by a jury in a trial in federal court in Ohio; the remedy pursuant to that verdict has not been determined and the Company plans to appeal.

In January 2020, the DOJ served the Company with a DEA administrative subpoena. The subpoena seeks documents relating to practices with respect to prescription opioids and other controlled substances at CVS Pharmacy locations concerning potential violations of the federal Controlled Substances Act and the federal False Claims Act. In January 2022, the DOJ served the Company with a CID regarding similar subjects. The Company is providing documents and information in response to these matters.

Prescription Processing Litigation and Investigations

The Company is named as a defendant in a number of lawsuits and is subject to a number of investigations concerning its prescription processing practices, including the following:

U.S. ex rel. *Bassan* et al. *v. Omnicare, Inc. and CVS Health Corp.* (U.S. District Court for the Southern District of New York). In December 2019, the U.S. Attorney's Office for the Southern District of New York (the "SDNY") filed a complaint-in-intervention in this previously sealed *qui tam* case. The complaint alleges that for certain non-skilled nursing facilities, Omnicare improperly filled prescriptions beyond one year where a valid prescription did not exist and that these dispensing events violated the federal False Claims Act. The Company is defending itself against these claims.

In July 2017, the Company also received a subpoena from the California Department of Insurance requesting documents concerning the Company's Omnicare pharmacies' cycle fill process for assisted living facilities. The Company has been cooperating with the California Department of Insurance and providing documents and information in response to this subpoena.

In December 2016, the Company received a CID from the U.S. Attorney's Office for the Northern District of New York requesting documents and information in connection with a federal False Claims Act investigation concerning whether the Company's retail pharmacies improperly submitted certain insulin claims to Part D of the Medicare program rather than Part B of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to this CID.

Provider Proceedings

The Company is named as a defendant in purported class actions and individual lawsuits arising out of its practices related to the payment of claims for services rendered to its members by providers with whom the Company has a contract and with whom the Company does not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that the Company paid too little to its health plan members and/or providers for out-of-network services and/or otherwise allege that the Company failed to timely or appropriately pay or administer out-of-network claims and benefits (including the Company's post payment audit and collection practices and reductions in payments to providers due to sequestration). Other major health insurers are the subject of similar litigation or have settled similar litigation.

The Company also has received subpoenas and/or requests for documents and other information from, and been investigated by, state Attorneys General and other state and/or federal regulators, legislators and agencies relating to, and the Company is involved in other litigation regarding, its out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against the Company with respect to its out-of-network benefit payment and/or administration practices.

CMS Actions

CMS regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to the Company's and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by providers. The Company collects claim and encounter data from providers and generally relies on providers to appropriately code their submissions to the Company and document their medical records, including the diagnosis data submitted to the Company with claims. CMS pays increased premiums to Medicare Advantage plans and Medicare PDP plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to the Company. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by providers and the resulting risk adjusted premium payments to the plans. CMS may require the Company to refund premium payments if the Company's risk adjusted premiums are not properly supported by medical record data. The Office of the Inspector General of the HHS (the "OIG") also is auditing the Company's risk adjustment-related data and that of other companies. The Company expects CMS and the OIG to continue these types of audits.

In 2012, CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will extrapolate the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. For contract years prior to 2011, CMS did not extrapolate sample error rates to the entire contract. As a result, the revised methodology may increase the Company's exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various contract years for RADV audit, and the number of RADV audits continues to increase. The Company is currently unable to predict which of its Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to the Company, the effect of any such refunds or adjustments on the actuarial soundness of the Company's Medicare Advantage bids, or whether any RADV audit findings would require the Company to change its method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in the Company's bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG or otherwise, including audits of the Company's MLR rebates, methodology and/or reports, could be material and could adversely affect the Company's operating results, cash flows and/or financial condition.

Medicare and Medicaid CIDs

The Company has received CIDs from the Civil Division of the DOJ in connection with a current investigation of the Company's patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to these CIDs.

In May 2017, the Company received a CID from the SDNY requesting documents and information concerning possible false claims submitted to Medicare in connection with reimbursements for prescription drugs under the Medicare Part D program. The Company has been cooperating with the government and providing documents and information in response to this CID.

Stockholder Matters

Beginning in February 2019, multiple class action complaints, as well as a derivative complaint, were filed by putative plaintiffs against the Company and certain current and former officers and directors. The plaintiffs in these cases assert a variety of causes of action under federal securities laws that are premised on allegations that the defendants made certain omissions and misrepresentations relating to the performance of the Company's LTC business unit. The Company and its current and former officers and directors are defending themselves against these claims. Since filing, several of the cases have been consolidated, and the first-filed federal case, *City of Miami Fire Fighters' and Police Officers' Retirement Trust,* et al. (formerly known as *Anarkat*), was dismissed with prejudice in February 2021. Plaintiffs have appealed that decision to the First Circuit after their motion for reconsideration was denied. *In re CVS Health Corp. Securities Act Litigation* (formerly known as *Waterford*) and *In*

re CVS Health Corp. Securities Litigation (formerly known as *City of Warren* and *Freundlich*) have been stayed pending the outcome of the First Circuit appeal.

In August and September 2020, two class actions under the Employee Retirement Income Security Act of 1974 ("ERISA") were filed in the U.S. District Court for the District of Connecticut against CVS Health, Aetna, and several current and former executives, directors and/or members of Aetna's Compensation and Talent Management Committee: *Radcliffe v. Aetna Inc.,* et al. and *Flaim v. Aetna Inc.,* et al. The plaintiffs in these cases assert a variety of causes of action premised on allegations that the defendants breached fiduciary duties and engaged in prohibited transactions relating to participants in the Aetna 401(k) Plan's investment in company stock between December 3, 2017 and February 20, 2019, claiming losses related to the performance of the Company's LTC business unit. The district court consolidated the actions and the Company is defending itself against these claims. In October 2021, the consolidated case was dismissed without prejudice. Plaintiffs may seek leave to file an amended complaint. The Company also received a related document request pursuant to ERISA § 104(b), to which the Company has responded.

In December 2021, the Company received a demand for inspection of books and records pursuant to Delaware Corporation Law Section 220 (the "Demand"). The Demand purports to be related to potential breaches of fiduciary duties by the Board in relation to certain matters concerning opioids.

Other Legal and Regulatory Proceedings

The Company is also a party to other legal proceedings and is subject to government investigations, inquiries and audits and has received and is cooperating with the government in response to CIDs, subpoenas or similar process from various governmental agencies requesting information. These other legal proceedings and government actions include claims of or relating to bad faith, medical or professional malpractice, breach of fiduciary duty, claims processing, dispensing of medications, non-compliance with state and federal regulatory regimes, marketing misconduct, denial of or failure to timely or appropriately pay or administer claims and benefits, provider network structure (including the use of performance-based networks and termination of provider contracts), rescission of insurance coverage, improper disclosure or use of personal information, anticompetitive practices, general contractual matters, product liability, intellectual property litigation and employment litigation. Some of these other legal proceedings are or are purported to be class actions or derivative claims. The Company is defending itself against the claims brought in these matters.

Awards to the Company and others of certain government contracts, particularly Medicaid contracts and other contracts with government customers in the Company's Health Care Benefits segment, frequently are subject to protests by unsuccessful bidders. These protests may result in awards to the Company being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect the Company's operating results. The Company will continue to defend contract awards it receives.

There also continues to be a heightened level of review and/or audit by regulatory authorities and legislators of, and increased litigation regarding, the Company's and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including manufacturers' rebates, pricing, the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers).

As a leading national health solutions company, the Company regularly is the subject of government actions of the types described above. These government actions may prevent or delay the Company from implementing planned premium rate increases and may result, and have resulted, in restrictions on the Company's businesses, changes to or clarifications of the Company's business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to the Company by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

The Company can give no assurance that its businesses, financial condition, operating results and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or

regulations as they may relate to one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iii) pending or future federal or state government investigations of one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting one or more of the industries in which the Company competes and/or the health care industry generally.

17. Segment Reporting

The Company has three operating segments, Health Care Benefits, Pharmacy Services and Retail/LTC, as well as a Corporate/Other segment. The Company's segments maintain separate financial information, and the Company's chief operating decision maker (the "CODM") evaluates the segments' operating results on a regular basis in deciding how to allocate resources among the segments and in assessing segment performance. The CODM evaluates the performance of the Company's segments based on adjusted operating income, which is defined as operating income (GAAP measure) excluding the impact of amortization of intangible assets and other items, if any, that neither relate to the ordinary course of the Company's business nor reflect the Company's underlying business performance. See the reconciliation of consolidated operating income (GAAP measure) to consolidated adjusted operating income below for further context regarding the items excluded from operating income in determining adjusted operating income. The Company uses adjusted operating income as its principal measure of segment performance as it enhances the Company's ability to compare past financial performance with current performance and analyze underlying business performance and trends. Non-GAAP financial measures the Company discloses, such as consolidated adjusted operating income, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

In 2021, 2020 and 2019, revenues from the federal government accounted for 17%, 16% and 16%, respectively, of the Company's consolidated total revenues, primarily related to contracts with CMS for coverage of Medicare-eligible individuals within the Health Care Benefits segment.

The following is a reconciliation of financial measures of the Company's segments to the consolidated totals:

In millions	Health Care Benefits	Pharmacy Services [1]	Retail/ LTC	Corporate/ Other	Intersegment Eliminations [2]	Consolidated Totals
2021:						
Revenues from external customers	$ 81,515	$ 143,194	$ 66,078	$ 125	$ —	$ 290,912
Intersegment revenues	85	9,828	34,010	—	(43,923)	—
Net investment income	586	—	17	596	—	1,199
Total revenues	82,186	153,022	100,105	721	(43,923)	292,111
Adjusted operating income (loss)	5,012	6,859	7,623	(1,471)	(711)	17,312
Depreciation and amortization	1,837	576	1,884	215	—	4,512
2020:						
Revenues from external customers	74,926	132,663	60,208	111	—	267,908
Intersegment revenues	58	9,275	30,990	—	(40,323)	—
Net investment income	483	—	—	315	—	798
Total revenues	75,467	141,938	91,198	426	(40,323)	268,706
Adjusted operating income (loss)	6,188	5,688	6,146	(1,306)	(708)	16,008
Depreciation and amortization	1,832	612	1,801	196	—	4,441
2019:						
Revenues from external customers	68,979	130,428	56,258	100	—	255,765
Intersegment revenues	26	11,063	30,350	—	(41,439)	—
Net investment income	599	—	—	412	—	1,011
Total revenues	69,604	141,491	86,608	512	(41,439)	256,776
Adjusted operating income (loss)	5,202	5,129	6,705	(1,000)	(697)	15,339
Depreciation and amortization	1,721	766	1,723	161	—	4,371

(1) Total revenues of the Pharmacy Services segment include approximately $11.6 billion, $10.9 billion and $11.5 billion of retail co-payments for 2021, 2020 and 2019, respectively. See Note 1 ''Significant Accounting Policies'' for additional information about retail co-payments.

(2) Intersegment revenue eliminations relate to intersegment revenue generating activities that occur between the Health Care Benefits segment, the Pharmacy Services segment, and/or the Retail/LTC segment. Intersegment adjusted operating income eliminations occur when members of Pharmacy Services Segment clients ("PSS members") enrolled in Maintenance Choice® elect to pick up maintenance prescriptions at one of the Company's retail pharmacies instead of receiving them through the mail. When this occurs, both the Pharmacy Services and Retail/LTC segments record the adjusted operating income on a stand-alone basis.

The following is a reconciliation of consolidated operating income to adjusted operating income for the years ended December 31, 2021, 2020 and 2019:

In millions	**2021**	**2020**	**2019**
Operating income (GAAP measure)	$ 13,193	$ 13,911	$ 11,987
Amortization of intangible assets [1]	2,259	2,341	2,436
Acquisition-related integration costs [2]	132	332	480
Store impairments [3]	1,358	—	231
Goodwill impairment [4]	431	—	—
Acquisition purchase price adjustment outside of measurement period [5]	(61)	—	—
(Gain) loss on divestiture of subsidiary [6]	—	(269)	205
Receipt of fully reserved ACA risk corridor receivable [7]	—	(307)	—
Adjusted operating income	$ 17,312	$ 16,008	$ 15,339

(1) The Company's acquisition activities have resulted in the recognition of intangible assets as required under the acquisition method of accounting which consist primarily of trademarks, customer contracts/relationships, covenants not to compete, technology, provider networks and value of business acquired. Definite-lived intangible assets are amortized over their estimated useful lives and are tested for impairment when events indicate that the carrying value may not be recoverable. The amortization of intangible assets is reflected in the Company's GAAP consolidated statements of operations in operating expenses within each segment. Although intangible assets contribute to the Company's revenue generation, the amortization of intangible assets does not directly relate to the underwriting of the Company's insurance products, the services performed for the Company's customers or the sale of the Company's products or services. Additionally, intangible asset amortization expense typically fluctuates based on the size and timing of the Company's acquisition activity. Accordingly, the Company believes excluding the amortization of intangible assets enhances the Company's and investors' ability to compare the Company's past financial performance with its current performance and to analyze underlying business performance and trends. Intangible asset amortization excluded from the related non-GAAP financial measure represents the entire amount recorded within the Company's GAAP financial statements, and the revenue generated by the associated intangible assets has not been excluded from the related non-GAAP financial measure. Intangible asset amortization is excluded from the related non-GAAP financial measure because the amortization, unlike the related revenue, is not affected by operations of any particular period unless an intangible asset becomes impaired or the estimated useful life of an intangible asset is revised.

(2) In 2021, 2020 and 2019, acquisition-related integration costs relate to the Aetna Acquisition. The acquisition-related integration costs are reflected in the Company's GAAP consolidated statements of operations in operating expenses within the Corporate/Other segment.

(3) During the year ended December 31, 2021, the store impairment charge relates to the write down of operating lease right-of-use assets and property and equipment in connection with the planned closure of approximately 900 retail stores between 2022 and 2024. During the year ended December 31, 2019, the store impairment charges related to the write down of operating lease right-of-use assets in connection with the planned closure of 68 underperforming retail pharmacy stores in 2019 and 2020. The store impairment charges are reflected in the Company's GAAP consolidated statements of operations within the Retail/LTC segment.

(4) During the year ended December 31, 2021, the goodwill impairment charge relates to the LTC reporting unit within the Retail/LTC segment.

(5) In June 2021, the Company received $61 million related to a purchase price working capital adjustment for an acquisition completed during the first quarter of 2020. The resolution of this matter occurred subsequent to the acquisition accounting measurement period and is reflected in the Company's GAAP consolidated statement of operations for the year ended December 31, 2021 as a reduction of operating expenses within the Health Care Benefits segment.

(6) In 2020, the gain on divestiture of subsidiary represents the pre-tax gain on the sale of the Workers' Compensation business, which the Company sold on July 31, 2020 for approximately $850 million. The gain on divestiture is reflected as a reduction of operating expenses in the Company's GAAP consolidated statement of operations within the Health Care Benefits segment. In 2019, the loss on divestiture of subsidiary represents the pre-tax loss on the sale of Onofre, which occurred on July 1, 2019. The loss on divestiture primarily relates to the elimination of the cumulative translation adjustment from accumulated other comprehensive income and is reflected in the Company's GAAP consolidated statement of operations in operating expenses within the Retail/LTC segment.

(7) In 2020, the Company received $313 million owed to it under the ACA's risk corridor program that was previously fully reserved for as payment was uncertain. After considering offsetting items such as the ACA's minimum MLR rebate requirements and premium taxes, the Company recognized pre-tax income of $307 million in the Company's GAAP consolidated statement of operations within the Health Care Benefits segment.

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of CVS Health Corporation

Opinion on Internal Control over Financial Reporting

We have audited CVS Health Corporation's internal control over financial reporting as of December 31, 2021, 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, CVS Health Corporation (the Company) maintained, in all material respects, effective internal control over financial reporting as of December 31, 2021, 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 2021 consolidated financial statements of the Company and our report dated February 9, 2022, 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

Boston, Massachusetts
February 9, 2022

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of CVS Health Corporation

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of CVS Health Corporation (the Company) as of December 31, 2021 and 2020, the related consolidated statements of operations, comprehensive income, shareholders' equity and cash flows for each of the three years in the period ended December 31, 2021, and the related notes (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, 2021 and 2020, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2021, 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, 2021, 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 9, 2022, 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 Matters

The critical audit matters communicated below are matters arising from the current period audit of the financial statements that were communicated or required to be communicated to the audit committee and that: (1) relate to accounts or disclosures that are material to the financial statements and (2) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters 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 matters below, providing separate opinions on the critical audit matters or on the accounts or disclosures to which they relate.

Annual goodwill impairment test of the Commercial Business reporting unit

Description of the Matter

At December 31, 2021, the Company's goodwill related to the Commercial Business reporting unit was $26.5 billion. As discussed in Note 1 to the consolidated financial statements, goodwill is not amortized, but rather is subject to an annual impairment review, or more frequent reviews, if events and circumstances indicate an impairment exists.

Auditing management's annual goodwill impairment test related to the Commercial Business reporting unit was complex and highly judgmental due to the significant estimation required to determine the fair value of the reporting unit. In particular, the fair value estimate was sensitive to changes in significant assumptions, such as the discount rate, projected revenue and projected operating income that are forward-looking and affected by future economic and market conditions.

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 annual goodwill impairment review process, including controls over management's review of the significant assumptions described above.

To test the estimated fair value of the Commercial Business reporting unit, we performed audit procedures that included, among others, assessing methodologies and testing the significant assumptions discussed above and the underlying data used by the Company in its analysis. We compared the significant assumptions to the reporting unit's historical results and third-party industry data. We performed sensitivity analyses of significant assumptions to evaluate the changes in the fair value of the reporting unit that would result from changes in the key assumptions. We involved valuation specialists to assist in our assessment of the methodology and significant assumptions (such as the discount rate) used by the Company. In addition, we tested management's reconciliation of the fair value of all reporting units to the market capitalization of the Company.

Valuation of health care costs payable

Description of the Matter

At December 31, 2021, the incurred but not reported ("IBNR") liabilities represented $6.6 billion of $8.8 billion of health care costs payable. As discussed in Note 1 to the consolidated financial statements, the Company's liability for health care costs payable includes estimated payments for (1) services rendered to members but not yet reported and (2) claims that have been reported but not yet paid, each as of the financial statement date (collectively, "IBNR"). The estimated IBNR liability is developed utilizing actuarial principles and assumptions that include historical and projected claim submission and processing patterns, historical and assumed medical cost trends, historical utilization of medical services, claim inventory levels, changes in membership and product mix, seasonality and other relevant factors to record the actuarial best estimate of health care costs payable. There is significant uncertainty inherent in determining management's actuarial best estimate of health care costs payable. In particular, the estimate is sensitive to the assumed completion factors and the assumed health care cost trend rates.

Auditing management's actuarial best estimate of IBNR reserves for health care costs payable for its products and services involved a high degree of subjectivity in evaluating management's assumptions used in the valuation process.

How We Addressed the Matter in Our Audit

We obtained an understanding, evaluated the design and tested the operating effectiveness of controls over the process for estimating IBNR reserves. This included, among others, controls over the completeness and accuracy of data used in the actuarial projections, the transfer of data between underlying source systems, and the review and approval processes that management has in place for the actuarial principles and assumptions used in estimating the health care costs payable.

To test IBNR reserves, our audit procedures included, among others, testing the completeness and accuracy of the underlying claim and membership data used in the calculation of IBNR reserves. We involved actuarial specialists to assist with our audit procedures, which included, among others, evaluating the methodologies applied by the Company in determining the actuarially determined liability, evaluating management's actuarial principles and assumptions used in their analysis based on historical claim experience, and independently calculating a range of reserve estimates for comparison to management's actuarial best estimate of the liability for health care costs payable. 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 2007.

Boston, Massachusetts
February 9, 2022

Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure.

None.

Item 9A. Controls and Procedures.

Evaluation of disclosure controls and procedures

The Company's Chief Executive Officer and Chief Financial Officer, after evaluating the effectiveness of the design and operation of the Company's disclosure controls and procedures (as defined in Rules 13a-15 (f) and 15d-15(f) under the Securities Exchange Act of 1934) as of December 31, 2021, have concluded that as of such date the Company's disclosure controls and procedures were adequate and effective at a reasonable assurance level and designed to ensure that material information relating to the Company and its consolidated subsidiaries would be made known to such officers on a timely basis.

Management's report on internal control over financial reporting

Management is responsible for establishing and maintaining adequate internal control over financial reporting. The 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 the Company's consolidated 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 Company's consolidated financial statements. In order to ensure the Company's internal control over financial reporting is effective, management regularly assesses such control and did so most recently for its financial reporting as of December 31, 2021.

Management conducted an assessment of the effectiveness of the Company's internal control over financial reporting based on the criteria established in *Internal Control-Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 Framework). This evaluation included review of the documentation, evaluation of the design effectiveness and testing of the operating effectiveness of controls. The Company's system of internal control over financial reporting is enhanced by periodic reviews by the Company's internal auditors, written policies and procedures and a written Code of Conduct adopted by CVS Health Corporation's Board of Directors, applicable to all employees of the Company. In addition, the Company has an internal Disclosure Committee, comprised of management from each functional area within the Company, which performs a separate review of disclosure controls and procedures. There are inherent limitations in the effectiveness of any system of internal control over financial reporting.

Based on management's assessment, management concluded that the Company's internal control over financial reporting is effective and provides reasonable assurance that assets are safeguarded and that the financial records are reliable for preparing financial statements as of December 31, 2021.

Ernst & Young LLP, the Company's independent registered public accounting firm, is appointed by CVS Health Corporation's Board of Directors and ratified by CVS Health Corporation's stockholders. They were engaged to render an opinion regarding the fair presentation of the Company's consolidated financial statements as well as conducting an audit of internal control over financial reporting. Their reports included in Item 8 of this Form 10-K are based upon audits conducted in accordance with the standards of the Public Company Accounting Oversight Board (United States).

Changes in internal control over financial reporting

There has been no change in the Company's internal control over financial reporting identified in connection with the evaluation required by paragraph (d) of Rule 13a-15 or Rule 15d-15 that occurred during the fourth quarter ended December 31, 2021 that has materially affected, or is reasonably likely to materially affect, the Company's internal control over financial reporting.

Item 9B. Other Information.

No events have occurred during the fourth quarter ended December 31, 2021 that would require disclosure under this item.

PART III

Item 10. Directors, Executive Officers and Corporate Governance.

Information concerning the Executive Officers of CVS Health Corporation is included in Part I of this 10-K pursuant to General Instruction G to Form 10-K.

The sections of the Proxy Statement under the captions "Committees of the Board as of the Annual Meeting," "Code of Conduct," "Audit Committee Report," and "Biographies of our Incumbent Board Nominees" are incorporated herein by reference.

Item 11. Executive Compensation.

The sections of the Proxy Statement under the captions "Non-Employee Director Compensation" and "Executive Compensation and Related Matters," including "Letter from the Management Planning and Development Committee," "Compensation Committee Report," "Compensation Discussion and Analysis" and "Compensation of Named Executive Officers" are incorporated herein by reference.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.

The sections of the Proxy Statement under the captions "Share Ownership of Directors and Certain Executive Officers" and "Share Ownership of Principal Stockholders" are incorporated herein by reference. Those sections contain information concerning security ownership of certain beneficial owners and management and related stockholder matters.

The following table summarizes information about the registrant's common stock that may be issued upon the exercise of options, warrants and rights under all of the Company's equity compensation plans as of December 31, 2021:

	Number of securities to be issued upon exercise of outstanding options, warrants and rights [1] [2] (a)	Weighted average exercise price of outstanding options, warrants and rights (b)	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in first column) [1] (c)
Equity compensation plans approved by stockholders [3]	29,075	$ 74.09	29,585
Equity compensation plans not approved by stockholders [4]	5,064	43.63	—
Total	34,139	$ 72.68	29,585

(1) Shares in thousands.

(2) Consists of: (i) 17,575 shares of common stock underlying outstanding options, (ii) 854 shares of common stock issuable upon the exercise of outstanding stock appreciation rights ("SARs") and (iii) 15,710 shares of common stock issuable on the vesting of outstanding restricted stock units, deferred stock units and performance stock units, assuming target level performance in the case of performance stock units. The number of shares included with respect to outstanding SARs is the number of shares of CVS Health Corporation common stock that would have been issued had the SARs been exercised based on the closing price per share of CVS Health Corporation common stock on December 31, 2021, as reported on the NYSE, which was $103.16.

(3) Consists of the CVS Health 2017 Incentive Compensation Plan.

(4) Consists of the Amended Aetna Inc. 2010 Stock Incentive Plan (the "Aetna Stock Plan"). The Aetna Stock Plan expired on May 21, 2020, therefore there are no securities available for future issuance under this plan.

The Aetna Stock Plan was last approved by Aetna's shareholders at Aetna's 2017 Annual Meeting on May 19, 2017. The Company elected to continue to grant awards under the Aetna Stock Plan to employees of Aetna and its subsidiaries following the completion of the Company's acquisition of Aetna. The Aetna Stock Plan was designed to promote the Company's interests and those of its stockholders and to further align the interests of stockholders and employees by tying awards to total return to stockholders, enabling plan participants to acquire additional equity interests in the Company and providing compensation opportunities dependent upon the Company's performance. The Aetna Stock Plan was not submitted to the Company's stockholders and expired on May 21, 2020. Under the Aetna Stock Plan, eligible participants could be granted stock options to

purchase shares of CVS Health Corporation common stock, SARs, time-vesting and/or performance-vesting incentive stock or incentive units and other stock-based awards.

Item 13. Certain Relationships and Related Transactions, and Director Independence.

The sections of the Proxy Statement under the captions “Independence Determinations for Directors” and “Related Person Transaction Policy” are incorporated herein by reference.

Item 14. Principal Accountant Fees and Services.

The section of the Proxy Statement under the caption “Item 2: Ratification of Appointment of Independent Registered Public Accounting Firm for 2021” is incorporated herein by reference.

PART IV

Item 15. Exhibits, Financial Statement Schedules.

The following documents are filed as part of this 10-K:

1. Financial Statements. See "Index to Consolidated Financial Statements" in Item 8 of this 10-K.

2. Financial Statement Schedules. All financial statement schedules are omitted because they are not applicable, not required under the instructions, or the information is included in the consolidated financial statements or related notes.

3. Exhibits. The exhibits listed in the "Index to Exhibits" in this Item 15 are filed or incorporated by reference as part of this 10-K. Exhibits marked with an asterisk (*) are management contracts or compensatory plans or arrangements. Exhibits other than those listed are omitted because they are not required to be listed or are not applicable. Pursuant to Item 601(b)(4)(iii) of Regulation S-K, the Registrant hereby agrees to furnish to the Securities and Exchange Commission a copy of any omitted instrument that is not required to be listed.

INDEX TO EXHIBITS

Exhibit	Description
3	**Articles of Incorporation and Bylaws**
3.1	Restated Certificate of Incorporation of the Registrant dated June 4, 2018 (incorporated by reference to Exhibit 3.1C of Registrant's Current Report on Form 8-K filed June 5, 2018).
3.2	By-Laws of the Registrant, as amended and restated July 8, 2020 (incorporated by reference to Exhibit 3.1 to the Registrant's Current Report on Form 8-K filed July 10, 2020).
4	**Instruments defining the rights of security holders, including indentures**
4.1	Specimen common stock certificate (incorporated by reference to Exhibit 4.1 to the Registration Statement of the Registrant ((then known as CVS Corporation) as successor to Melville Corporation) on Form 8-B filed November 4, 1996).
4.2	Senior Indenture dated August 15, 2006, between the Registrant and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed August 15, 2006).
4.3	Form of the Registrant's 2021 Floating Rate Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.4	Form of the Registrant's 2021 Note (incorporated by reference to Exhibit 4.4 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.5	Form of the Registrant's 2023 Note (incorporated by reference to Exhibit 4.5 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.6	Form of the Registrant's 2025 Note (incorporated by reference to Exhibit 4.6 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.7	Form of the Registrant's 2028 Note (incorporated by reference to Exhibit 4.7 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.8	Form of the Registrant's 2038 Note (incorporated by reference to Exhibit 4.8 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.9	Form of the Registrant's 2048 Note (incorporated by reference to Exhibit 4.9 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.10	Form of the Registrant's 2024 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed August 15, 2019).
4.11	Form of the Registrant's 2026 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed August 15, 2019).
4.12	Form of the Registrant's 2029 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed August 15, 2019).
4.13	Form of the Registrant's 2027 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed on March 31, 2020).
4.14	Form of the Registrant's 2030 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed on March 31, 2020).
4.15	Form of the Registrant's 2040 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed on March 31, 2020).

4.16	Form of the Registrant's 2050 Note (incorporated by reference to Exhibit 4.4 to the Registrant's Current Report on Form 8-K filed on March 31, 2020).
4.17	Form of the Registrant's 2027 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed on August 21, 2020).
4.18	Form of the Registrant's 2030 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed on August 21, 2020).
4.19	Form of the Registrant's 2040 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed on August 21, 2020).
4.20	Form of the Registrant's 2027 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed on December 16, 2020).
4.21	Form of the Registrant's 2031 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed on December 16, 2020).
4.22	Form of the 2031 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed on August 18, 2021).
4.23	Material terms of outstanding securities that are registered under Section 12 of the 1934 Act as required by Item 202(a)-(d) and (f) of Regulation S-K.
10	**Material Contracts**
10.1	Five Year Credit Agreement dated as of May 11, 2021, by and among the Registrant, the lenders party thereto, and Bank of America, N.A., as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2021).
10.2	Five Year Credit Agreement, dated as of May 16, 2019, by and among the Registrant, the lenders party thereto and Bank of America N.A., as Administrative Agent (incorporated by reference to Exhibit 10.2 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).
10.3	Amendment No. 1 to Five Year Credit Agreement dated as of May 16, 2019, to the Five Year Credit Agreement dated as of May 17, 2018, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.3 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).
10.4	Five Year Credit Agreement dated as of May 17, 2018, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018).
10.5*	The Registrant's Supplemental Retirement Plan I for Select Senior Management, as amended and restated as of December 31, 2008 (incorporated by reference to Exhibit 10.6 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2009).
10.6*	Form of Enterprise Non-Competition, Non-Disclosure and Developments Agreement between the Registrant and certain of the Registrant's executive officers (incorporated by reference to Exhibit 10.25 of the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2013).
10.7*	The Registrant's Deferred Stock Compensation Plan, as amended and restated (incorporated by reference to Exhibit 10.11 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2019).
10.8*	The Registrant's 2007 Employee Stock Purchase Plan, as amended (incorporated by reference to Exhibit 99.2 to the Registrant's Registration Statement on Form S-8 filed May 19, 2020).
10.9*	Universal 409A Definition Document, as amended (incorporated by reference to Exhibit 10.28 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
10.10*	The Registrant's Amended and Restated Deferred Compensation Plan.
10.11*	The Registrant's Partnership Equity Program, as amended (incorporated by reference to Exhibit 10.25 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.12*	The Registrant's Performance-Based Restricted Stock Unit Plan, as amended (incorporated by reference to Exhibit 10.27 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.13*	The Registrant's 2017 Incentive Compensation Plan, as amended (incorporated by reference to Exhibit 99.1 to the Registrant's Registration Statement on Form S-8 filed May 19, 2020).
10.14*	The Registrant's Executive Incentive Plan, as amended (incorporated by reference to Exhibit 10.4 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017).
10.15*	The Registrant's Long-Term Incentive Plan, as amended (incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017).
10.16*	Form of Non-Qualified Stock Option Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.29 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.17*	Form of Restricted Stock Unit Agreement - Annual Grant - between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.30 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).

10.18*	Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.19*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Pre-Tax) (incorporated by reference to Exhibit 10.32 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.20*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Post-Tax) (incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.21*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2018).
10.22*	Form of Performance Stock Unit Agreement (LTIP) - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2018).
10.23*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended September 30, 2020).
10.24*	The Registrant's Management Incentive Plan (incorporated by reference to Exhibit 10.27 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2019).
10.25*	The Registrant's Amended and Restated Severance Plan for Non-Store Employees dated October 11, 2021.
10.26*	The Registrant's Performance-Based Restricted Stock Unit Program, as amended (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.27*	Form of Non-Qualified Stock Option Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.39 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.28*	Form of Restricted Stock Unit Agreement - Annual Grant - between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.40 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.29*	Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.41 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.30*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Pre-Tax) (incorporated by reference to Exhibit 10.42 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.31*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Post-Tax) (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2013).
10.32*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.5 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).
10.33*	Amended and Restated Employment Agreement between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2008).
10.34*	Amendment dated as of December 21, 2012 to the Amended and Restated Employment Agreement between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012).
10.35*	Form of Non-Qualified Stock Option Agreement - Annual Grant between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.37 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.36*	Form of Restricted Stock Unit Agreement - Annual Grant between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.37*	Amendment dated January 22, 2015 to Nonqualified Stock Option Agreements between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K filed January 23, 2015).
10.38*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).
10.39*	Change in Control Agreement effective as of July 19, 2010 between the Registrant and Eva Boratto (incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2019).

10.40*	Restrictive Covenant Agreement dated June 21, 2019 between the Registrant and Eva Boratto (incorporated by reference to Exhibit 10.48 to the registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2019).
10.41*	Separation Agreement dated June 9, 2021 between CVS Pharmacy, Inc. and Eva C. Boratto (incorporated by reference to Exhibit 10.3 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2021).
10.42*	Change in Control Agreement dated December 22, 2008 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012).
10.43*	Amendment dated as of December 31, 2012 to the Change in Control Agreement dated December 22, 2008 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.34 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012).
10.44*	Restricted Stock Unit Agreement - Annual Grant dated April 1, 2016 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.44 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.45*	Restrictive Covenant Agreement dated May 20, 2016 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.45 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.46*	Change in Control Agreement dated October 1, 2012 between the Registrant and Thomas Moriarty (incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2015).
10.47*	Restrictive Covenant Agreement dated July 8, 2019 between the Registrant and Thomas Moriarty (incorporated by reference to Exhibit 10.56 of the Registrant's Annual Report on form 10-K for the fiscal year ended December 31, 2019).
10.48*	Amended and Restated Employment Agreement dated November 5, 2020 between the Registrant and Karen S. Lynch (incorporated by reference to Exhibit 10.51 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2020).
10.49*	Restrictive Covenant Agreement dated November 6, 2020 between the Registrant and Karen S. Lynch (incorporated by reference to Exhibit 10.52 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2020).
10.50*	Restrictive Covenant Agreement dated September 29, 2020 between the Registrant and Alan Lotvin (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2021).
10.51*	Change in Control Agreement dated October 15, 2012 between the Registrant and Alan Lotvin (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2021).
10.52*	Letter Agreement dated May 16, 2021 between the Registrant and Shawn Guertin (incorporated by reference to Exhibit 10.4 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2021).
10.53*	Restrictive Covenant Agreement dated May 16, 2021 between CVS Pharmacy, Inc. and Shawn Guertin (incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2021).
10.54*	Change in Control Agreement dated May 16, 2021 between the Registrant and Shawn Guertin (incorporated by reference to Exhibit 10.6 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2021).
10.55*	Form of Nonqualified Stock Option Agreement between the Registrant and selected employees of the Registrant.
10.56*	Descriptions of certain arrangements not embodied in formal documents as described under the heading "Non-Employee Director Compensation" are incorporated herein by reference to the Proxy Statement (when filed).
21	**Subsidiaries of the registrant**
21.1	Subsidiaries of CVS Health Corporation.
23	**Consents of experts and counsel**
23.1	Consent of Ernst & Young LLP.
31	**Rule 13a-14(a)/15d-14(a) Certifications**
31.1	Certification by the Chief Executive Officer.
31.2	Certification by the Chief Financial Officer.
32	**Section 1350 Certifications**
32.1	Certification by the Chief Executive Officer.

32.2	Certification by the Chief Financial Officer.
101	**Interactive Data File**
101	The following materials from the CVS Health Corporation Annual Report on Form 10-K for the fiscal year ended December 31, 2021 formatted in Inline XBRL: (i) the Consolidated Statements of Operations, (ii) the Consolidated Statements of Comprehensive Income, (iii) the Consolidated Balance Sheets, (iv) the Consolidated Statements of Cash Flows, (v) the Consolidated Statements of Shareholders' Equity and (vi) the related Notes to Consolidated Financial Statements. The instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
104	
104	Cover Page Interactive Data File - The cover page from the Company's Annual Report on Form 10-K for the year ended December 31, 2021, formatted in Inline XBRL (included as Exhibit 101).

Item 16. Form 10-K Summary.

None.

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SIGNATURES

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

CVS HEALTH CORPORATION

Date: February 9, 2022

By: /s/ SHAWN M. GUERTIN

Shawn M. Guertin

Executive Vice President and Chief Financial Officer

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

Signature	Title(s)	Date
/s/ FERNANDO AGUIRRE **Fernando Aguirre**	Director	February 9, 2022
/s/ C. DAVID BROWN II **C. David Brown II**	Director	February 9, 2022
/s/ JAMES D. CLARK **James D. Clark**	Senior Vice President - Controller and Chief Accounting Officer (Principal Accounting Officer)	February 9, 2022
/s/ ALECIA A. DECOUDREAUX **Alecia A. DeCoudreaux**	Director	February 9, 2022
/s/ NANCY-ANN M. DEPARLE **Nancy-Ann M. DeParle**	Director	February 9, 2022
/s/ DAVID W. DORMAN **David W. Dorman**	Chair of the Board and Director	February 9, 2022
/s/ ROGER N. FARAH **Roger N. Farah**	Director	February 9, 2022
/s/ ANNE M. FINUCANE **Anne M. Finucane**	Director	February 9, 2022
/s/ SHAWN M. GUERTIN **Shawn M. Guertin**	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 9, 2022
/s/ EDWARD J. LUDWIG **Edward J. Ludwig**	Director	February 9, 2022
/s/ KAREN S. LYNCH **Karen S. Lynch**	President and Chief Executive Officer (Principal Executive Officer) and Director	February 9, 2022
/s/ JEAN-PIERRE MILLON **Jean-Pierre Millon**	Director	February 9, 2022
/s/ MARY L. SCHAPIRO **Mary L. Schapiro**	Director	February 9, 2022
/s/ WILLIAM C. WELDON **William C. Weldon**	Director	February 9, 2022
/s/ TONY L. WHITE **Tony L. White**	Director	February 9, 2022

Exhibit 4.23

DESCRIPTION OF COMMON STOCK REGISTERED UNDER SECTION 12 OF THE SECURITIES EXCHANGE ACT OF 1934

The following description (this "Description") of the terms of the common stock of CVS Health Corporation ("CVS Health") is a summary only and is qualified by reference to the relevant provisions of Delaware law and the Restated Certificate of Incorporation (the "Charter") and the By-Laws (the "By-Laws") of CVS Health. Copies of the Charter and the By-Laws are incorporated by reference as exhibits to the Annual Report on Form 10-K to which this Description is an exhibit.

Authorized Capital Stock

Under the Charter as of February 9, 2022, the authorized capital stock of CVS Health consisted of (i) 3,200,000,000 shares of common stock, par value of $0.01 per share ("common stock"), (ii) 120,619 shares of cumulative preferred stock, par value $0.01 per share ("preferred stock"), and (iii) 50,000,000 shares of preference stock, par value $1.00 per share ("preference stock").

Common Stock

The holders of shares of common stock are entitled to one vote per share on all matters voted on by CVS Health stockholders, including elections of directors. Except as otherwise required by law, or by the provisions of the preferred stock or the preference stock, or provided in any resolution adopted by the CVS Health board of directors (the "board") with respect to any subsequently created class or series of shares of CVS Health, the holders of the shares of common stock exclusively possess all voting power. The Charter precludes cumulative voting in the election of directors. The Charter provides for a majority vote standard for uncontested elections of directors, and a plurality of votes standard for contested elections of directors. Subject to any rights of any outstanding series of preferred stock or preference stock, (i) the holders of shares of common stock are entitled to such dividends as may be declared from time to time by the board from funds available therefor, (ii) no dividends may be declared, paid, or set aside for payment on shares of common stock unless full cumulative dividends are paid on any outstanding preference stock and any other preferred stock issued and outstanding at such time that is designated to have such dividend preference and (iii) upon dissolution the holders of shares of common stock are entitled to receive pro rata all assets of CVS Health available for distribution to such holders, subject to any liquidation preferences designated to any preferred stock or preference stock that may be issued and outstanding at such time of liquidation.

No Preemptive Rights

The Charter provides that no holder of any shares of CVS Health of any class or series may have any preemptive right to purchase or subscribe to any shares of CVS Health or any security convertible into shares of CVS Health of any class or series.

Provisions Relating to Amendments to CVS Health's Charter and By-Laws

Under Delaware law, stockholders have the right to adopt, amend or repeal the certificate of incorporation and by-laws of a corporation. However, Delaware law requires that any amendment to the Charter also be approved by the board. Under Delaware law, unless a higher vote is required in a corporation's certificate of incorporation, amendments to the corporation's certificate of incorporation will be adopted upon receiving at a properly convened meeting the affirmative vote of a majority of the votes cast by all stockholders entitled to vote thereon, and if any class or series is entitled to vote thereon as a class, the affirmative vote of a majority of the votes cast in each class vote.

In addition, the By-Laws may be amended by the board with respect to all matters not exclusively reserved by law to the stockholders. Amendments to the By-Laws may be adopted and approved by the affirmative vote of the holders of record of a majority of the outstanding shares of stock of CVS Health entitled to vote at any annual or special meeting, or by the affirmative vote of a majority of the directors cast at any regular or special meeting, at which a quorum is present.

Certain Statutory and Charter Provisions

Certain provisions of the Charter and By-Laws summarized in the following paragraphs may be deemed to have an antitakeover effect and may delay, defer or prevent a tender offer or takeover attempt.

Potential Issuances of Preferred Stock and Preference Stock

As of February 9, 2022, the Charter authorized 120,619 shares of preferred stock, par value $0.01 per share and 50,000,000 shares of preference stock, par value $1.00 per share. The Charter also authorizes the board to issue shares of preferred stock or preference stock, from time to time, in such class or classes, and such series within any class, and with such designations, preferences and relative, participating, optional or other special rights, and qualifications, limitations or restrictions thereof as the board may determine, including, for example, (i) the designation of the class or series; (ii) the number of shares of the class or series, which number the board may thereafter (except where otherwise provided in the designation of any subsequently authorized class or series) increase or decrease (but not below the number of shares thereof then outstanding); (iii) whether dividends, if any, will be cumulative or noncumulative and the dividend rate of the class or series; (iv) the dates on which dividends, if any, will be payable; (v) the redemption rights and price or prices, if any, for shares of the class or series; (vi) the terms and amounts of any sinking fund provided for the purchase or redemption of shares of the class or series; (vii) the amounts payable on shares of the class or series in the event of any voluntary or involuntary liquidation, dissolution or winding up of the affairs of CVS Health; (viii) whether the shares of the class or series will be convertible into shares of any other class or series, or any other security, of CVS Health or any other corporation, and, if so, the specification of such other class or series or such other security, the conversion price or prices or rate or rates, any adjustments thereof, the date or dates as of which such shares will be convertible and all other terms and conditions upon which such conversion may be made; (ix) restrictions on the issuance of shares of the same class or series or of any other class or series; and (x) the voting rights, if any, of the holders of such class or series. The authorized capital stock of CVS Health, including preferred stock, preference stock and common stock, will be available for issuance without further action by CVS Health stockholders, unless such action is required by applicable law or the rules of any stock exchange or automated quotation system on which CVS Health's securities may be listed or traded. If the approval of CVS Health stockholders is not so required, the board does not intend to seek stockholder approval.

Although the board has no intention at the present time of doing so, it could issue a class or series of preferred stock or preference stock that could, depending on the terms of such class or series, impede completion of a merger, tender offer or other takeover attempt that the holders of some, or a majority, of CVS Health shares might believe to be in their best interests or in which CVS Health stockholders might receive a premium for their shares over the then-current market price of such shares.

Potential Issuances of Rights to Purchase Securities

CVS Health does not currently have a stockholder rights plan, although the board retains the right to adopt a new plan at a future date. The Charter grants the board exclusive authority to create and issue rights entitling the holders thereof to purchase from CVS Health shares of capital stock or other securities and to elect to repurchase, redeem, terminate or amend any such rights. The times at which and terms upon which such rights are to be issued, repurchased, redeemed, terminated or amended are to be determined exclusively by the board and set forth in the contracts or instruments that evidence any such rights. The authority of the board with respect to such rights includes determining, for example, (i) the purchase price of the capital stock or other securities or property to be purchased upon exercise of such rights; (ii) provisions relating to the times at which and the circumstances under which such rights may be exercised or sold or otherwise transferred, either together with or separately from any other shares or other securities of CVS Health; (iii) provisions which adjust the number or exercise price of such rights or the amount or nature of the shares, other securities or other property receivable upon exercise of such rights in the event of a combination, split or recapitalization of any shares of CVS Health, a change in ownership of CVS Health's shares or other securities or a reorganization, merger, consolidation, sale of assets or other occurrence relating to CVS Health or any shares of CVS Health, and provisions restricting the ability of CVS Health to enter into any such transaction absent an assumption by the other party or parties thereto of the obligations of CVS Health under such rights; (iv) provisions which deny the holder of a specified percentage of the outstanding securities of CVS Health the right to exercise such rights and/or cause such rights held by such holder to become void; (v) provisions which

permit CVS Health to redeem or exchange such rights; and (vi) the appointment of the rights agent with respect to such rights. This provision is intended to confirm the board's exclusive authority to issue, repurchase, redeem, terminate or amend share purchase rights or other rights to purchase shares or securities of CVS Health or any other corporation.

Stockholder Action by Written Consent

The Charter provides that stockholder action may be taken at an annual or special meeting of stockholders or by written consent in lieu of a meeting, but only if such action is taken in accordance with the provisions of the Charter and By-Laws. Any person other than CVS Health seeking to have the CVS Health stockholders authorize or take corporate action by written consent without a meeting is required to deliver a written notice signed by holders of record of at least twenty-five percent (25%) of the voting power of the outstanding capital stock of CVS Health entitled to express consent on the relevant action and request that a record date be fixed for such purpose.

Stockholder Vote on Fundamental or Extraordinary Corporate Transactions

Under Delaware law, a sale, lease or exchange of all or substantially all of CVS Health's assets, an amendment to the Charter, a merger or consolidation of CVS Health with another corporation or a dissolution of CVS Health generally requires the affirmative vote of the board and, with limited exceptions, the affirmative vote of a majority of the aggregate voting power of the outstanding stock entitled to vote on the transaction.

With respect to transactions with related persons (persons who own at least 10% of the outstanding capital stock of CVS Health), the Charter provides that a majority of outstanding shares (excluding those owned by the related person) voting as a single class is required to approve a business combination transaction with a related person, unless (i) such transaction is approved by a majority of continuing directors (directors who are not the related person, or an affiliate or associate thereof (or a representative or nominee of the related person or such affiliate or associate), that is involved in the relevant business combination and (a) who were members of the board immediately prior to the time that such related person became a related person or (b) whose initial election as a director was recommended by the affirmative vote of a least a majority of the continuing directors then in office, provided that, in either such case, such continuing director has continued in office after becoming a continuing director) or (ii) certain fair price requirements are met.

State Anti-Takeover Provisions

CVS Health has not opted out of Section 203 of the Delaware General Corporation Law, which provides that, if a person acquires 15% or more of the outstanding voting stock of a Delaware corporation, thereby becoming an "interested stockholder," that person may not engage in certain "business combinations" with the corporation, including mergers, purchases and sales of 10% or more of its assets, stock purchases and other transactions pursuant to which the percentage of the corporation's stock owned by the interested stockholder increases (other than on a pro rata basis) or pursuant to which the interested stockholder receives a financial benefit from the corporation, for a period of three years after becoming an interested stockholder unless one of the following exceptions applies: (i) the board approved the acquisition of stock pursuant to which the person became an interested stockholder or the transaction that resulted in the person becoming an interested stockholder prior to the time that the person became an interested stockholder; (ii) upon consummation of the transaction that resulted in the person becoming an interested stockholder such person owned at least 85% of the outstanding voting stock of CVS Health, excluding, for purposes of determining the voting stock outstanding, voting stock owned by directors who are also officers and certain employee stock plans; or (iii) the transaction is approved by the board and by the affirmative vote of two-thirds of the outstanding voting stock which is not owned by the interested stockholder. An "interested stockholder" also includes the affiliates and associates of a 15% or more owner and any affiliate or associate of CVS Health who was the owner of 15% or more of the outstanding voting stock within the three-year period prior to determine whether a person is an interested stockholder.

Exhibit 10.10

CVSHealth

CVS HEALTH CORPORATION

DEFERRED COMPENSATION PLAN

Amended and Restated Effective January 1, 2022

CVS HEALTH CORPORATION

Deferred Compensation Plan

ARTICLE I – INTRODUCTION

1.1 Name of Plan.

CVS Health Corporation (the "Company") hereby adopts the CVS Health Deferred Compensation Plan as amended and restated as of January 1, 2022 (the "Plan").

1.2 Purpose of Plan.

The purpose of the Plan is to provide certain eligible employees of the Company or an Affiliate authorized by the Committee to participate in the Plan the opportunity to defer elements of his or her compensation which might not otherwise be deferrable under other plans maintained by the Company or an Affiliate and to make deferrals and receive contributions that would be obtainable under the CVS Health Future Fund 401(k) Plan ("Future Fund") in the absence of certain restrictions and limitations in the Internal Revenue Code.

1.3 "Top Hat" Pension Benefit Plan.

The Plan is an "employee pension benefit plan" within the meaning of ERISA. However, the Plan is unfunded and maintained for a select group of management or highly compensated employees and, therefore, it is intended that the Plan will be exempt from Parts 2, 3 and 4 of Title I of ERISA. The Plan is not intended to qualify under Section 401(a) of the Code.

1.4 Funding.

The Plan is unfunded. All benefits will be paid from the general assets of the Company. Participants in the Plan shall have the status of general unsecured creditors of the Company.

1.5 Effective Date.

The Plan was originally effective as of January 1, 1997, and amended and restated in its entirety effective as of December 31, 2008, to comply with the provisions of Section 409A of the Internal Revenue Code and regulations promulgated thereunder and as of December 17, 2014, October 1, 2015, November 1, 2016, and January 1, 2020 to reflect certain design and administrative changes desired by the Company.

1.6 Administration.

The Plan shall be administered by the Deferred Compensation Plans Committee, as defined in Article VII.

1.7 Number and Gender.

Wherever appropriate herein, words used in the singular shall be considered to include the plural and words used in the plural shall be considered to include the singular. The masculine gender, where appearing in the Plan, shall be deemed to include the feminine gender. The feminine gender, where appearing in the Plan, shall be deemed to include the masculine gender.

1.8 Headings.

The headings of Articles and Sections herein are included solely for convenience, and if there is any conflict between such headings and the text of the Plan, the text shall control.

ARTICLE II – DEFINITIONS

For purposes of the Plan, the following words and phrases shall have the meanings set forth below, unless their context clearly requires a different meaning:

2.1 Account.

The Company Account, Deferral Account, Grandfathered Company Account, and the Grandfathered Deferral Account maintained by the Company on behalf of each Participant pursuant to the Plan.

2.2 Aetna Plans.

The Aetna Deferred Compensation Program ("Aetna Program") and the Aetna Supplemental 401K Plan ("Aetna Supplemental Plan").

2.3 Affiliate.

A subsidiary of the Company, as defined in the Company's Universal 409A Definition Document.

2.4 Annual Cash Incentive.

The amount awarded to a Participant in cash for a Plan Year under a regular (annual) incentive plan (other than an exceptional performance award program or a one-time incentive plan or program) maintained by the Company or an Affiliate, and any other amount otherwise included in Annual Cash Incentive for purposes of the Plan under rules as are adopted by the Committee.

Effective January 1, 2015, Operation Production Incentives shall be excluded from the definition of Annual Cash Incentive.

2.5 Annual Cash Incentive Deferral.

The amount of a Participant's Annual Cash Incentive which a Participant elects to have withheld on a pre-tax basis from his or her Annual Cash Incentive and credited to his or her Deferral Account pursuant to the Plan.

2.6 Base Salary.

The base rate of cash compensation paid by the Company or an Affiliate to or for the benefit of a Participant for services rendered or labor performed while a Participant, including deferrals pursuant to the Plan and any pre-tax contribution to be made on the Participant's behalf to any qualified plan maintained by the Company or an Affiliate pursuant to a cash or deferred arrangement maintained by the Company or an Affiliate (as defined under Section 401(k) of the Code) or under any cafeteria plan (as defined under Section 125 of the Code) or under a qualified transportation fringe (as defined under Section 132(f) of the Code). Base Salary shall exclude any overtime, premium pay, shift differentials, bonuses, commissions or any other form of supplemental cash compensation, except to the extent otherwise deemed "Base Salary" for purposes of the Plan under rules as are adopted by the Committee.

2.7 Base Salary Deferral.

The amount of a Participant's Base Salary which the Participant elects to have withheld on a pre- tax basis from his or her Base Salary and credited to his or her Deferral Account pursuant to the Plan.

2.8 Beneficiary.

The person or persons (which may include trusts) designated in writing (either by hand or electronic submission) by the Participant on the beneficiary designation form prescribed by the Plan Administrator to receive the amounts, if any, payable under the Plan upon the death of the Participant. In the absence of such written designation by the Participant, the Beneficiary shall mean, in the following order, the Participant's spouse, if any; the person named as the Participant's beneficiary under the Company's life insurance program; or the Participant's estate.

2.9 Board.

The Board of Directors of the Company.

2.10 Change in Control.

"Change in Control" as such term is defined in the Universal 409A Definition Document.

2.11 Code.

The Internal Revenue Code of 1986, as amended. References to any provision of the Code or regulation (including a proposed regulation) thereunder shall include any successor provisions or regulations.

2.12 Commissions.

The amount of a Participant's sales commissions or other commissions payable under a sales commissions or other commissions plan maintained by the Company or an Affiliate. (Sales commissions for purposes of the Plan shall mean sales commissions as defined in Treas. Reg. Section 1.409A-2(a)(12)(i) and any subsequent guidance and such sales commissions are considered to be earned in the taxable year of the Participant in which the sale is completed so that the amount of the Commissions are reasonably determinable.)

2.13 Commissions Deferral.

The amount of a Participant's Commissions that a Participant elects to have withheld on a pre-tax basis from his or her Commissions and credited to his or her Deferral Account pursuant to the Plan.

2.14 Committee.

The Management Planning and Development Committee of the Board of Directors of the Company or any other directors of the Company designated as the Committee.

2.15 Company Account.

The bookkeeping account (or subaccount(s) thereof) maintained for each Participant to record the amount of Company Contributions that are either (i) credited on his or her behalf under Section 4.4 on or after January 1, 2005 or (ii) were credited on his or her behalf under Section 4.4 prior to January 1, 2005, but became vested on or after January 1, 2005, as adjusted pursuant to Section 5.6.

2.16 Company Contribution.

The amount, as determined by the Company on an annual basis based on the provisions of the Plan, which is credited on the Participant's behalf by the Company to his or her Company Account pursuant to the provisions of Section 4.4(a) of the Plan.

2.17 CVS Caremark Retention Payment.

The amount granted to an Eligible Executive, as defined in and provided for under the provisions of the employment term sheet agreement entered into between the Company or an Affiliate and said Eligible Executive, as a former employee of Caremark Rx, Inc., in connection with the merger involving Caremark, Rx, Inc. and the Company.

2.18 Deferrals.

The amount of deferrals credited to a Participant pursuant to Section 4.1.

2.19 Deferral Account.

The bookkeeping account (or subaccount(s) thereof) maintained for each Participant to record any and all deferrals made under the Plan.

2.20 Deferred Compensation Election.

The written election (either by hand or electronic submission) including any amendments, attachments and appendices thereto as prescribed by the Plan Administrator, regardless of how it may be titled, under which the Participant agrees to defer a portion of his or her Base Salary and/or Annual Cash Incentive or Commissions under the Plan (or any other cash remuneration payable to a Participant that he or she may elect to defer under the provisions of the Plan, including but not limited to awards under the Company's Long Term Incentive Plan (LTIP). This election as to deferral and the related form and timing of distribution is made by the Participant and constitutes the agreement entered into between the Company and a Participant for participation in the Plan. The Participant elects the terms of his or her deferral pursuant to the provisions of this Plan and the administrative procedures established by the Plan Administrator.

2.21 Disability.

"Disability" as defined in the Company's Long-Term Disability Plan.

2.22 Distribution Date.

The date on which a Participant's distribution is scheduled to be paid with respect to his or her Account under the Plan pursuant to his or her Deferred Compensation Election, which date shall take into account any processing period.

2.23 Effective Date.

January 1, 1997.

2.24 Elective Deferrals.

Elective Deferrals as defined in the Future Fund.

2.25 Eligible Executive.

An Executive who is eligible to participate in the Plan as provided in Section 3.1(a).

2.26 Employee.

Any common-law full-time salaried exempt employee of the Company or an Affiliate, other than a store manager, pharmacist or MinuteClinic practitioner, who has been authorized by the Committee to participate in the Plan.

2.27 ERISA.

The Employee Retirement Income Security Act of 1974, as amended.

2.28 Executive.

An Employee whose Base Salary (determined on the basis of a maximum forty (40) hour work week) equals or exceeds $175,000 (as adjusted from time to time by the Committee).

2.29 Future Fund.

The CVS Health Future Fund 401(k) Plan.

2.30 Grandfathered Company Account.

The bookkeeping account (or subaccount(s)) maintained for each Participant to record the amount of Company Contributions credited on a Participant's behalf under Section 4.4, which were vested as of December 31, 2004, adjusted as provided in Section 5.6.

2.31 Grandfathered Deferral Account.

The bookkeeping account (or subaccount(s)) maintained for each Participant to record (i) the amount of Base Salary and/or Annual Cash Incentive or Commissions deferred in accordance with Section 4.1, (ii) the amount of LTIP deferrals deferred in accordance with Section 4.4, and/or (iii) the amount of cash retention award deferrals deferred in accordance with Section 4.4, as of December 31, 2004, adjusted pursuant to Section 5.6.

2.32 Lost Matching Contributions.

The amounts credited on a Participant's behalf to his or her Company Account pursuant to the provisions of Section 4.4(a).

2.33 Participant.

Each Eligible Executive participating in the Plan as set forth in Section 3.2.

2.34 Plan Administrator.

The Deferred Compensation Plans Committee appointed pursuant to Section 7.1 to administer the Plan.

2.35 Plan Year.

A calendar year ending on December 31.

2.36 Qualified Future Fund Matching Contribution.

The total of all matching contributions that could have been made by the Company or an Affiliate with respect to a Plan Year for the benefit of a Participant under and in accordance with the terms of Future Fund.

2.37 Retirement.

Termination of Employment with the Company and all Affiliates on or after (i) age fifty-five (55) and the completion of ten (10) or more Years of Service or, if earlier, (ii) age sixty (60) and the completion of five (5) or more Years of Service.

2.38 Specified Employee.

"Specified Employee" as such term is defined in the Universal 409A Definition Document.

2.39 Specific Future Year.

A calendar year in the future elected by a Participant with respect to the distribution of his or her Account(s) (or subaccount(s) thereof) pursuant to the Plan.

2.40 Termination of Employment.

"Termination of employment" as such term is defined in the Universal 409A Definition Document.

2.41 Total Pay

The total of Base Salary, Annual Cash Incentive and Commissions.

2.42 Universal 409A Definition Document.

The document developed by the Company for the purpose of defining terms relating to benefits or amounts in all plans covered by Section 409A of the Code and sponsored by the Company or any Affiliate.

2.43 Valuation Date.

The date on which an Account is valued under the Plan, as determined by the Committee, by reference to the New York Stock Exchange.

2.44 Year of Service.

Year of Participation Service as defined in Future Fund.

ARTICLE III – ELIGIBILITY AND PARTICIPATION

3.1 Eligibility.

(a) An Employee who is an Executive on October 1st of a calendar year (or such other date in the calendar year as designated by the Committee) shall be eligible to participate in the Plan. The Committee may, in its sole discretion, designate other key employees of the Company or an Affiliate who are members of a select group of management or highly compensated employees as eligible to participate in the Plan.

(b) Notwithstanding any Plan provision to the contrary, Employees must also be subject to the income tax laws of the United States in order to be eligible for participation in the Plan.

(c) Subject to the provisions of Sections 3.3 and Section 4.1, an Eligible Executive shall remain eligible to continue participation in the Plan for each Plan Year following his or her initial year of participation in the Plan.

(d) A Participant who ceases to be an Executive can continue to be eligible to participate unless and until such Participant fails to make an annual deferral election under the Plan or under the CVS Health Corporation Deferred Stock Compensation Plan, at which point the Employee must meet the threshold compensation level in order to be eligible to participate for a future Plan Year.

(e) Deferred Compensation Plan Participants who made a deferral under the Deferred Compensation Plan with respect to the two most recent enrollment periods shall, regardless of compensation threshold, be eligible to participate in the Deferred Compensation Plan for the 2020 Plan Year.

(f) Active Aetna employees who elected to defer in either of the Aetna Plans in the two most recent enrollment periods shall, regardless of compensation threshold, be eligible to participate in the Deferred Compensation Plan for the 2020 Plan Year.

3.2 Commencement of Participation.

An Eligible Executive shall become a Participant effective as of the date that the Eligible Executive's first Deferred Compensation Election becomes effective, provided that the Eligible Executive has provided such information as the Plan Administrator deems necessary to properly administer the Plan.

3.3 Termination of Participation.

(a) Participation shall cease when the benefits that have been credited to a Participant's Deferral Account have been distributed to him or her.

(b) Subject to the provisions of Section 4.3(c), a Participant shall only be eligible to make Deferrals under the Plan for as long as he or she remains an Eligible Executive.

(c) If a former Participant who has incurred a Termination of Employment with the Company and all Affiliates and whose participation in the Plan ceased under Section 3.3(a) is reemployed as an Executive, the former Participant may again become eligible to participate in accordance with the provisions of Section 3.1(a).

ARTICLE IV – DEFERRALS & COMPANY CONTRIBUTIONS

4.1 Deferrals.

(a) Subject to the following provisions of this Article IV, an Eligible Executive may defer for any Plan Year: (i) up to fifty percent (50%) of Base Salary otherwise earned and payable in that Plan Year, and/or (ii) up to eighty percent (80%) of Annual Cash Incentive otherwise earned in that Plan Year and payable in that Plan Year or in the first calendar quarter of the following Plan Year, and/or (iii) with respect to Deferred Compensation Elections made prior to November 1, 2021, up to eighty percent (80%) of Commissions otherwise earned in that Plan Year and payable in that Plan Year or in the first calendar quarter of the following Plan Year, and with respect to Deferred Compensation Elections made on or after November 1, 2021, up to eighty percent (80%) of Commissions otherwise payable in the applicable Plan Year in accordance with Section 4.2. The Plan Administrator may, as it deems appropriate, establish maximum or minimum limits on the amounts which may be deferred for a Plan Year and/or the times of such Deferred Compensation Elections. An Eligible Executive shall be given advance notice of any such limits. Notwithstanding anything in the Plan to the contrary, a previously submitted Participant's Deferred Compensation Election (with respect to Base Salary, Annual Cash Incentive and/or Commissions) shall be disregarded following the Participant's Termination of Employment.

(b) Deferrals under the Plan shall be calculated with respect to the gross cash compensation payable to the Participant prior to any deductions (e.g., 401(k) deferrals) or withholdings. However, the Deferrals shall be reduced by the Plan Administrator as necessary if it is later determined, after Deferrals are made under the Plan and after additional deduction of all required income and employment taxes, 401(k) and other employee benefit deductions, and other deductions required by law, that all such total deferrals will exceed one hundred percent (100%) of the cash compensation of the Participant available under Section 4.1(a). Changes to payroll withholdings that affect the amount of compensation being deferred to the Plan shall be allowed only to the extent permissible under Section 409A of the Code.

4.2 Filing Requirements of Deferred Compensation Elections.

Subject to the following provisions of this Section, during an annual enrollment period established by the Plan Administrator in any Plan Year, an Eligible Executive described in Section 3.1 may elect, subject to Section 4.1 above, to defer: (a) a portion of his or her Base Salary that is otherwise earned and payable in the next Plan Year, and/or (b) a portion of his or her Annual Cash Incentive otherwise earned in the next Plan Year and payable in that Plan Year or in the first calendar quarter of the subsequent Plan Year, and/or (c) with respect to Deferred Compensation Elections made prior to November 1, 2021, a portion of his or her Commissions otherwise earned in the next Plan Year and payable in that Plan Year or in the first calendar quarter of the subsequent Plan Year, and with respect to Deferred Compensation Elections made on or after November 1, 2021, a portion of his or her Commissions payable in the second succeeding Plan Year following the calendar year in which such Deferred Compensation Election is made. The aforementioned Deferred Compensation Elections are to be made by submitting a Deferred Compensation Election during such annual enrollment period. If an Executive becomes an Eligible Executive after October 1 (or such later date as prescribed by the Plan Administrator) in any calendar year, he or she may not make a Deferred Compensation Election for Base Salary, Annual Cash Incentive or Commissions earned in the next Plan Year (and on or after November 1, 2021, for Commissions payable in the second succeeding Plan Year).

A Participant shall submit a Deferred Compensation Election in the manner specified by the Plan Administrator and a Deferred Compensation Election that is not timely filed shall be considered void and have no effect. If a Participant does not file a Deferred Compensation Election applicable to his or her Base Salary, Annual Cash Incentive or Commissions earned in a Plan Year on or before the close of the applicable annual enrollment period (or such later date prescribed by the

Plan Administrator), the Participant shall be deemed to have elected not to make a Deferred Compensation Election for such Plan Year. The Plan Administrator shall establish procedures that govern deferral elections under the Plan, including the ability to make separate elections for Base Salary, Annual Cash Incentive or Commissions, and any other cash remuneration payable to the Participant that the Committee or Plan Administrator permits a Participant to defer under the Plan.

Subject to the provisions of this Article, an Eligible Executive must file a new Deferred Compensation Election for each Plan Year that the Eligible Executive is eligible to participate in the Plan if the Eligible Executive intends to make a deferral under the Plan for such Plan Year.

4.3 Modification or Revocation of Election by Participant.

(a) A Participant's Deferred Compensation Election for a Plan Year shall become irrevocable as of the close of business on the date established by the Plan Administrator, but not later than the applicable date described below.

i. In the case of a deferral of Base Salary and/or Annual Cash Incentives and with respect to Commissions, Deferred Compensation Elections made before November 1, 2021, on the last day of the calendar year preceding the Plan Year in which such Base Salary or Annual Cash Incentive or Commissions applicable to that Deferred Compensation Election is earned. Such Deferred Compensation Elections shall become effective as of the first day of the Plan Year in which such Base Salary and/or Annual Cash Incentive and/or Commission is earned.

ii. In the case of a deferral of Commissions, for Deferred Compensation Elections made on or after November 1, 2021, on the last day of the second calendar year preceding the Plan Year in which such Commissions applicable to that Deferred Compensation Election are paid. Such Deferred Compensation Elections shall become effective as of the first day of the Plan Year that precedes the Plan Year in which such Commission is paid.

Notwithstanding the foregoing, the Plan Administrator may cancel a Participant's Deferred Compensation Elections for the balance of a Plan Year if the Participant submits evidence of an unforeseeable emergency (as defined in the Universal 409A Definition Document) to the Plan Administrator. Any Base Salary, Annual Cash Incentive, Commissions or other cash remuneration which would have been deferred pursuant to that cancelled Deferred Compensation Election shall be paid to the Eligible Executive as if he or she had not made that election.

A Participant may revoke or change a Deferred Compensation Election any time prior to the date such election becomes irrevocable. Any such change or revocation shall be made in a form and manner determined by the Plan Administrator. Under no circumstances may a Participant's Deferred Compensation Election be made, modified or revoked retroactively.

(b) If a Participant's Deferred Compensation Election applicable to his or her Base Salary and/or Annual Cash Incentive or Commissions is cancelled for a Plan Year, he or she will not be permitted to elect to make Deferrals again until the next Plan Year.

(c) If a Participant ceases to be an Executive after the date a Deferred Compensation Election becomes effective but continues to be employed by the Company or an Affiliate, his or her Deferred Compensation Election currently in effect shall remain in force.

(d) Notwithstanding anything in the Plan to the contrary, if an Eligible Executive:

i. receives a withdrawal of deferred cash contributions on account of hardship from any plan which is maintained by the Company or an Affiliate and which meets the requirements of Section 401(k) of the Code (or any successor thereto); and

ii. is precluded from making contributions to such 401(k) plan for at least six (6) months after receipt of the hardship withdrawal,

the Eligible Executive's Deferred Compensation Election with respect to Base Salary, Annual Cash Incentive or Commissions in effect at that time shall be cancelled. Any Base Salary, Annual Cash Incentive or Commissions payment which would have been deferred pursuant to that Deferred Compensation Election but for the application of this Section 4.3(d) shall be paid to the Eligible Executive as if he or she had not made that election.

4.4 Company Contributions and Other Deferrals.

(a) *Company Contributions – Restoration of Lost Matching Contribution*.

The amount of Lost Matching Contributions credited under the Plan on a Participant's behalf each calendar year shall be equal to (i) minus (ii) where:

i. is the lesser of (a) total Qualified Future Fund Matching Contribution that would have been allocated on the Participant's behalf under Future Fund for the Plan Year, without giving effect to any reductions or limitations required by Sections 401(a)(17), 401(k), 402(g) and/or 415 of the Code (i.e., 5% of Total Pay), and (b) the Future Fund matching contribution that would have been allocated on the participants behalf, had the participant contributed the maximum amount permissible by law for that plan year, plus his or her Deferral under Section 4.1 for the Plan Year; and

ii. If the Participant is eligible to contribute to Future Fund (whether pre-tax or after-tax) during the Plan Year, (ii) is the maximum amount of matching contributions that could have been made on the participants behalf to Future Fund had the participant contributed the maximum amount permissible by law for that Plan Year.

In addition, if the Participant is not eligible to contribute to Future Fund during the Plan Year but is eligible to contribute to another qualified defined contribution plan (whether pre-tax or after-tax) maintained by the Company or an Affiliate during that Plan Year, the amount under this clause (ii) shall equal, unless otherwise provided by the Committee, the maximum amount of matching contributions the Participant would have received under the provisions of Future Fund for that Plan Year had he or she been eligible to contribute to Future Fund during that Plan Year, based on his or her Base Salary and/or Annual Cash Incentive or Commissions otherwise earned and payable in that Plan Year.

For purposes of this subsection (a), for the Plan Year in which the requirement to complete one (1) Year of Service is met, Total Compensation for the entire Plan Year shall be taken into account.

Notwithstanding the foregoing, for purposes of determining the Lost Matching Contributions to be credited under this Section 4.4(a), Years of Service with respect to a Participant employed by Red Oak Sourcing, LLC, the limited liability corporation formed pursuant to the Framework Agreement between CVS Pharmacy, Inc. and Cardinal Health 110 Inc., dated December 10, 2013 ("Cardinal"), who immediately prior to becoming employed by Red Oak Sourcing, LLC was employed by Cardinal, shall include the period of such Participant's employment rendered with Cardinal.

Lost Matching Contributions shall be credited under this Section 4.4(a) with respect to a Participant who made a Bonus Deferral Contribution election under the Omnicare, Inc. Deferred Compensation Plan with respect to the 2016 Plan Year but such Lost Matching Contributions shall be subject to the Participant's distribution election and the distribution provisions of the Omnicare, Inc. Deferred Compensation Plan in effect on the date of such Participant's election.

Notwithstanding anything in the Plan to the contrary, a Participant shall not be eligible to receive a Lost Matching Contribution following the Participant's Termination of Employment, unless the Participant terminates due to Retirement.

For purposes of clarification, in no event shall a Participant be eligible to receive a Lost Matching Contribution if the Participant does not make an actual deferral into the Plan for the Plan Year.

(b) LTIP Deferrals.

At the sole discretion of the Committee, all or a portion of a Participant's cash award under the LTIP may be deferred under the Plan. Such election shall be made in accordance with the procedures established by the Plan Administrator. The deferral election applicable to an LTIP cash award shall be made prior to the close of the calendar year preceding the first day of the performance period applicable to that award. Notwithstanding the foregoing, such election shall become irrevocable as of the close of business of the last day of the calendar year preceding the first day of the performance period applicable to that award. However, if such award meets the definition of performance-based compensation (as defined under Treas. Reg. Section 1.409A-1(e) and any subsequent guidance), the Plan Administrator may permit such election to be made in accordance with the provisions under Treas. Reg. Section 1.409A-2(a)(8) and subsequent guidance. Notwithstanding anything in the Plan to the contrary, a previously submitted deferral election of a Participant's cash award under the LTIP shall be disregarded following the Participant's Termination of Employment.

(c) Cash Retention Award Deferrals.

At the sole discretion of the Committee and subject to the procedures established by the Plan Administrator, an Eligible Executive may elect to defer all or a portion of a cash retention award that may be otherwise paid under a cash retention program maintained by the Company or an Affiliate. The deferral election applicable to such cash retention award shall be made in accordance with the provisions of Treasury Regulations Section 1.409A- 2(a)(5). Notwithstanding anything in the Plan to the contrary, a previously submitted deferral election of a Participant's cash retention award shall be disregarded following the Participant's Termination of Employment.

4.5 Deferral and Contribution Timing.

Base Salary Deferrals will be credited to the Account of each Participant as of the date of the paycheck from which the deferral was withheld. A Participant whose employment terminates during a payroll period will cease deferral withholding effective as of the first day of the following payroll period.

Annual Cash Incentive Deferrals and Commission Deferrals will be credited to the Account of each Participant as of the day on which such Annual Cash Incentive or Commissions, whichever is applicable, otherwise would have been paid to the Participant in cash.

Company Contributions for the Restoration of Lost Matching Contribution pursuant to Section 4.4(a)

above will generally be credited to the Participant's Company Account as of the last day of each Plan Year following the Participant's completion of one (1) Year of Participation Service (as defined in Future Fund).

LTIP deferrals shall be credited to the Account of the Participant at the time designated by the Plan Administrator.

Cash retention awards Deferrals will be credited to the Account of the Participant as of the day on which such cash retention award otherwise would have been paid to the Participant in cash.

ARTICLE V– ACCOUNTS

5.1 Establishment of Bookkeeping Accounts.

Separate bookkeeping accounts shall be maintained for each Participant. Said accounts (or subaccount(s) thereof) shall be credited with the deferrals and contributions made by or on behalf of the Participant pursuant to the Plan and credited (or charged, as the case may be) with the hypothetical investment results determined pursuant to this Article of the Plan.

5.2 Subaccounts.

Within each Participant's bookkeeping account, separate subaccount(s) shall be maintained to the extent necessary for the administration of the Plan. Generally, subaccount(s) will be set up for each year, for each Deferred Compensation Election the Participant makes, and for the Company Contribution credited each year on behalf of a Participant.

5.3 Hypothetical Nature of Accounts.

The accounts established under this Article shall be hypothetical in nature and shall be maintained for bookkeeping purposes only so that hypothetical gains or losses on the deferrals or contributions made to the Plan can be credited (or charged, as the case may be).

Neither the Plan nor any of the accounts, or subaccount(s), established hereunder shall hold any actual funds or assets. The right of any person to receive one or more payments under the Plan shall be an unsecured claim against the general assets of the Company. Any liability of the Company to any Participant, former Participant, or Beneficiary with respect to a right to payment shall be based solely upon contractual obligations created by the Plan. The Company, an Affiliate, the Board, the Committee, or any other person shall not be deemed to be a trustee of any amounts to be paid under the Plan. Nothing contained in the Plan, and no action taken pursuant to its provisions, shall create or be construed to create a trust of any kind, or a fiduciary relationship, between the Company, an Affiliate, the Board, the Committee, the Plan Administrator, or any other person and a Participant or any other person.

5.4 Vesting.

Deferral Account. A Participant shall be one hundred percent (100%) vested in his or her Deferral Account and Grandfathered Deferral Account at all times. A Participant shall be one hundred percent (100%) vested in the LTIP deferrals credited on his or her behalf pursuant to Section 4.4(b) and any cash retention award deferrals credited on his or her behalf pursuant to Section 4.4(c).

Company Account. A Participant shall be one hundred percent (100%) vested in his or her Company Account and Grandfathered Company Account at all times.

5.5 Deferral Crediting Options.

Deferral Crediting Options are similar to investment choices in a qualified defined contribution plan, except that they are hypothetical in nature and no funds are actually held in the Plan. Deferral Crediting Options determine the hypothetical gain or loss to be reflected in the Participant Accounts and shall be elected by Participants in the manner determined by the Plan Administrator.

The Deferral Crediting Options offered to Participants are determined by the Plan Administrator at its sole discretion. The Plan Administrator specifically retains the right to change the Deferral Crediting Options at any time, in its sole discretion.

In the event the Plan Administrator designates more than one Deferral Crediting Option, each Participant shall electronically submit a Deferral Crediting Option election during each annual

enrollment period, which shall be used to measure the hypothetical investment performance of his or her Accounts, within such time period and on such form as the Plan Administrator may prescribe. The designation of a Deferral Crediting Option shall not require the Company to invest or earmark their general assets in any manner. If a Participant fails to make a Deferral Crediting Option, his or her Accounts shall be deemed invested in a Deferral Crediting Option as determined by the Plan Administrator.

A Participant may change his or her election of a Deferral Crediting Option used to measure the hypothetical investment performance of his or her Account balance within such time periods and in such manner prescribed by the Plan Administrator. The election shall be effective as soon as administratively practicable after the date on which the election is submitted in the manner specified by the Plan Administrator.

Any amounts added to or subtracted from a Participant's Account on any given Valuation Date will be converted to hypothetical unit equivalents ("Hypothetical Units") with a value per Hypothetical Unit ("Unit Price") based on the daily closing price on said date ("Unit Price") for any given Deferral Crediting Option.

5.6 Hypothetical Gains or Losses.

Any hypothetical dividends, capital gains and any other income or unit activity will be reflected in the Deferral Crediting Options. The timing of these will be the same as for the funds on which each Deferral Crediting Option is based.

The gain or loss on Participant Accounts will be calculated each Valuation Date. The Unit Price shall determine each Deferral Crediting Option's hypothetical value, based on the number of units within the Account for any given Deferral Crediting Option. Account balances on a given day will be based on the previous day's New York Stock Exchange closing price.

ARTICLE VI – DISTRIBUTION OF ACCOUNT

6.1 Distribution Elections – Timing of Payment.

(a) Subject to the limitations set forth in this Article VI, each time a Participant makes a Deferred Compensation Election with respect to a Plan Year beginning on or after January 1, 2016, the Participant shall designate on that applicable Deferred Compensation Election, separately for Participant deferrals and Company Contributions, as adjusted pursuant to Article V, that the distribution of such deferrals shall be made or commence, as the case may be, pursuant to Section 6.6, as of (i) the Participant's Retirement; or (ii) a Specific Future Year not later than the Plan Year in which the Participant attains age seventy-one (71).

A Participant may choose different options with respect to each Deferred Compensation Election. A Participant may not change the election made pursuant to the provisions of this Section 6.1, except as otherwise provided in Section 6.7 below.

i. Retirement. The distribution of the portion of a Participant's Deferral or Company Account (or subaccount(s)) that is deferred to Retirement under this Section shall commence on the first business day in the January next following his or her Retirement, pursuant to the provisions of Section 6.6, provided, however, that with respect to a Participant who is a Specified Employee as of the date of his or her Retirement, payment of any portion of his or her Deferral or Company Account (or any subaccount(s) thereof) that is subject to Section 409A of the Code will be delayed until the first business day of the seventh (7th) month following the date such Retirement occurs.

ii. Specific Future Year. In the event a Participant elects to have the distribution of such deferrals made or commence as of a Specific Future Year, subject to rules established by the Plan Administrator, the deferral period must be at least five (5) Plan Years. The distribution of the portion of a Participant's Deferral or Company Account (or subaccount(s)) that is deferred to a Specific Future Year shall commence on the first business day of January in that specific year pursuant to the provisions of Section 6.6.

(b) Company Contributions shall be distributed pursuant to the Participant's distribution election. In the event a Participant has not made a distribution election for the Company Contributions for that Plan Year, such distribution shall mirror his or her distribution election made with respect to his or her Base Salary Deferral or Annual Cash Incentive or Commissions Deferral for that Plan Year, if any, in such order; otherwise, such distribution shall be made at the Participant's Retirement.

6.2 Disability Distributions.

Notwithstanding the foregoing, if a Participant has a Termination of Employment because he or she has become Disabled, as determined by the Plan Administrator, such Participant will receive the balance of his or her Deferral Account and Company Account paid out in five (5) annual substantially equal installments with the first payment to be made within seventy-five (75) days from the date of the Participant's Termination of Employment. Subsequent annual payments will be paid as of the first business day in January of each subsequent year of the installment period.

6.3 Distributions in the Event of Death.

Notwithstanding the foregoing, in the event of a Participant's death, the Participant's Beneficiary will receive the remaining balance of the Participant's Deferral Account and Company Account paid

in two (2) annual installments with the first payment to be made within seventy-five (75) days of the Participant's date of death. The second annual payment will be paid as of the first business day in January of the subsequent calendar year.

6.4 Distributions Upon Termination of Employment Other Than Retirement, Death or Disability.

Notwithstanding the foregoing, in the event a Participant incurs a Termination of Employment from the Company and all Affiliates for any reason other than Retirement, death or Disability, said Participant will receive his or her entire Deferral Account and Company Account balance in a single lump sum payment. Such payment shall be made within seventy-five (75) days of the date the Participant's Termination of Employment occurs; provided, however, that with respect to a Participant who is a Specified Employee as of the date of his or her Termination of Employment for reasons other than death, payment of any portion of his or her Deferral or Company Account (or any subaccount(s) thereof) pursuant to the provisions of this Section 6.4 will be delayed until the first business day of the seventh (7th) month following the date such Termination of Employment occurs.

6.5 Change in Control.

Notwithstanding the foregoing provisions of this Article VI, upon the occurrence of a Change in Control, a Participant who has a valid change in control election(s) in effect shall automatically receive the balance of his or her Deferral Account and Company Account related to that election, in cash, in a single lump sum payment. Such lump sum payment shall be paid within forty-five (45) business days after the Change in Control occurs. If such Participant dies after such Change in Control event occurs, but before receiving such payment, it shall be made to his or her Beneficiary.

6.6 Form of Payment.

(a) *Installments*. Subject to the limitations set forth in Article VI, distributions will be made in annual (or quarterly, if the election was made prior to October 1, 2008) installments, as elected by the Participant, for up to, and including, ten (10) years (fifteen (15) years for an election made prior to October 1, 2008). The initial installment of an annual or quarterly payment stream will begin as of the first business day of the January (a) next following the Participant's date of Retirement or (b) of the Specific Future Year, as the case may be, in accordance with the provisions of set forth in Section 6.1. Subsequent annual or quarterly payments will be as of the first business day of each subsequent calendar year or quarter of the installment period.

Each installment will be equal to a fraction of the Account balance (or subaccount(s) thereof) as of the date the installment is paid, with the numerator of the fraction being "1" and the denominator being the number of payments remaining in the payment schedule.

Notwithstanding the foregoing provisions of this paragraph (a), if a Participant dies before receiving payment of the entire balance of his or her Deferral and Company Accounts under the provisions of this Section, the remaining value of such Accounts shall be payable to his or her Beneficiary in accordance with the provisions of Section 6.9.

(b) *Lump sum*. A Participant may elect distribution in the form of a single lump sum payment. Except for Specified Employees, distribution shall be made as of the first business day of the January (a) next following the Participant's date of Retirement or (b) of the Specific Future Year, as the case may be, in accordance with the provisions of set forth in Section 6.1.

(c) Distributions to a Participant made pursuant to Section 6.1 will occur pursuant to the Participant's payment elections at the time he or she submits the applicable Deferred Compensation Election. A Participant may choose different forms of payment with respect to each Deferred Compensation Election. Company Contributions, adjusted pursuant to Article V, shall be distributed pursuant to the Participant's form of payment election made with respect to his or her Company Contributions for that year. If the Participant has not made an election with respect to his or her Company Contributions, the portion of his or her Company Account attributable to such Company contributions will be distributed in accordance with his or her form of payment election with respect to his or her Base Salary Deferral, Annual Cash Incentive or Commissions Deferrals for that year, if any, in that order; otherwise payment will be made in a lump sum payment. In the absence of an election of the form of payment by a Participant on a Deferred Compensation Election, the portion of the Participant's Account deferred pursuant to that Deferred Compensation Election, adjusted pursuant to the provisions of Article V, shall be paid in a single lump sum.

(d) A Participant shall not change his or her form of payment election, except as otherwise provided in Section 6.7 below.

6.7 Change of Distribution Election.

(a) In accordance with such procedures as the Plan Administrator may prescribe, a Participant may elect to change his or her Specific Future Year election under Section 6.1(a)(ii) with respect to a portion of his or her Deferral Account (or an Interim Distribution date election applicable to a portion of his or her Deferral Account or Company Account made pursuant to the provisions of the Plan as in effect prior to December 31, 2008) to a later Specific Future Year (or, if applicable, a later Interim Distribution date) by duly completing, executing and filing with the Plan Administrator a new Specific Future Year election (or Interim Distribution date election) applicable to such Deferrals, subject to the following limitations:

i. such election must be made at least twelve (12) months prior to the Specific Future Year (or Interim Distribution date) then in effect with respect to that portion of his or her Deferral or Company Account (or subaccount(s) thereof), and such election will not become effective until at least twelve (12) months after the date on which the election is made; and

ii. the new Specific Future Year (or Interim Distribution date) shall be a calendar year that is not less than five (5) years from the Specific Future Year (or Interim Distribution date) then in effect.

Notwithstanding the foregoing, effective for election changes made on or after January 1, 2021, a Participant may elect to delay his or her distribution from an elected Specific Future Year to a new Specific Future Year that is at least five (5) years from the Specific Future Year then in effect, provided the election is made in accordance with the foregoing provisions of this Section 6.7(a). A Participant may elect to delay his or her distribution from an elected Specific Future Year (or Interim Distribution date) pursuant to this Section 6.7(a) more than once, provided that all such elections comply with the provisions of this Section 6.7(a).

(b) In accordance with such procedures as the Plan Administrator may prescribe, a Participant may elect to delay the payment of a portion of his or her Deferral or Company Account (or any subaccount(s) thereof) scheduled to be paid at his or her Retirement to his or her Retirement plus five (5) calendar years by duly completing, executing and filing with the Plan Administrator a new Retirement election applicable to such deferrals; provided,

however such election must be made at least twelve (12) months prior to Retirement and shall not become effective until at least twelve (12) months after the date on which the election is made.

(c) In accordance with such procedures as the Plan Administrator may prescribe, a Participant may elect to change the form of payment election under Section 6.6 applicable to his or her distribution under Section 6.1(a)(i) or (ii) by duly completing, executing and filing with the Plan Administrator a new form of payment election applicable to such deferrals, subject to the following limitations:

i. such election must be made at least twelve (12) months prior to the Specific Future Year then in effect with respect to that portion of his or her Deferral or Company Account (or subaccount(s) thereof), and such election will not become effective until at least twelve (12) months after the date on which the election is made; and

ii. the distribution of that portion of his or her Deferral or Company Account (or subaccount(s) thereof) shall be deferred for five (5) years from the date such amount would otherwise have been paid absent this election.

Notwithstanding the foregoing or any provision of any Appendix to this Plan, effective for election changes made on or after January 1, 2021, in no case may a Participant elect to change the form of payment election to an installment form that includes payments for a period in excess of ten (10) years.

(d) It is the Company's intent that the provisions of Sections 6.7(a), (b) and (c) comply with the subsequent election provisions in Section 409A(a)(4)(C) of the Code, related regulations and other applicable guidance, and this Section 6.7 shall be interpreted accordingly. The Plan Administrator may impose additional restrictions or conditions on a Participant's ability to make an election pursuant to this Section 6.7. For avoidance of doubt, a Participant may not elect to alter the distribution of any portion of his or her Deferral or Company Accounts (or any subaccount(s) thereof) from Retirement to a Specific Future Year or, except as provided in paragraph (a) above, from a Specific Future Year to Retirement.

6.8 Account Valuation upon a Distribution.

With respect to a distribution made pursuant to this Article, the Valuation Date of a Participant's Account shall be the day immediately preceding the Distribution Date.

6.9 Designation of Beneficiary.

Each Participant shall have the right to designate a Beneficiary to receive payment of his or her Account in the event of death. Any such designation may be changed at any time by executing and submitting (either by hand or electronic submission) a new designation on a form prescribed by the Plan Administrator.

6.10 Unclaimed Account.

If the Plan Administrator is unable to locate a Participant or Beneficiary to whom an Account is payable, such Account may be forfeited to the Company upon the Plan Administrator's determination. Notwithstanding the foregoing, if subsequent to any such forfeiture, the Participant or Beneficiary to whom such Account is payable makes a valid claim, such forfeited Account shall be restored to the Plan and paid by the Company.

6.11 Hardship Withdrawals.

A Participant may apply in writing to the Plan Administrator for, and the Plan Administrator may

grant, a hardship withdrawal of all or any part of a Participant's Deferral or Company Account if the Plan Administrator, in its sole discretion, determines that the Participant has incurred an Unforeseeable Emergency, as defined in the Universal 409A Definition Document.

The Plan Administrator shall determine whether an event qualifies as a hardship within this Section, in its sole and absolute discretion. Such request shall be made in a time and manner determined by the Plan Administrator. The payment made from a Participant's Deferral or Company Account (or any subaccount(s) thereof) pursuant to the provisions of this Section 6.11 shall not be in excess of the amount necessary to meet such financial hardship of the Participant, including amounts necessary to pay any federal, state or local income taxes with respect to the payment and shall not be available unless all other financial resources of the Participant have been exhausted. Payment shall be made in the month following the date the Plan Administrator determines that the Participant has incurred an unforeseeable severe financial hardship and grants the right to a withdrawal pursuant to this Section 6.11.

6.12 Distribution of Grandfathered Deferral Account and the Grandfathered Company Account.

Notwithstanding the foregoing provisions of this Article VI, the distribution from a Participant's Grandfathered Deferral Account and Grandfathered Company Account (or subaccount(s)) shall be made pursuant to the provisions of the Plan as set forth on October 3, 2004, without regard to any amendments after October 3, 2004 which would constitute a material modification for Section 409A of the Code, as modified in Appendix A attached hereto.

ARTICLE VI — ADMINISTRATION

7.1 Plan Administrator.

The Plan shall be administered by the Deferred Compensation Plans Committee, appointed by the Committee as Plan Administrator. The Plan Administrator shall be responsible for the general operation and administration of the Plan and for carrying out the provisions thereof. The Plan Administrator may delegate to others certain aspects of the management and operations of the Plan including the employment of advisors and the delegation of ministerial duties to qualified individuals, provided that such delegation is in writing.

7.2 General Powers of Administration.

The Plan Administrator shall have the exclusive responsibility and complete discretionary authority to control the operation, management and administration of the Plan, with all powers necessary to enable it properly to carry out such responsibilities, including, but not limited to, the power to interpret the Plan and any related documents, to establish procedures for making any elections called for under the Plan, to make factual determinations regarding any and all matters arising hereunder, including, but not limited to, the right to determine eligibility for benefits, the right to construe the terms of the Plan, the right to remedy possible ambiguities, inequities, inconsistencies or omissions, and the right to resolve all interpretive, equitable or other questions arising under the Plan. The decisions of the Plan Administrator or such other party as is authorized under the terms of any grantor trust on all matters shall be final, binding and conclusive on all persons to the extent permitted by law. The Plan Administrator shall have all powers necessary or appropriate to enable it to carry out its administrative duties. Not in limitation, but in application of the foregoing, the Plan Administrator shall have the duty and power to interpret the Plan and determine all questions that may raise hereunder as to the status and rights of Employees, Participants, Beneficiaries, and any other person. The Plan Administrator may exercise the powers hereby granted in its sole and absolute discretion. No member of the Deferred Compensation Plans Committee shall be personally liable for any actions taken by the Plan Administrator unless the member's action involves gross negligence or willful misconduct.

7.3 Costs of Administration.

The costs of administering the Plan shall be borne by the Company unless and until the Participant receives written notice of the imposition of such administrative costs; with such costs to begin with the next Plan Year and none may be assessed retroactively for prior Plan Years.

Such costs shall be charged against the Participant's Account and shall be uniform or proportional for all Participants. Such costs shall not exceed the standard rates for similarly designed nonqualified plans under administration by high quality third party administrators at the time such costs are initially imposed and thereafter.

7.4 Indemnification.

The Company shall indemnify each director, officer or employee of the Company or any Affiliate and each member of the Committee and Deferred Compensation Plans Committee, including any subcommittee or delegates thereof, against any and all claims, losses, damages, expenses, including attorney's fees, incurred by them, and any liability, including any amounts paid in settlement with their approval, arising from their action or failure to act, except when the same is judicially determined to be attributable to their gross negligence or willful misconduct, as a result of the fact that he or she is or was serving the Plan in any capacity at the request of the Company.

7.5 409A Compliance.

With respect to the accounts subject to Section 409A of the Code, the Plan is intended to comply with the requirements of Section 409A of the Code and the provisions hereof shall be interpreted in a manner that satisfies the requirements of Section 409A of the Code and the regulations thereunder, and the Plan shall be operated accordingly. Regardless of, and superseding any other provision of the Plan to the contrary, if any provision of the Plan would otherwise frustrate or conflict with this intent, the provision will be interpreted and deemed amended so as to avoid this conflict.

ARTICLE VIII – CLAIMS PROCEDURE

8.1 Claims.

A person who believes that he or she is being denied a benefit to which he or she is entitled under the Plan (hereinafter referred to as a "Claimant") may file a written request for such benefit with the Plan Administrator, setting forth his or her claim. The request must be addressed to the Senior Vice President, Compensation and Benefits, at the Company's then principal place of business.

8.2 Claim Decision.

Upon receipt of a claim, the Plan Administrator or its delegate shall review and determine the claim within ninety (90) days. If the Plan Administrator determines that additional time is needed to review the claim, the Plan Administrator will provide the Claimant with a notice of the extension before the end of the initial ninety (90)-day period. The notice of extension will provide the date by which the Plan Administrator expects to make a decision.

If the claim is denied in whole or in part, the Plan Administrator shall notify the Claimant in writing of the following:

(a) The reason or reasons for such denial;

(b) The pertinent provisions of the Plan;

(c) Appropriate information as to the steps to be taken if the Claimant wishes to submit the claim for review; and

(d) The time limits for requesting a review under this Section.

8.3 Request for Review/Appeal.

Within sixty (60) days after the receipt by the Claimant of the initial written notice of a denial, the Claimant may request in writing that the initial determination be reviewed. Such request must be addressed to the Senior Vice President, Compensation and Benefits, at the Company's then principal place of business. The Claimant or his or her duly authorized representative may, but need not, submit issues and comments in writing for consideration by the Appeals Committee, a subcommittee of the Deferred Compensation Plans Committee. If the Claimant does not request a review of the initial determination within such sixty (60)-day period, he or she shall be barred and stopped from challenging the Plan Administrator's initial determination.

8.4 Review of Decision.

Within sixty (60) days after the Plan Administrator's receipt of a request for review, the Appeals Committee of the Plan Administrator will review the Plan Administrator's initial determination. After considering all materials presented by the Claimant, the Appeals Committee will render a written decision, setting forth the reasons for the decision and containing references to the pertinent provisions of the Plan. If the Appeals Committee requires an extension of the sixty (60)-day time period, the Appeals Committee will so notify the Claimant and will render the decision as soon as possible, but no later than one hundred twenty (120) days after receipt of the request for review.

8.5 Time Limit for Bringing Legal Action.

Any legal action by the Claimant must be brought within ninety (90) days following the date of the decision on the final review under Section 8.4 above.

ARTICLE IX – MISCELLANEOUS

9.1 Not Contract of Employment.

The adoption and maintenance of the Plan shall not be deemed to be a contract between the Company or an Affiliate and any person and shall not be consideration for the employment of any person. Nothing herein contained shall be deemed to give any person the right to be retained in the employ of the Company or an Affiliate or to restrict the right of the Company or an Affiliate to discharge any person at any time nor shall the Plan be deemed to give the Company or an Affiliate the right to require any person to remain in the employ of the Company or an Affiliate or to restrict any person's right to terminate his or her employment at any time.

9.2 Non-Assignability of Benefits.

No Participant, Beneficiary or distributees of benefits under the Plan shall have any power or right to transfer, assign, anticipate, hypothecate or otherwise encumber any part or all of the amounts payable hereunder, which are expressly declared to be unassignable and nontransferable. Any such attempted assignment or transfer shall be void. No amount payable hereunder shall, prior to actual payment thereof, be subject to seizure by any creditor of any such Participant, Beneficiary or other distributees for the payment of any debt judgment or other obligation, by a proceeding at law or in equity, nor transferable by operation of law in the event of the bankruptcy, insolvency or death of such Participant, Beneficiary or other distributee hereunder.

9.3 Withholding and Deduction and Taxes.

All deferrals and payments provided for hereunder shall be subject to applicable withholding and other deductions as shall be required of the Company under any applicable local, state or federal law. The Company may require that the Participant or Beneficiary making a deferral or receiving payments pay to the Company the amount of any federal, state or local taxes, if any, that the Company or any Affiliate is required to withhold with respect to such deferrals or payments or the Company or any Affiliate may deduct from other wages paid by the Company or any Affiliate the amount of any withholding taxes due with respect to such deferrals or payments. A Participant or Beneficiary shall be solely responsible for any tax consequences related to deferrals or payments made under the Plan. The Company shall have no obligation to make any payment under the Plan until the Company's or any Affiliate's tax withholding obligations have been satisfied by the Participant or Beneficiary.

9.4 Amendment and Termination.

The Committee or its delegate may from time to time, in its discretion, amend, in whole or in part, any or all of the provisions of the Plan; provided, however, that no amendment may be made that would impair the rights of a Participant with respect to amounts already allocated to his or her Account without the Participant's consent. To the extent consistent with the rules relating to plan terminations and liquidations in Treas. Reg. Section 1.409A-3(j)(4)(ix) or otherwise consistent with Section 409A of the Code, the Committee, in its sole discretion, may terminate the Plan and any related Deferred Compensation Election at any time and in that event the Committee may provide that, without the prior written consent of Participants, the Participants' Accounts shall be distributed in a single cash lump sum upon termination of the Plan. Unless so distributed in accordance with the preceding sentence, in the event of a Plan termination, the Plan Administrator shall continue to maintain the Participants' Accounts until distributed pursuant to the terms of the Plan and Participants shall remain one hundred percent (100%) vested in all amounts credited to their Accounts. In the event of a Plan termination, the distribution of a Participant's Grandfathered Deferral Account and Grandfathered Company Account shall be made pursuant to the provisions of the Plan as set forth on October 3, 2004, without regard to any amendments after October 3,

2004 which would constitute a material modification for Section 409A of the Code, as modified in Appendix A attached hereto.

9.5 Compliance with Securities and Other Laws.

Notwithstanding any Plan provision to the contrary, the Committee may at any time impose such restrictions on the Plan and participation therein, including limiting the amount of any deferral or the timing thereof, as the Committee may deem advisable from time to time in order to comply or preserve compliance with any applicable laws, including any applicable state and federal securities laws and exemptions from registration available thereunder.

9.6 No Trust Created.

Nothing contained in the Plan and no action taken pursuant to its provisions by the Company or any person, shall create, nor be construed to create, a trust of any kind or a fiduciary relationship between the Company or an Affiliate and the Participant, Beneficiary, or any other person.

9.7 Unsecured General Creditor Status of Employee.

The payments to the Participant, Beneficiary or any other distributees hereunder shall be made from assets which shall continue, for all purposes, to be a part of the general, unrestricted assets of the Company. No person shall have or acquire any interest in any such assets by virtue of the provisions of the Plan. The Company's obligation hereunder shall be an unfunded and unsecured promise to pay money in the future. To the extent that the Participant, Beneficiary or other distributees acquire a right to receive payments from the Company under the provisions hereof, such right shall be no greater than the right of any unsecured general creditor of the Company. No such person shall have or acquire any legal or equitable right, interest or claim in or to any property or assets of the Company.

In the event that, in its discretion, the Company purchases an insurance policy, or policies, insuring the life of the Employee, or any other property, to allow the Company to recover the cost of providing the benefits, in whole, or in part, hereunder, neither the Participant, Beneficiary or other distributee shall have or acquire any rights whatsoever therein or in the proceeds therefrom. The Company shall be the sole owner and beneficiary of any such policy or policies and, as such, shall possess and, may exercise all incidents of ownership therein. No such policy, policies or other property shall be held in any trust for a Participant, Beneficiary or other distributee or held as collateral security for any obligation of the Company hereunder. An Employee's participation in the underwriting or other steps necessary to acquire such policy or policies may be required by the Company and, if required, shall not be a suggestion of any beneficial interest in such policy or policies to a Participant.

9.8 Limitation.

A Participant and his or her Beneficiary shall assume all risk in connection with any decrease in value of his or her Account, and neither the Company nor the Committee or the Plan Administrator shall be liable or responsible therefor.

9.9 Payment to Minors and Incompetents.

If any Participant, spouse, or Beneficiary entitled to receive any benefits hereunder is a minor or is deemed by the Plan Administrator or is adjudicated to be legally incapable of giving a valid receipt and discharge for such benefits, the benefits will be paid to the person or entity as the Plan Administrator determines has been appointed or established to receive such payment on behalf of such person. Such payment shall, to the extent made, be deemed a complete discharge of any payment obligation under the Plan.

9.10 Acceleration of or Delay in Payments.

The Plan Administrator, in its sole and absolute discretion, may elect to accelerate the time or form of payment of a benefit owed to the Participant hereunder, provided such acceleration is permitted under Treas. Reg. Section 1.409A-3(j)(4) and any subsequent guidance. The Plan Administrator may also, in its sole and absolute discretion, delay the time for payment of a benefit owed to the Participant hereunder, to the extent permitted under Treas. Reg. Section 1.409A- 2(b)(7) and any subsequent guidance.

9.11 Severability.

If any provision of the Plan shall be held illegal or invalid for any reason, said illegality or invalidity shall not affect the remaining provisions hereof; instead, each provision shall be fully severable and the Plan shall be construed and enforced as if said illegal or invalid provision had never been included herein.

9.12 Governing Laws.

All provisions of the Plan shall be construed in accordance with the laws of Rhode Island, except to the extent preempted by federal law.

9.13 Binding Effect.

The terms of the Plan shall be binding on each Participant and his or her heirs and legal representatives and on the Company and its successors and assigns.

APPENDIX A – PROVISIONS APPLICABLE TO A PARTICIPANT'S GRANDFATHERED DEFERRAL ACCOUNT AND GRANDFATHERED COMPANY ACCOUNT

This Appendix A constitutes an integral part of the Plan and is applicable with respect to the Grandfathered Deferral Account and the Grandfathered Company Account of those individuals who were Participants in the Plan on December 31, 2004. The Grandfathered Deferral Account and Grandfathered Company Account are subject to all the terms and conditions of the Plan as set forth on October 3, 2004, without regard to any Plan amendments after October 3, 2004 which would constitute a material modification for Section 409A of the Code, as modified below. Section references in this Appendix A correspond to appropriate Sections of the Plan as set forth on October 3, 2004.

Article I – Definitions

Section 2.15. Company Account means the Participant's Grandfathered Company Account as set forth in Section 2.28.

Section 2.19. Deferral Account means the Participant's Grandfathered Deferral Account as set forth in Section 2.29 of the foregoing provisions of the Plan.

For purposes of a Participant's Grandfathered Deferral Account and Grandfathered Company Account, the term Change in Control shall have the meaning set forth in the 1997 Incentive Compensation Plan as in effect on October 3, 2004.

Article IV – Deferrals and Company Contributions

The provisions of Section 4.03 shall continue to apply to a Participant's Grandfathered Deferral Account, Grandfathered Company Account and amounts transferred from the Melville Deferred Compensation Plan that were vested on or earlier than December 31, 2004.

Article V – Maintenance of Accounts

The provisions of Section V as set forth in the foregoing provisions of the Plan as amended and restated effective as of December 31, 2008 shall be applicable to a Participant's Grandfathered Deferral Account and Grandfathered Company Account on and after January 1, 2009.

Article VI – Payment of Benefit

For purposes of this Article VI – Payment of Benefit, the term "termination of employment" or any other similar language means with respect to a Participant the complete cessation of providing service to the Company and any Affiliate as an employee.

6.2. *Form of Payment*

Effective on or after October 1, 2008, a Participant shall not elect installments in excess of ten (10) years or quarterly installments.

6.3. *Disability Distributions*

A Participant shall be entitled to distribution under this Section if such Participant becomes "Disabled" as such term is defined under Section 6.03 of the Plan.

6.6. *Change of Distribution Election*

On and after January 1, 2009, a change in a Specific Future Year distribution date or an Interim distribution date shall be effective only if the new Specific Future Year distribution date or an Interim

distribution date is not less than five (5) years later then the date in effect prior to the change election.

Notwithstanding the foregoing, the forms of distribution election available to Participants covered by this Appendix A shall be limited to the forms of distribution described in Section 6.6 of the Plan, but in no case may a Participant elect to change the form of payment election to an installment form that includes payments for a period of in excess of ten (10) years

APPENDIX B – PROVISIONS APPLICABLE TO A PARTICIPANT'S ACCOUNT UNDER THE OMNICARE, INC. DEFERRED COMPENSATION PLAN

This Appendix B constitutes an integral part of the Plan and is applicable with respect to a Participant's Account ("Omnicare Account") under the Omnicare, Inc. Deferred Compensation Plan, effective January 1, 2017. The Participants' Omnicare Accounts are subject to all the terms and conditions of the Omnicare Plan as set forth on January 1, 2013. Section references in this Appendix B correspond to appropriate Sections of the Omnicare Plan as set forth on January 1, 2013.

Article 2: Participation

Effective December 31, 2016, there shall be no new Participants in the Plan.

Article 3: Contributions & Deferral Elections

3.1 *Elections to Defer Compensation.*

Effective December 31, 2016 there shall be no new Elections to defer Compensation.

3.2 *Company Contributions.*

Effective December 31, 2016 there shall be no Discretionary Company Contributions or Company Matching Contributions.

3.3 *Investment Elections.*

Effective January 1, 2017, a Participant shall be eligible to designate the investment of his or her Omnicare Account solely in accordance with the Deferral Crediting Options of the CVS Health Corporation Deferred Compensation Plan.

APPENDIX C APPENDIX C – PROVISIONS APPLICABLE TO A PARTICIPANT'S ACCOUNT UNDER THE AETNA SUPPLEMENTAL 401(K) PLAN AND AETNA DEFERRED COMPENSATION PROGRAM

This Appendix C constitutes an integral part of the Plan and is applicable with respect to a Participant's accounts under the Aetna Supplemental 401(k) Plan and Aetna Deferred Compensation Program (collectively, the "Aetna Accounts"), effective January 1, 2020, which have been merged into the Plan. The Participants' Aetna Accounts are subject to all the terms and conditions of the Plan except that the Aetna Accounts shall remain subject to the distribution provisions of the Supplemental 401(k) Plan as set forth on January 1, 2009, as amended, and the Deferred Compensation Program as set forth on January 1, 2008, as applicable, and as set forth below:

AETNA SUPPLEMENTAL 401(K) PLAN

Payment of Deferred Amounts

1. Timing of Payment for Participants whose Termination from Service Occurs on or after January 1, 2005.

The vested Account balance of any Participant whose Termination from Service ("separation from service" as defined Code Section 409A) occurs on or after January 1, 2005 shall be paid in a lump sum no later than thirty [30] days after later of (a) the date that is six (6) months following the Participant's Termination from Service Date; or (b) the January 1 next following the Participant's Termination from Service Date.

2. Election as to Time of Payment – Prior Participants.

Each Participant who incurred a Termination from Service prior to January 1, 2005 shall have had an opportunity to make an election, on a form and in the manner prescribed by the Company for this purpose, specifying the time at which his or her vested Account balance is to be paid.

Except as otherwise provided in paragraph 3 and 4 below, payment of any such Participant's vested Account balance shall be made to the Participant in a lump sum as soon as practicable after the Valuation Date on or next following the time specified for payment in the election made by the Participant under this paragraph 2.

In the absence of an election which complies with either paragraph 2 or 3, any such Participant's vested Account balance shall be paid in a lump sum as soon as practicable after the Valuation Date on or next following the Participant's Termination from Service.

3. Time of Payment-Certain Prior Participants.

This paragraph 3 applies to Participants who ceased to be Employees prior to October 1, 1996 without having made an election pursuant to paragraph 2 hereof. Payment of the Account balance of any such Participant shall be made in a lump sum at the earlier of the commencement of the Participant's (i) final distribution from the Aetna 401(k) Plan; or (ii) required minimum distributions following attainment of age 70½, unless the Participant has otherwise elected, prior to termination of employment, to receive payment at a later date.

4. Payment in the Event of Participant's Death.

Notwithstanding any election that may have been made by a Participant pursuant to paragraph 2 or 3, and notwithstanding the provisions of paragraph 1, any vested Account balance that has not been paid to the Participant as of the date of the Participant's death shall be paid to the Participant's Beneficiary in a lump sum on the Valuation Date on or next following the Participant's death.**Acceleration of Payment.**

If a Participant experiences an "unforeseeable emergency" as defined in Section 409A, the Participant may submit to the Administrator a written request for a distribution, including such documentation as the Administrator may require. The Administrator shall review the request and make a determination approving or denying the requested distribution. If approved, distribution shall be made on the first business day of the month following the approval and shall be limited to such amount as is reasonably necessary to alleviate the Participant's emergency need, taking into account other assets available to the Participant to the extent required by Section 409A. In addition, and notwithstanding any other provision of this Plan to the contrary, the Company, in its sole discretion, may accelerate the payment of vested Account balances in any other circumstances permitted under Section 409A.

5. Change of Distribution Election.

The provisions of Section 6.7(c) shall apply to Aetna Accounts.

AETNA DEFERRED COMPENSATION PROGRAM

Payment

1. Payment will begin on the specified date or event elected by the Participant for each year's deferrals. The form of payment(s) will be made according to the option(s) elected by the Participant for each year's deferred funds. If the Participant failed to specify the time and form of payment on an election form, payment shall be made in accordance with: (a) if applicable, the time and form specified by the Company in the separate written arrangement providing for the compensation or (b) if not so specified, the time of payment shall be the Participant's separation from service and the form of payment shall be a single lump sum. Payments are subject to such deductions as may be required in accordance with federal and state tax regulations.

2. Notwithstanding the preceding paragraph, if a Participant is a "Specified Employee" within the meaning of Section 409A at the time of termination of employment, any payment of "deferred compensation" hereunder to which the participant would otherwise be entitled, due to such termination of employment, during the first six months following termination of employment, shall remain in the Participant's bookkeeping account and be paid in a lump sum on the six-month anniversary of the Specified Employee's termination of employment date (or, if earlier, death). This requirement shall only apply to the extent required by Section 409A.

3. The payment of "deferred compensation" (within the meaning of Section 409A) under this program may not be accelerated in violation of Section 409A.

4. Unless otherwise noted in the deferral election form, in the event of the Participant's "disability" (within the meaning of Section 409A) or death during the deferral period, payment shall be made to the Participant or the Participant's beneficiary upon such event.

5. In case of an "unforeseeable emergency," within the meaning of Section 409A, a Participant may submit a request for payment of amounts already deferred to be advanced and/or a deferral election to be canceled, to the extent permitted under Section 409A. The Company shall make the determination of unforeseeable emergency in its sole discretion consistent with the requirements of Section 409A. If approved, payment shall be made on the first day of the month following approval and shall be limited to such amount as is reasonably necessary to alleviate the Participant's emergency need, taking into account other assets available to the Participant to the extent required by Section 409A.

6. The provisions of Section 6.7(c) shall apply to Aetna Accounts.

Exhibit 10.25

CVS HEALTH SEVERANCE PLAN FOR NON-STORE EMPLOYEES
(Amended and Restated as of October 11, 2021)

CVS HEALTH SEVERANCE PLAN
FOR NON-STORE EMPLOYEES
(Amended and Restated as of October 11, 2021)

WHEREAS, CVS Health Corporation (the "Company") has established the CVS Health Severance Plan for Non-Store Employees (the "Plan") to provide financial assistance to employees in non-store positions who are involuntarily terminated and are eligible within the terms and conditions of the Plan;

WHEREAS, it is intended that the Plan constitute an employee welfare benefit plan within the scope of Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), that the Plan constitute a separation pay plan within the scope of Department of Labor ("DOL") Regulation Section 2510.3- 2(b), and that all payments made under the Plan be deductible by the Company under Section 162(a) of the Internal Revenue Code of 1986, as amended (the "Code");

WHEREAS, the benefits provided under the Plan are intended to constitute separation pay within the meaning of Treasury Regulation Section 1.409A-1(b)(9)(iii);

WHEREAS, this document is the official plan document; and

WHEREAS, the Company wishes to make certain amendments to the Plan, effective as of October 11, 2021 (the "Effective Date");

NOW, THEREFORE, as of the Effective Date, the Company does hereby amend the Plan to provide as follows:

ARTICLE 1
DEFINITIONS

For purposes of the Plan, the following terms, when used with an initial capital letter, shall have the meaning set forth below unless a different meaning is plainly required by the context.

1.1 "Affiliate" shall mean (a) any corporation which is required to be aggregated with the Company under Code Section 414(b), (c), (m), or (o) and (b) any other entity in which the Company has an ownership interest and which the Company designates as an Affiliate for purposes of the Plan.

1.2 "Cause" shall refer to a termination of an Eligible Employee's employment because of the Eligible Employee's (a) failure to satisfactorily perform under a performance improvement plan of the Employer; (b) acts of unethical business activity, including but not limited to fraud, misappropriation, embezzlement, dishonesty, harassment, discrimination in violation of Employer policies, or willful or negligent destruction of property of an Employer or an Affiliate; (c) misconduct that could cause damage (monetary, reputational or otherwise) to the Employer, an Affiliate, or any personnel thereof; (d) conviction of or a plea of guilty or nolo contendere to any felony, whether or not any right to appeal has been or may be exercised; (e) negligence of duty; (f) insubordination; or (g) a violation of the Employer's policy, procedure, or practice.

1.3 "Code" shall mean the Internal Revenue Code of 1986, as amended.

1.4 "Eligible Employee" shall mean an individual who is employed by the Employer on a regular basis in a non-store position and has been employed by the Employer in any position for a minimum of ninety (90) days prior to the individual's separation of employment. For purposes of the Plan, distribution warehouse employees, field managers and employees employed by CVS ProCare, Inc. working at Company headquarters, shall be treated as working in a non-store location and therefore not subject to exclusion from eligibility. For purposes of the Plan, individuals in the following categories will not be considered Eligible Employees:

(a) individuals who are covered by a collective bargaining agreement, provided welfare benefits were the subject of bargaining, unless the terms of the collective bargaining agreement provide for participation in the Plan;

(b) individuals who are seasonal employees, leased employees, independent contractors, temporary employees, or consultants;

(c) individuals who work for the Employer or an Affiliate in a store location of the Company or an Affiliate, or whose compensation is paid through or according to a store payroll, including but not limited to: pharmacists, store managers, assistant store managers, crew, and pharmacy staff;

(d) individuals employed by MinuteClinic, L.L.C. or by any practitioner-owned entity managed by MinuteClinic, L.L.C.;

(e) the President and CEO of CVS Health Corporation;

(f) individuals employed in Puerto Rico; and

(g) individuals employed outside the United States of America.

The decision of whether an individual falls into one of these categories and whether an individual is employed by an Employer on a regular basis in a non-store position for a minimum of ninety (90) days shall be made by the Employer in its sole discretion. Any individual who is excluded from being considered an Eligible Employee under the Plan shall be excluded from the Plan regardless of the individual's reclassification by a government agency, including a reclassification by the Internal Revenue Service for tax withholding purposes.

1.5 "Employer" shall mean CVS Pharmacy, Inc., Caremark Rx, L.L.C. and Aetna Inc. and any current or future Affiliate thereof that does not maintain its own severance plan for employees of that Affiliate.

1.6 "ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended.

1.7 "Exempt Employee" shall mean an Eligible Employee who is paid on a salaried basis for payroll purposes and classified in the sole discretion of the Employer under its normal classification procedures as an exempt employee under the Fair Labor Standards Act.

1.8 "Involuntary Termination" shall mean an Eligible Employee's termination of employment with the Employer due to the unilateral action of the Employer, including but not limited to a termination as a result of the elimination of an Eligible Employee's position due to a reorganization or changes in responsibilities, a reduction in force, or a closing of the business unit in which the Eligible Employee works; provided, however, that such Involuntary Termination constitutes a separation from service under Treasury Regulation Section 1.409A-1(h). Notwithstanding the foregoing, an Eligible Employee will not have an Involuntary Termination if the Eligible Employee: (a) is terminated for Cause, as determined by the Employer in its sole discretion; (b) voluntarily terminates his or her employment at any time or resigns prior to an Involuntary Termination; (c) takes a leave of absence; (d) is administratively terminated for failure to return from a leave of absence upon expiration of his or her leave; (e) terminates employment due to his or her death or disability; (f) transfers to an Affiliate; (g) transfers to a new employer in connection with the sale of an Employer facility; or (h) fails to accept an offer for a job with the Employer that is comparable to the job that he or she is performing for the Employer at the time of the offer. For purposes of Subsection (h) of this Section 1.8, whether a job is considered "comparable" shall be determined in the sole discretion of the Employer, taking into account whether the new job is located 50 or fewer miles from the Eligible Employee's job at the time of the offer, whether the compensation offered is materially less than the Eligible Employee's compensation at the time of the offer, and

whether the new job will result in a substantial change of duties from the Eligible Employee's job at the time of the offer. The determination of whether an Eligible Employee's termination of employment is an Involuntary Termination shall be made in the sole discretion of the Employer. If an Employer deems an Eligible Employee's termination of employment to be an Involuntary Termination and, Employer later learns of facts and circumstances that, had the Employer known such facts and circumstances at the time of termination, would have resulted in a termination of employment for Cause, the Eligible Employee's termination shall be deemed as of the date of termination to not have been an Involuntary Termination.

1.9 "Non-exempt Employee" shall mean an Eligible Employee who is paid on an hourly basis for time worked and classified in the sole discretion of the Employer under its normal classification procedures as a non-exempt employee under the Fair Labor Standards Act.

1.10 "Plan Administrator" shall mean the Senior Vice President of Human Resources of CVS Pharmacy, Inc., or such other person, designated by the Chief People Officer of the Company to act as the Plan Administrator.

1.11 "Rehire Date" shall mean the date an Eligible Employee accepts reemployment with any Employer.

1.12 "Severance Pay" shall mean the pay an Eligible Employee is eligible to receive under Subsection (b) of Section 2.1 of the Plan upon his or her Involuntary Termination.

1.13 "Severance Period" shall mean the period of time during which an Eligible Employee is eligible to receive Severance Pay

1.14 "Weekly Rate" shall mean, (a) with respect to an Eligible Employee paid on a salaried basis, an Eligible Employee's annual base salary (as determined by the Employer), as of the date of the Eligible Employee's Involuntary Termination, expressed on a weekly basis (as determined in the sole discretion of the Employer), and (b) with respect to an Eligible Employee paid on an hourly basis, the hourly wage rate of the Eligible Employee as of the date of the Eligible Employee's Involuntary Termination multiplied by the Eligible Employee's regularly scheduled number of hours of service per week (as determined by the Employer), not in excess of 40 hours. Weekly Rate shall exclude any overtime, incentive, and bonus payments, unless otherwise required by law.

1.15 "Year of Service" shall mean each full year of service performed by the Eligible Employee for an Employer as reflected in the records of the Employer and as determined as of the Eligible Employee's date of termination of employment, based on the Employer's policies and procedures for determining periods of service, and the applicable law.

ARTICLE 2
SEVERANCE PAY AND ELIGIBLE EMPLOYEE BENEFITS

2.1 (a) Eligibility. Upon his or her Involuntary Termination, an Eligible Employee may, in the discretion of the Plan Administrator, be granted Severance Pay and benefits provided under Subsections (b), (c), and (d) of this Section 2.1, provided the conditions of Section 2.2 are satisfied. The determination of whether Severance Pay is payable under the Plan, and the form and amount of such pay, shall be made in the sole discretion of the Plan Administrator.

(b) Severance Pay. The Severance Pay payable to an Eligible Employee in the event of Involuntary Termination shall be determined by the Plan Administrator in its, his or her sole discretion, using the guidelines set forth in Appendix A for the applicable Eligible Employee's grade, as determined by the Employer. Notwithstanding such referenced guidelines, the Plan Administrator may increase or decrease (including, to zero) the amount of Severance Pay with respect to any Eligible Employee for reasons it, he or

she deems appropriate in its sole discretion at any time, whether before or after payments of Severance Pay have commenced (including, but not limited to, a decrease to take into account any debts owed to an Employer or a decrease if an Eligible Employee fails to satisfactorily perform his or her duties and is not on or has not completed a performance improvement plan at the time of termination of employment), at any time, whether before or after payments of Severance Pay have commenced. A special one-time lump sum payment shall be made with respect to each Eligible Employee who experienced an Involuntary Termination on or after January 1, 2021 and prior to October 11, 2021 equal to the difference, if any, between the Severance Pay payable to such Eligible Employee under Appendix A as in effect upon his or her Involuntary Termination and the Severance Pay that would have been paid to him or her under Appendix A as in effect as of October 11, 2021.

(c) COBRA Assistance. In the event an Eligible Employee who has an Involuntary Termination (i) is eligible to elect continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended ("COBRA") in accordance with the terms of the medical and prescription drug plan and/or dental plan of the Employer and (ii) properly and timely elects such continuation coverage, the Employer may pay for a portion of the cost of COBRA coverage equivalent to the contribution which the Employer makes on behalf of similarly situated active employees under such plan for the appropriate tier of coverage selected and in place immediately prior to the date of the Eligible Employee's Involuntary Termination (*e.g.*, employee-only, family coverage), for a period determined in the sole discretion of the Plan Administrator, which generally shall be the Severance Period but in any event no longer than eighteen (18) months from the date of the Involuntary Termination. Any COBRA assistance provided under this Subsection (c) shall be paid by the Employer directly to the insurance carrier, if applicable. The portion of the COBRA premium not covered by the COBRA assistance specified in this Subsection (c) must be paid by the Eligible Employee directly to the insurance carrier or service provider that administers COBRA, as applicable, based on the standard rules under the respective plan for payment of COBRA premiums. This Subsection (c) does not provide COBRA assistance in the event the Eligible Employee fails to properly and timely elect COBRA continuation coverage, regardless of whether his or her covered dependents elect COBRA continuation coverage.

(d) Outplacement Services. Upon an Involuntary Termination, the outplacement services provided to an Eligible Employee shall be provided in the sole discretion of the Plan Administrator based on the guidelines contained in this Subsection (d).

(i) If an Eligible Employee so desires, he or she may be eligible for outplacement services for assistance in obtaining new employment, provided through a vendor selected by the Employer, with the Employer directly providing payment to such vendor. The provision of outplacement services is contingent upon the Eligible Employee's cooperation with the outplacement service vendor, upon the active efforts of the Eligible Employee to locate a new position, and upon the Eligible Employee initiating outplacement services during the Severance Period.

(ii) Subject to the requirements of Paragraph (i) of this Subsection (d), outplacement services shall be offered for a period of time determined in the sole discretion of the Plan Administrator, based on the guidelines set forth in Appendix A for the applicable Eligible Employee's grade, as determined by the Employer, provided that in no event shall such services extend beyond twelve (12) months following the Involuntary Termination of the Eligible Employee.

(e) Form and Timing of Payment. In the event an Eligible Employee is awarded Severance Pay under the terms of Subsection (a) of this Section 2.1, such Severance Pay shall be paid following an Eligible Employee's Involuntary Termination (except as provided in Section 2.3, below), as follows: No Severance Pay shall commence (with respect to salary continuation payments) or be paid (with respect to a lump sum) (i) prior to the expiration of the later of a period that is identified in a severance agreement with the Eligible Employee during which he or she may consider the execution of the release of claims form (the "Consideration Period") or a period ending at least seven (7) days following the execution of the release of claims form (the "Revocation Period"), or (ii) later than sixty (60) days following the date of Eligible Employee's Involuntary Termination. Severance Pay that is paid in the form of salary continuation shall

commence as soon as feasible following expiration of the later of the Consideration Period or the Revocation Period, which generally shall be the first regularly scheduled payroll date following the expiration of the Consideration Period or the Revocation Period, as the case may be, and shall thereafter be paid in substantially equal installments in accordance with the Employer's regular payroll practice, except as provided in Section 2.3 of the Plan, except that the first installment paid after the expiration of the later of the Consideration Period or the Revocation Period shall include, on a retroactive basis, all installments that would have been paid had they started as soon as administratively feasible after the date of the Eligible Employee's Involuntary Termination. It is the intent of the Plan that the Severance Period in all cases be measured from the date of the Eligible Employee's Involuntary Termination. Further, in the Plan Administrator's sole discretion, Severance Pay may be paid to any Eligible Employees in a single lump sum, in which event Severance Pay shall be paid within the period that satisfies the 409A requirements for short-term deferrals under Section 409A of the Code.

(f) Withholding. Any payment of Severance Pay to an Eligible Employee shall be subject to normal withholding for state and federal income taxes and Social Security taxes.

(g) Death. Upon the death of the Eligible Employee who had an Involuntary Termination and who has not received all Severance Pay payable under the Plan, the Severance Pay otherwise payable under Section 2.1(b) of the Plan shall be paid in the form of a lump sum to the Eligible Employee's surviving legal spouse or, if there is no surviving legal spouse, to the Eligible Employee's estate as soon as practicable, but in no event later than 60 days following death. Any other severance benefits provided under this Section 2.1 (COBRA assistance and outplacement services) shall cease upon the Eligible Employee's death.

2.2 Conditions on Payment of Severance Pay and Benefits. Payment of the Severance Pay and benefits provided in Section 2.1 of the Plan shall be subject to and conditioned upon the following:

(a) to the extent an Eligible Employee receives notice of a date selected by the Employer (in its sole discretion) on which the Eligible Employee's Involuntary Termination shall occur (a "Designated Termination Date"), the Eligible Employee must continue to work in a satisfactory manner until his or her Designated Termination Date;

(b) the Eligible Employee must cooperate in transitioning all of the Eligible Employee's work in consultation with the Eligible Employee's supervisor or other designated employee;

(c) the Eligible Employee must execute and deliver a severance agreement that includes a release of claims, which agreement shall be in a form specified by the Employer from time to time, which may include restrictive covenants and a waiver as described in Subsection (d) of this Section 2.2) within the time period specified under the terms of the applicable severance offer. Further, in no event will Severance Pay be paid with respect to an Eligible Employee in the event the release of claims form is revoked during the Revocation Period (described in Section 2.1(e) of the Plan); and

(d) the Eligible Employee must waive the right to receive any other severance payment relating to salary continuation or salary replacement the Eligible Employee may otherwise be eligible to receive upon termination of employment under any employment agreement, severance plan, practice, policy or program of the Employer or an Affiliate.

2.3 Maximum Severance Pay. Notwithstanding any other provisions to the contrary, benefits paid hereunder (a) shall not exceed two times the lesser of (i) the Eligible Employee's Compensation (as defined in this Section 2.3) during the calendar year immediately preceding the Eligible Employee's Involuntary Termination or (ii) the maximum amount that may be taken into account under a qualified plan pursuant to Section 401(a)(17) of the Code for the calendar year in which the Eligible Employee's Involuntary Termination occurs and (b) shall be paid in full within twenty-four (24) months after the date the Eligible Employee's Involuntary Termination occurs. In the event that any Severance Pay payable to an Eligible Employee would exceed the twenty-four (24) month period provided in the foregoing sentence if the Severance Pay continued to

be paid in accordance with the Employer's regular payroll practice, any Severance Pay that would otherwise exceed the twenty-four (24) month time period will be paid to the Eligible Employee in a lump sum on the last regular payroll date within the twenty-four (24) month period. For purposes of this Section 2.3, "Compensation" shall mean the Eligible Employee's total annualized compensation, based upon the annual rate of pay for services provided to the Employer for the calendar year preceding the calendar year in which the Eligible Employee's Involuntary Termination occurs, adjusted for any increase in such preceding calendar year that was expected to continue indefinitely if the Eligible Employee had not had an Involuntary Termination.

2.4 Cessation of Severance Pay Upon Reemployment. If an Eligible Employee who had an Involuntary Termination and who is receiving Severance Pay thereafter accepts reemployment with any Employer during the Severance Period, such Employee's Severance Pay shall cease on the Rehire Date and any remaining Severance Pay shall be forfeited.

2.5 Cessation of Severance Pay After Commencement of Payments. If an Eligible Employee is deemed to have an Involuntary Termination and begins to receive Severance Pay under the Plan and the Employer or the Plan Administrator becomes aware of facts and circumstances that, had the Employer known same at the time of the Eligible Employee's termination of employment, would have affected the Employer's determination as to whether such Employee's termination was an Involuntary Termination, the Plan Administrator may suspend any future Severance Pay payments to the Eligible Employee while the Employer investigates the facts and circumstances and finalizes such investigation, and, if the Employer determines that the Eligible Employee should have been terminated for Cause, such Eligible Employee's Severance Pay shall cease as of the suspension date, any remaining Severance Pay shall be forfeited and any Severance Pay that has been paid shall be subject to repayment by the Eligible Employee.

2.6 Impact of Debt on Severance Pay. In the event an Eligible Employee is indebted to the Company or Employer (determined in the sole discretion of the Company or Employer, as applicable), the Plan Administrator reserves the right to reduce, offset, withhold, and/or forfeit the Severance Pay otherwise payable under the Plan.

2.7 Employee Benefits. As of the date of an Eligible Employee's Involuntary Termination, the Eligible Employee's active participation in any benefit plan, program, or policy sponsored or subsidized by the Employer shall cease, unless otherwise continued pursuant to the terms of such plan, program or policy.

2.8 Awards. Any award or grant made to the Eligible Employee under any stock option, stock purchase, or stock appreciation rights plan of the Company or Employer shall be administered and interpreted in accordance with the terms of the applicable plan documents.

2.9 Paid Time Off. Any pay for accrued paid time off shall be determined under the terms of the Employer's applicable policies

2.10 Bonuses. Whether any bonuses or other incentive payments are payable to an Eligible Employee shall be determined based on the terms of any applicable bonus or incentive program, plan, or policy.

2.11 Benefits Not Vested. No one under any circumstance is automatically entitled to Severance Pay or benefits described in Section 2.1 of the Plan. Notwithstanding anything in the Plan to the contrary, the Plan Administrator reserves the right, at its, his or her sole discretion, to increase, decrease, or eliminate Severance Pay and benefits under the Plan.

ARTICLE 3
ADMINISTRATION OF THE PLAN

3.1 Control and Administration. Notwithstanding any other provision in the Plan, and to the full extent permitted under ERISA and the Internal Revenue Code, the Plan Administrator shall have the exclusive right, power and final authority, in its, his or her sole and absolute discretion, to administer, apply, construe and

interpret the terms of the Plan and all related plan documents and all facts surrounding claims for benefits under the Plan and shall determine all questions arising in the administration, interpretation and application of the Plan, including, but not limited to, those concerning eligibility for benefits. Accordingly, benefits under the Plan shall be paid only if the Plan Administrator decides in its, his or her sole discretion that an Eligible Employee is entitled to benefits, and the Plan Administrator shall decide all questions regarding the form, amount and duration of benefits. The Plan Administrator may consult with attorneys, consultants and other persons for advice, counsel and reports to make determinations under the Plan, and the Plan Administrator may delegate its administrative duties and responsibilities to persons or entities of its choice, in all cases who may be employees of the Company. All determinations of the Plan Administrator shall be conclusive and binding on all parties. The Plan Administrator shall be the named fiduciary of the Plan for purposes of ERISA.

3.2 Claim Procedures.

(a) Procedure for Granting or Denying Claims. An Eligible Employee, or his or her duly authorized representative, may file a claim for payment of benefits under the Plan within 30 days after termination of employment. Such a claim must be made in writing and be delivered to the Plan Administrator, in person or by mail, postage paid. Within 90 days after receipt of such claim, the Plan Administrator shall notify the claimant of the granting or denying, in whole or in part, of such claim, unless special circumstances require an extension of time for processing the claim. In no event may the extension exceed 90 days from the end of the initial 90-day period. If such extension is necessary, the claimant will be given a written notice to this effect prior to the expiration of the initial 90-day period. The Plan Administrator shall have full discretion to deny or grant a claim in whole or in part.

(b) Requirement for Notice of Claim Denial. The Plan Administrator shall provide to every claimant who is denied a claim for benefits a written or electronic notice setting forth in a manner calculated to be understood by the claimant:

(i) The specific reason or reasons for the denial;

(ii) Specific reference to pertinent Plan provisions on which the denial is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material is necessary; and

(iv) An explanation of the Plan's claim review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse determination on review.

(c) Right to Appeal on Claim Denial. Within 60 days after receipt by the claimant of written or electronic notification of the denial (in whole or in part) of his or her claim, the claimant or his or her duly authorized representative may make a written application to the Plan Administrator, in person or by certified mail, postage prepaid, to be afforded a full and fair review of such denial. The claimant or his or her duly authorized representative may submit written comments, documents, records, and other information relating to the claim for benefits. Moreover, the claimant or his or her duly authorized representative shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

(d) Disposition of Disputed Claims. Upon receipt of a request for review, the Plan Administrator shall make a decision on the claim. The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The decision on review shall be made not later than 60 days after the Plan Administrator's receipt of a request for a review, unless special circumstances require an extension of time for processing, in which case a decision shall be rendered not later than 120 days after receipt of

the request for review. If an extension is necessary, the claimant shall be given written notice of the extension prior to the expiration of the initial 60-day period.

The Plan Administrator shall provide the claimant or his or her duly authorized representative with written or electronic notification of the Plan Administrator's determination on review. In the case of an adverse determination, the notification shall set forth, in a manner calculated to be understood by the claimant, the specific reason or reasons for the decision as well as specific references to the Plan provisions on which the decision was based. The decision shall also include a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Moreover, the decision shall contain a statement of the claimant's right to bring an action under Section 502(a) of ERISA.

3.3 Conditions to Legal Action. No legal action may be commenced or maintained against the Plan, the Company or any Employer prior to the claimant's exhaustion of the claims procedures set forth in Section 3.2 of the Plan. In addition, no legal action may be commenced against the Plan more than ninety (90) days after the Plan Administrator's final claim determination on review pursuant to Section 3.2(d) of the Plan. Any legal action must be conducted in the United States District Court for Rhode Island.

3.4 Named Fiduciary. The Plan Administrator of the Plan shall be the Named Fiduciary of the Plan for purposes of ERISA Section 402(a)(1).

ARTICLE 4
MISCELLANEOUS

4.1 Amendment or Termination. The Plan may be amended, terminated, withdrawn or suspended at any time in writing by the Management Planning and Development Committee of the Company or any individual designated by such Committee to take such actions.

4.2 Choice of Law. The validity, interpretation, construction and performance of the obligations created under the Plan shall be governed by ERISA, and to the extent not preempted by federal law, the laws of the State of Rhode Island without regard to its conflicts of law principles.

4.3 Validity. The invalidity or unenforceability of any provision of the Plan shall not affect the validity or enforceability of any other provision of the Plan, which shall remain in full force and effect.

4.4 Plan Exclusive Source of Rights. The Plan contains all of the terms and conditions with respect to the benefits provided hereunder, and no employee or former employee of the Company or any Employer may rely on any other communication or representation, whether oral or written, of the Company or any Employer or any of its subsidiaries, or any officer or employee thereof, as creating any right or obligation not expressly provided by the Plan.

4.5 Non-assignability. No benefit which shall be payable under the Plan to any Eligible Employee shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge (except as required by law), and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge a benefit shall be null and void. No benefit shall in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements, or torts of any Eligible Employee. No benefit shall be subject to legal attachment or legal process for, or against, the Eligible Employee and the same shall not be recognized under the Plan. Notwithstanding the preceding sentence, the Employer retains the discretion, in accordance with federal and/or state laws, to reduce the amount of benefits payable under the Plan to any Eligible Employee to recover any amounts that the Eligible Employee owes to the Employer.

4.6 No Employment Rights. The Plan shall not give any Eligible Employee any right or claim except to the extent that the right is specifically provided under the terms of the Plan. The establishment of the Plan shall not be construed (a) to give any Eligible Employee a right to continue in the employ of the Employer

or (b) to interfere with the right of the Employer to terminate the employment of any Eligible Employee at any time.

4.7 Headings. Article and section headings are for convenience only and the language of the Plan itself will be controlling.

4.8 Gender and Numbers. Masculine pronouns include the feminine as well as the neuter genders, and the singular shall include the plural, unless indicated otherwise by the context.

4.9 Code Section 409A. The benefits provided under the terms of the Plan are intended to fall within the short-term deferral exception, the separation pay exception or another exception to the application of Section 409A of the Code and the applicable guidance issued thereunder. In furtherance of this intent, the Plan shall be interpreted, operated and administered in a manner consistent with this intention. To the extent the benefits provided under the Plan become subject to Code Section 409A and applicable guidance issued thereunder, the Plan shall be construed, and benefits paid hereunder, as necessary to comply with Section 409A of the Code and such guidance. Further, to the extent that an Eligible Employee becomes entitled to receive Severance Pay under the terms of the Plan, and, at the time of the Eligible Employee's Involuntary Termination, he or she is a "specified employee" within the meaning of Treasury Regulation Section 1.409A- 1(i), any portion of Severance Pay payable to such Eligible Employee that is subject to Code Section 409A and applicable guidance thereunder shall be delayed until the date that is the earlier of (i) the Eligible Employee's death or (ii) six months following the date of the Eligible Employee's Involuntary Termination, at which time the payments that were delayed for such six month period shall be paid in a lump sum on the date of the next occurring regular payroll date of the Employer, and any remaining payments shall be paid according to the original schedule provided herein. In addition, each payment of a salary continuation stream of installment payments hereunder shall be a separate payment for purposes of Section 409A of the Code.

4.10 Funding. The Plan is not funded, and Severance Pay and benefits under the Plan are paid from the general assets of the Employer.

4.11 Plan Year. The Plan's records shall be maintained on the basis of the calendar year.

IN WITNESS WHEREOF, the Management Planning and Development Committee of the Company, or its duly authorized delegate, has amended the Plan as of the Effective Date pursuant to the execution hereof on its behalf by a duly authorized officer on October 11, 2021.

CVS HEALTH CORPORATION

By: /s/ Laurie P. Havanec

Date: October, 26, 2021 Title: EVP and Chief People Officer

Appendix A
Amount of Severance Pay and Outplacement Services, effective as of October 11, 2021

Severance Pay is the Weekly Rate payable for the number of weeks listed below, determined by Grade and Years of Service (YOS)

	Tier 1	Tier 2	Tier 3	Tier 4	Executive Tier 1	Executive Tier 2
	Grades 101, 102, 103, 104, 105, 106, 550, 551, 552, 652, 752	Grades 107, 108, 201, 202, 203, 301, 302, 405, 406, 407, 408, 553, 554, 653, 753, 654, 754	Grades 109, 110, 111, 204, 205, 303, 304, 409, 410, 411, 555, 556, 557, 558, 655, 656, 657, 658, 755, 756, 757, 758	Grades 112, 206, 305, 412, 559, 560, 659, 759	Grades 36 A-Z, 70G	Grades 38 A-Z, 39 A-Z, 71G, 72G
Full YOS	Number of Weeks	Number of Weeks	Number of Weeks	Number of Weeks	Number of Weeks	Number of Weeks
0	2	4	13	26	52	52
1	4	6	13	26	52	*52 or 78
2	6	8	13	26	52	78
3	8	10	13	26	52	78
4	10	12	13	26	52	78
5	12	14	14	26	52	78
6	13	16	16	26	52	78
7	13	18	18	26	52	78
8	13	20	20	26	52	78
9	13	20	20	26	52	78
10	13	20	20	26	52	78
11	13	20	21	26	52	78
12	13	20	22	26	52	78
13	13	20	23	26	52	78
14	14	20	24	26	52	78
15	15	20	25	28	52	78
16	16	21	26	29	52	78
17	17	22	26	30	52	78
18	18	23	26	31	52	78
19	19	24	26	32	52	78
20	20	25	26	33	52	78
21	21	26	26	34	52	78
22	22	26	26	35	52	78
23	23	26	26	36	52	78
24	24	26	26	37	52	78
25	25	26	26	38	52	78
26	26	26	27	39	52	78
27	26	26	28	39	52	78
28	26	26	29	39	52	78

29	26	26	30	39	52	78
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Executive Tier 1**	**Executive Tier 2**
	Grades 101, 102, 103, 104, 105, 106, 550, 551, 552, 652, 752	**Grades 107, 108, 201, 202, 203, 301, 302, 405, 406, 407, 408, 553, 554, 653, 753, 654, 754**	**Grades 109, 110, 111, 204, 205, 303, 304, 409, 410, 411, 555, 556, 557, 558, 655, 656, 657, 658, 755, 756, 757, 758**	**Grades 112, 206, 305, 412, 559, 560, 659, 759**	**Grades 36 A-Z, 70G**	**Grades 38 A-Z, 39 A-Z, 71G, 72G**
Full YOS	**Number of Weeks**	**Number of Weeks**	**Number of Weeks**	**Number of Weeks**	**Number of Weeks**	**Number of Weeks**
30	26	26	31	39	52	78
31	26	26	32	39	52	78
32	26	26	33	39	52	78
33	26	26	34	39	52	78
34	26	26	35	39	52	78
35	26	26	36	39	52	78
36+	26	26	39	39	52	78
	6-Week Virtual Outplacement	**3-Month Virtual Outplacement**	**3-Month Professional Outplacement**	**3-Month Professional Outplacement**	**6-Month Executive Outplacement**	**6-Month Executive Outplacement**

*** Under 18 months of service receives 52 weeks**

CVS HEALTH CORPORATION
NONQUALIFIED STOCK OPTION AGREEMENT

GRANT DATE: [MERGED FIELD]

1. GRANT OF AWARD. Pursuant and subject to the provisions of the **[MERGED FIELD]** of CVS Health Corporation (the "**Plan**"), on the date set forth above (the "**Grant Date**"), CVS Health Corporation (the "**Company"**) has granted and hereby evidences the Grant to the person named below (the "**Participant**"), subject to the terms and conditions set forth or incorporated in this Nonqualified Stock Option Agreement ("**Agreement**"), the right, and option, to purchase from the Company the aggregate number of shares of Common Stock ($.01 par value) of the Company ("**Shares**") set forth below, at the purchase price indicated below (the "**Option**"), such Option to be exercised as hereinafter provided. The Plan is hereby made a part hereof and Participant agrees to be bound by all the provisions of the Plan. Capitalized terms not otherwise defined herein shall have the meaning assigned to such term(s) in the Plan. The Option is a nonqualified option as defined in the Plan.

Participant:	**[MERGED FIELD]**
Employee ID:	**[MERGED FIELD]**
Shares:	**[MERGED FIELD]**
Option Price:	**[MERGED FIELD]**

2. TERM OF OPTION. The term of this Option shall be for a period of ten (10) years from the Grant Date, subject to the earlier termination of the Option, as set forth in the Plan and in this Agreement. No portion of the Option shall be exercisable after the term of the Option.

3. EXERCISE OF OPTION. (a) The Option, subject to the provisions of the Plan, shall be exercised by submitting a request to exercise to the Company's stock option administrator, in accordance with the Company's current exercise policies and procedures, specifying the number of Shares to be purchased, which number may not be less than one hundred (100) Shares (unless the number of Shares purchased is the total balance which is then exercisable). An exercise by Participant of all or part of this Option shall be effected through the Company's "cashless exercise" procedures. Otherwise, at the time of exercise, Participant shall tender to the Company cash or cash equivalent for the aggregate option price of the Shares Participant has elected to purchase or certificates for Shares of Common Stock of the Company owned by Participant for at least six (6) months with a fair market value at least equal to the aggregate option price of the Shares Participant has elected to purchase, or a combination of the foregoing.

(b) Prior to its expiration or termination and except as otherwise provided herein, the Option will become vested in accordance with the vesting schedule set forth below, each date on which vesting occurs a "**Vesting Date**", and any vested Option will be exercisable by Participant prior to the expiration of its term so long as Participant has maintained continuous employment with the Company or a subsidiary of the Company from the Grant Date through the exercise date:

(i) 25% of the Option shall vest on the 1st anniversary of the Grant Date.
(ii) 25% of the Option shall vest on the 2nd anniversary of the Grant Date.
(iii) 25% of the Option shall vest on the 3rd anniversary of the Grant Date.
(iv) 25% of the Option shall vest on the 4th anniversary of the Grant Date.

4. TAXES. Upon a cashless exercise of the Option the Company shall withhold from the proceeds of the exercise of the Option any required taxes. If the Option is exercised other than through a cashless exercise Company shall have the right to require Participant to pay the amount of any withholding taxes immediately, upon notification from the Company, before the proceeds from the exercise of the Option are delivered to Participant. Furthermore, the Company may elect to deduct such taxes from any other amounts then payable to Participant in cash or in Shares or from any other amounts payable any time thereafter to Participant to the extent allowed under applicable law.

5. NON-TRANSFERABILITY. The Option shall not be transferable by Participant other than by will or by the laws of descent and distribution, and during Participant's lifetime shall be exercised only by the Participant during the continuance of Participant's employment with the Company and any of its subsidiaries.

6. FORFEITURE OF OPTION UPON TERMINATION OF EMPLOYMENT. Unless otherwise provided for in the Plan or in this Agreement, as of the date on which Participant's employment with the Company and its subsidiaries terminates, the Option, to the extent unexercised as of the employment termination date, shall be forfeited immediately in its entirety, provided that, if the Participant's employment with the Company and its subsidiaries terminates without Cause, the Option, to the extent vested and unexercised, shall be exercisable at any time on or before the ninetieth (90^{th}) day immediately following the employment termination date and, to the extent unvested, shall be forfeited immediately.

7. TERMINATION OF PARTICIPANT'S EMPLOYMENT WITHOUT CAUSE. In the event that Participant's employment with the Company and its subsidiaries is terminated without Cause and Participant receives severance pay following Participant's employment pursuant to a written agreement, vesting of the Option shall continue through the end of the severance period set forth in the agreement providing for such severance pay. To the extent vested, the Option shall be exercisable at any time during the severance period and on or before the ninetieth (90th) day following the last day of the severance period, as long as no government regulations or rules are violated by such continued vesting or exercise period; provided, however, that in no event will the Option be exercisable beyond its original term. Any portion of the Option not vested as of the last day of the severance period shall be forfeited as of the last day of the severance period. In the event that Participant returns to employment with the Company or any subsidiary prior to the expiration of the severance period, Participant shall be treated as if his or her employment with the Company or any subsidiary of the Company had continued through the severance period for purposes of determining eligibility for continued vesting.

8. RETIREMENT OF PARTICIPANT. In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of a Qualified Retirement, Participant (a) shall continue to vest in the Option, to the extent unvested as of the retirement date, for a period of three (3) years following Participant's retirement date and (b) may exercise the Option, to the extent vested, at any time within the period of three (3) years following Participant's retirement date, but not beyond the original term of the Option, in both cases as long as no government regulations or rules are violated by such continued vesting or exercise period. To the extent unvested or unexercised at the end of the three (3) year period following Participant's retirement date, the Option shall be forfeited. In the event Participant's termination of employment qualifies as a Qualified Retirement and Participant also enters into a severance agreement with the Company, the terms of this Section 8 shall apply with respect to the vesting and exercise of the Option as of the Participant's employment termination date. "**Qualified Retirement**" shall mean termination of employment on or after attainment of age fifty-five (55) with at least ten (10) years of continuous service, or attainment of age sixty (60) with at least five (5) years of continuous service, provided that: (i) if Participant elects to terminate his or her employment voluntarily, Participant has provided the Company with at least twelve (12) months advance notice, in accordance with the provisions of Section 13 below, of his or her retirement date or such other term of advance notice as is determined by the Chief Human Resources Officer of the Company; or (ii) if the Company elects to terminate Participant's employment, such termination is without cause. A Participant shall also be deemed to have

experienced a Qualified Retirement if the Company elects to terminate Participant's employment without Cause and Participant shall meet the age and service requirement set forth above during the severance period set forth in a severance agreement with the Company.

9. DISABILITY OF PARTICIPANT. In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of total and permanent disability (as defined in the Company's Long-Term Disability Plan, or, if not defined in such Plan, as defined by the Social Security Administration), the Option shall vest as of the employment termination date on a pro-rata basis as follows: the Option shall vest with respect to a total number of Shares as of the employment termination date (which is the last day that Participant is employed by the Company and any subsidiary of the Company) equal to (i) the number of Shares subject to the Option on the Grant Date *multiplied* by the following fraction: (A) the numerator shall be the whole number of months elapsed as of the employment termination date since the Grant Date and (B) the denominator shall be forty-eight (48), *minus* (ii) the number of Shares with respect to which the Option vested prior to the employment termination date (whether or not the Option was previously exercised). For purposes of this calculation, the number of months in the numerator in sub-section (A) above shall include any partial month in which Participant has worked. For example, if the time elapsed between the Grant Date and the employment termination date is eight months and five days, the numerator in sub-section (A) above shall be nine**.** The Option may be exercised to the extent vested at any time within one (1) year of Participant's employment termination date but not beyond the original term of the Option. The prorated Option shall vest on the Participant's employment termination date.

10. DEATH OF PARTICIPANT. In the event of Participant's death while Participant is employed with the Company and any subsidiary of the Company, the Option shall immediately vest in full, and the Option shall remain exercisable for a period of one (1) year after Participant's death, or until the Option expiration date, whichever occurs first, by Participant's Beneficiary. At the end of said one (1)-year time period, all rights with respect to any Option that is unexercised shall terminate and the Option shall be cancelled.

11. TRANSFER OF EMPLOYMENT. Transfer of Participant's employment from the Company to a subsidiary of the Company, among or between subsidiaries of the Company, or from a subsidiary of the Company to the Company shall not be treated as termination of employment.

12. REQUIRED ACCEPTANCE OF AWARD. The Option may not be exercised unless and until the Company has received the Participant's acceptance of the terms and conditions set forth herein. Acceptance shall be submitted electronically as required by the Company.

13. NOTICE. Any notice required to be given hereunder to the Company shall be in writing. If by regular mail, any required notice shall be addressed to: CVS Health Corporation, Attention: Senior Director, Executive Compensation, One CVS Drive, Woonsocket, RI 02895. If by electronic mail, any notice required shall be sent to: equityadministration@cvshealth.com, with "Retirement Notice" in the subject line. Any notice required to be given hereunder to Participant shall be addressed to Participant at his or her address as shown on the records of the Company, subject to the right of either party hereafter to designate in writing to the other some other address.

14. RECOUPMENT OF OPTION AWARD. The Option subject to this Agreement under the Plan shall be subject to the terms of the Company's Recoupment Policy as it exists from time to time, which may require the Participant to immediately repay to the Company the value of any pre-tax economic benefit that he or she may derive from the Award. By accepting this Award, Participant acknowledges that a copy of the Company's Recoupment Policy has been made available for the Participant's reference.

15. COMMITTEE AUTHORITY. The Committee shall have the authority, in its sole discretion, to make any interpretations, determinations, and/or take any administrative actions with respect to the Plan and this Agreement, including whether any post-termination payments to Participant shall be deemed severance pay, the duration of any severance period, and/or whether a termination was without cause.

16. GOVERNING LAW. This Nonqualified Stock Option Agreement and the Option evidenced hereby shall be governed by the laws of Delaware, without giving effect to principles of conflict of laws.

17. ACKNOWLEDGEMENT. This Agreement shall be fully effective only upon the Participant's formal acceptance of the terms and conditions set forth above as required by the Company.

BY: _____

Executive Vice President, Chief Human Resources Officer
CVS Health Corporation

Exhibit 21.1

Subsidiaries of CVS Health Corporation

Listed below are subsidiaries under CVS Health Corporation at December 31, 2021 with their jurisdictions of organization shown in parentheses. Subsidiaries excluded from the list below are not insurance companies and would not, in the aggregate, constitute a "significant subsidiary" of CVS Health Corporation, as that term is defined in Rule 1-02(w) of Regulation S-X.

- **CVS Foreign, Inc. (New York)**
  - CVS Caremark Indemnity Ltd. (Bermuda)
  - CVS International, L.L.C. (Delaware)

- **CVS Pharmacy, Inc. (Rhode Island)**
  - Aetna Inc. (Pennsylvania)
    - Aetna Health Holdings, LLC (Delaware)
      - Aetna Health of California Inc. (California)
      - Aetna Health Inc. (Connecticut)
      - Aetna Health Inc. (Florida)
      - Aetna Health Inc. (Georgia)
      - Aetna Health Inc. (Maine)
      - Aetna Health of Michigan Inc. (Michigan)
      - Aetna Health Inc. (New Jersey)
      - Aetna Health Inc. (New York)
        - Aetna Better Health Inc. (New York)
      - Aetna Health Inc. (Pennsylvania)
      - Aetna Health Inc. (Texas)
      - Aetna Better Health of California Inc. (California)
      - Aetna Health of Ohio Inc. (Ohio)Aetna Better Health of Texas Inc. (Texas)
      - Aetna Better Health of Washington, Inc. (Washington)
      - Aetna Better Health Inc. (Georgia)
      - Aetna HealthAssurance Pennsylvania, Inc. (Pennsylvania)
      - Aetna Dental of California Inc. (California)
      - Aetna Dental Inc. (New Jersey)
      - Aetna Dental Inc. (Texas)
      - Aetna Rx Home Delivery, LLC (Delaware)
      - Aetna Health Management, LLC (Delaware)
      - Aetna Ireland Inc. (Delaware)
      - Aetna Specialty Pharmacy, LLC (Delaware)
      - Cofinity, Inc. (Delaware)
      - @Credentials Inc. (Delaware)
      - Aetna Better Health Inc. (Pennsylvania)
      - Aetna Better Health Inc. (Connecticut)
      - Aetna Better Health of Illinois Inc. (Illinois)
      - Aetna Better Health Premier Plan MMAI Inc. (Illinois)
      - Aetna Better Health of Kansas Inc. (Kansas)
      - Aetna Better Health, Inc. (Louisiana)
      - Aetna Florida Inc. (Florida)
      - Aetna Better Health of Indiana Inc. (Indiana)

- Aetna Better Health Inc. (Ohio)
- Aetna Better Health of Oklahoma Inc. (Oklahoma)
- Aetna Better Health of Nevada Inc. (Nevada)
- Aetna Better Health Inc. (New Jersey)
- Aetna Better Health of North Carolina Inc. (North Carolina)
- Aetna Network Services LLC (Connecticut)
- Aetna Risk Assurance Company of Connecticut Inc. (Connecticut)
- Aetna Student Health Agency Inc. (Massachusetts)
- Delaware Physicians Care, Incorporated (Delaware)
- Schaller Anderson Medical Administrators, Incorporated (Delaware)
- Aetna Medicaid Administrators LLC (Arizona)
- iTriage, LLC (Delaware)
- Medical Examinations of New York, P.C. (New York)
- bswift LLC (Illinois)
- Prodigy Health Group, Inc. (Delaware)
  - Niagara Re, Inc. (New York)
  - Performax, Inc. (Delaware)
  - Scrip World, LLC (Utah)
  - Precision Benefit Services, Inc. (Delaware)
  - American Health Holding, Inc. (Ohio)
  - Meritain Health, Inc. (New York)
    - Administrative Enterprises, Inc. (Arizona)
    - U.S Healthcare Holdings, LLC (Ohio)
    - Prime Net, Inc. (Ohio)
    - Professional Risk Management, Inc. (Ohio)
- ADMINCO, Inc. (Arizona)
- Aetna ACO Holdings Inc. (Delaware)
- Aetna Pharmacy Management Services LLC (Delaware)
- Coventry Transplant Network, Inc. (Delaware)
- Aetna Health of Iowa Inc. (Iowa)
- Coventry Health Care of Nebraska, Inc. (Nebraska)
- Aetna Health Inc. (Louisiana)
- HealthAssurance Pennsylvania, Inc. (Pennsylvania)
- Coventry Prescription Management Services Inc. (Nevada)
- Coventry Health and Life Insurance Company (Missouri)
  - Aetna Better Health of Kentucky Insurance Company (Kentucky)
- Coventry Health Care of Virginia, Inc. (Virginia)
- Coventry Health Care of Missouri, Inc. (Missouri)
- Aetna Better Health of Missouri LLC (Missouri)
- Coventry Health Care of Illinois, Inc. (Illinois)
- Coventry Health Care of West Virginia, Inc. (West Virginia)
- Coventry HealthCare Management Corporation (Delaware)
- Coventry Health Care of Kansas, Inc. (Kansas)
- Coventry Health Care National Accounts, Inc. (Delaware)
- Aetna Better Health of Michigan Inc. (Michigan)
- Aetna Health of Utah Inc. (Utah)
- Aetna Better Health of Tennessee Inc. (Tennessee)

- Coventry Health Care National Network, Inc. (Delaware)
- Coventry Consumer Advantage, Inc. (Delaware)
- MHNet Specialty Services, LLC (Maryland)
  - Mental Health Network of New York IPA, Inc. (New York)
  - Mental Health Associates, Inc. (Louisiana)
  - MHNet of Florida, Inc. (Florida)
- Group Dental Service, Inc. (Maryland)
  - Group Dental Service of Maryland, Inc. (Maryland)
- Florida Health Plan Administrators, LLC (Florida)
  - Aetna Better Health of Florida Inc. (Florida)
  - Carefree Insurance Services, Inc. (Florida)
  - Coventry Health Plan of Florida, Inc. (Florida)
- First Health Group Corp. (Delaware)
  - First Health Life & Health Insurance Company (Texas)
  - Claims Administration Corp. (Maryland)
  - First Choice of the Midwest LLC (South Dakota)

- Continental Life Insurance Company of Brentwood, Tennessee (Tennessee)
  - American Continental Insurance Company (Tennessee)
- Aetna Life Insurance Company (Connecticut)
  - AHP Holdings, Inc. (Connecticut)
    - Aetna Insurance Company of Connecticut (Connecticut)
    - AE Fourteen, Incorporated (Connecticut)
    - Aetna Life Assignment Company (Connecticut)
  - Aetna ACO Holdings Inc. (Delaware)
    - Innovation Health Holdings, LLC (Delaware)
      - Innovation Health Insurance Company (Virginia)
        - Innovation Health Plan, Inc. (Virginia)
    - Texas Health + Aetna Health Insurance Holding Company LLC (Texas)
      - Texas Health + Aetna Health Insurance Company (Texas)
        - Texas Health + Aetna Health Plan Inc. (Texas)
  - Banner Health and Aetna Health Insurance Holding Company LLC (Delaware)
    - Banner Health and Aetna Health Insurance Company (Arizona)
      - Banner Health and Aetna Health Plan Inc. (Arizona)
  - Sutter Health and Aetna Insurance Holding Company LLC (Delaware)
    - Sutter Health and Aetna Administrative Services LLC (Delaware)
    - Sutter Health and Aetna Insurance Company (California)
  - Allina Health and Aetna Insurance Holding Company LLC (Delaware)
    - Allina Health and Aetna Insurance Company (Minnesota)
    - Allina Health and Aetna Health Plan Inc. (Minnesota)
  - Aetna International LLC (Connecticut)
    - Aetna Life & Casualty (Bermuda) Ltd. (Bermuda)
    - Aetna International Ex Pat LLC (Delaware)
    - Aetna Global Holdings Limited (England & Wales)
      - Aetna Insurance (Hong Kong) Limited (Hong Kong)
      - Virtual Home Healthcare LLC (Dubai)
      - Minor Health Enterprise Co, Ltd. (Thailand)
      - Health Care Management Co. Ltd. (Thailand)

- Aetna Services (Thailand) Limited (Thailand)
- Aetna Health Insurance (Thailand) Public Company Limited (Thailand)

▪ Aetna Health Insurance (Thailand) Public Company Limited (Thailand)
▪ Aetna Holdings (Thailand) Limited (Thailand)

- Health Care Management Co. Ltd. (Thailand)
- Minor Health Enterprise Co, Ltd. (Thailand)

◦ Aetna Health Insurance (Thailand) Public Company Limited (Thailand)

◦ Aetna Global Benefits (Bermuda) Limited (Bermuda)
▪ Goodhealth Worldwide (Global) Limited (Bermuda)
▪ Aetna Global Benefits (Europe) Limited (England & Wales)
▪ Aetna Global Benefits (Asia Pacific) Limited (Hong Kong)

- PT Aetna Management Consulting (Indonesia)

▪ Goodhealth Worldwide (Asia) Limited (Hong Kong)
▪ Aetna Global Benefits Limited (DIFC, UAE)
▪ Aetna Global Benefits (Middle East) LLC (UAE)
▪ Pt. Aetna Global Benefits Indonesia (Indonesia)
▪ Spinnaker Topco Limited (Bermuda)

- Spinnaker Bidco Limited (England and Wales)

◦ Aetna Holdco (UK) Limited (England and Wales)

- Aetna Global Benefits (UK) Limited (England and Wales)
- Aetna Insurance Company Limited (England and Wales)

◦ Aetna Insurance (Singapore) Pte. Ltd. (Singapore)
◦ Aetna Health Insurance Company of Europe DAC (Ireland)
◦ Aetna (Shanghai) Enterprise Services Co. Ltd. (China)
▪ Aetna (Beijing) Enterprise Management Services Co., Ltd. (China)
◦ Aetna Global Benefits (Singapore) PTE. LTD. (Singapore)
▪ Indian Health Organisation Private Limited (India)
◦ PT Aetna Management Consulting (Indonesia)

◦ PE Holdings, LLC (Connecticut)
◦ Aetna Resources LLC (Delaware)
◦ Canal Place, LLC (Delaware)
◦ Aetna Ventures, LLC (Delaware)

◦ Phoenix Data Solutions LLC (Delaware)
◦ Aetna Financial Holdings, LLC (Delaware)
◦ Aetna Asset Advisors, LLC (Delaware)
◦ U.S. Healthcare Properties, Inc. (Pennsylvania)
◦ Aetna Capital Management, LLC (Delaware)
▪ Aetna Partners Diversified Fund, LLC (Delaware)
◦ Aetna Workers' Comp Access, LLC (Delaware)
◦ Aetna Behavioral Health, LLC (Delaware)
◦ Managed Care Coordinators, Inc. (Delaware)
◦ Horizon Behavioral Services, LLC (Delaware)
▪ Employee Assistance Services, LLC (Kentucky)
▪ Health and Human Resource Center, Inc. (California)
▪ Resources for Living, LLC (Texas)
▪ The Vasquez Group Inc. (Illinois)
▪ Work and Family Benefits, Inc. (New Jersey)

        - Aetna Card Solutions, LLC (Connecticut)
        - PayFlex Holdings, Inc. (Delaware)
            - PayFlex Systems USA, Inc. (Nebraska)
    - Aetna Health and Life Insurance Company (Connecticut)
    - Aetna Health Insurance Company (Pennsylvania)
    - Aetna Health Insurance Company of New York (New York)
    - AUSHC Holdings, Inc. (Connecticut)
        - PHPSNE Parent Corporation (Delaware)
    - Active Health Management, Inc. (Delaware)
        - Health Data & Management Solutions, Inc. (Delaware)
        - Aetna Integrated Informatics, Inc. (Pennsylvania)
    - Health Re, Inc. (Vermont)
    - ASI Wings, LLC (Delaware)
    - Aetna Corporate Services LLC (Delaware)
    - Echo Merger Sub, Inc. (Delaware)

- CVS Pharmacy, Inc. (continued)

    - Alabama CVS Pharmacy, L.L.C. (Alabama)
    - Alaska CVS Pharmacy, L.L.C. (Alaska)
    - American Drug Stores Delaware, L.L.C. (Delaware)
    - Arkansas CVS Pharmacy, L.L.C. (Arkansas)
    - CareCenter Pharmacy, L.L.C. (Delaware)
    - Caremark Rx, L.L.C. (Delaware)
        - ACS ACQCO CORP. (Delaware)
            - Advanced Care Scripts, Inc. (Florida)
        - CaremarkPCS, L.L.C. (Delaware)
            - CaremarkPCS Health, L.L.C. (Delaware)
            - Caremark IPA, L.L.C. (New York)
        - Accordant Health Services, L.L.C. (Delaware)
        - AdvancePCS SpecialtyRx, LLC (Delaware)
        - AdvanceRx.com, L.L.C. (Delaware)
        - Caremark PhC, L.L.C. (Delaware)
        - Caremark Ulysses Holding Corp. (New York)
            - MemberHealth LLC (Delaware)
            - UAC Holding, Inc. (Delaware)
        - Caremark, L.L.C. (California)
            - Caremark Arizona Mail Pharmacy, LLC (Arizona)
            - Caremark Arizona Specialty Pharmacy, L.L.C. (Arizona)
            - Caremark California Specialty Pharmacy, L.L.C. (California)
            - Caremark Florida Mail Pharmacy, LLC (Florida)
            - Caremark Florida Specialty Pharmacy, LLC (Florida)
            - Caremark Hawaii Mail Pharmacy, L.L.C. (Hawaii)
            - Caremark Hawaii Specialty Pharmacy, LLC (Hawaii)
            - Caremark Illinois Mail Pharmacy, LLC (Illinois)
            - CVS Caremark Advanced Technology Pharmacy, L.L.C. (Illinois)
            - Caremark Illinois Specialty Pharmacy, LLC (Illinois)

- Caremark Irving Resource Center, LLC (Texas)
- Caremark Kansas Specialty Pharmacy, LLC (Kansas)
- Caremark Logistics, LLC (Delaware)
- Caremark Louisiana Specialty Pharmacy, LLC (Louisiana)
- Caremark Maryland Specialty Pharmacy, LLC (Maryland)
- Caremark Massachusetts Specialty Pharmacy, L.L.C. (Massachusetts)
- Caremark Michigan Specialty Pharmacy, LLC (Michigan)
- Caremark Minnesota Specialty Pharmacy, LLC (Minnesota)
- Caremark New Jersey Specialty Pharmacy, LLC (New Jersey)
- Caremark North Carolina Specialty Pharmacy, LLC (North Carolina)
- Caremark Ohio Specialty Pharmacy, L.L.C. (Ohio)
- Caremark Pennsylvania Specialty Pharmacy, LLC (Pennsylvania)
- Caremark Redlands Pharmacy, L.L.C. (California)
- Caremark Repack, LLC (Illinois)
- Caremark Tennessee Specialty Pharmacy, LLC (Tennessee)
- Caremark Texas Mail Pharmacy, LLC (Texas)
- Caremark Texas Specialty Pharmacy, LLC (Texas)
- Caremark Washington Specialty Pharmacy, LLC (Washington)
- Central Rx Services, LLC (Nevada)
- CVS Caremark TN SUTA, LLC (Delaware)
- Generation Health, L.L.C. (Delaware)
- NovoLogix, LLC (Delaware)

- CaremarkPCS Alabama Mail Pharmacy, LLC (Alabama)
- CVS Caremark Part D Services, L.L.C. (Delaware)
- Eckerd Corporation of Florida, Inc. (Florida)
- Express Pharmacy Services of PA, L.L.C. (Delaware)
- Ocean Acquisition Sub, L.L.C. (Delaware)
  - Coram LLC (Delaware)
  - T2 Medical, Inc. (Delaware)
    - Coram Healthcare Corporation of Alabama (Delaware)
    - Coram Healthcare Corporation of Florida (Delaware)
    - Coram Healthcare Corporation of Greater D.C. (Delaware)
    - Coram Healthcare Corporation of Greater New York (New York)
    - Coram Healthcare Corporation of Indiana (Delaware)
    - Coram Healthcare Corporation of Mississippi (Delaware)
    - Coram Healthcare Corporation of Nevada (Delaware)
    - Coram Healthcare Corporation of Northern California (Delaware)
    - Coram Healthcare Corporation of Southern California (Delaware)
    - Coram Healthcare Corporation of Southern Florida (Delaware)
    - Coram Specialty Infusion Services, L.L.C. (Delaware)
      - Coram Rx, LLC (Delaware)
      - Coram Healthcare Corporation of North Texas (Delaware)
      - Coram Healthcare Corporation of Utah (Delaware)
      - Coram Healthcare Corporation of Massachusetts (Delaware)
  - Coram Alternate Site Services, Inc. (Delaware)
      - Geneva Woods Management, LLC (Delaware)

- Part D Holding Company, L.L.C. (Delaware)
  - Accendo Insurance Company (Utah)
  - Silverscript Insurance Company (Tennessee)
- Connecticut CVS Pharmacy, L.L.C. (Connecticut)
- Coram Clinical Trials, Inc. (Delaware)*
  - CVS Cabot Holdings Inc. (Delaware)*
  - CVS Shaw Holdings Inc. (Delaware)*
    - Omnicare, LLC (Delaware)*
      - Evergreen Pharmaceutical of California, LLC (California)
      - JHC Acquisition, LLC (Delaware)
        - Geneva Woods Pharmacy, LLC (Alaska)
          - Geneva Woods Health Services, LLC (Delaware)
            - Geneva Woods Retail Pharmacy LLC (Delaware)
            - Geneva Woods LTC Pharmacy, LLC
              - Geneva Woods Pharmacy Wyoming, LLC (Delaware)
              - Geneva Woods Pharmacy Washington, LLC (Delaware)
              - Geneva Woods Pharmacy Alaska, LLC (Delaware)
        - AMC - Tennessee, LLC (Delaware)
        - CHP Acquisition, LLC (Delaware)
          - Home Pharmacy Services, LLC (Missouri)
        - CP Acquisition, LLC (Oklahoma)
        - Managed Healthcare, LLC (Delaware)
        - Medical Arts Health Care, LLC (Georgia)
        - NIV Acquisition, LLC (Delaware)
        - OCR Services, LLC (Delaware)
          - Shore Pharmaceutical Providers, LLC (Delaware)
        - Omnicare of Nevada, LLC (Delaware)
        - Omnicare Pharmacies of the Great Plains Holding, LLC (Delaware)
          - Omnicare of Nebraska LLC (Delaware)
        - Pharmacy Associates of Glenn Falls, LLC (New York)
        - Sterling Healthcare Services, LLC (Delaware)
        - Superior Care Pharmacy, LLC (Delaware)
        - TCPI Acquisition, LLC (Delaware)
        - UC Acquisition, LLC (Delaware)
        - Weber Medical Systems LLC (Delaware)
        - Williamson Drug Company, LLC (Virginia)
      - Med World Acquisition Corp. (Delaware)
      - MHHP Acquisition Company, LLC (Delaware)

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*Coram Clinical Trials, Inc. – CVS Pharmacy, Inc. 75%/Aetna Life Insurance Company 25%

* CVS Cabot Holdings, Inc. – Coram Clinical Trials, Inc. 99.72%/Aetna Inc. .28%

*CVS Shaw Holdings, Inc. – Coram Clinical Trials, Inc. 99.72%/Aetna Inc. .28%

*Omnicare, LLC – Aetna Inc 0.28%/CVS Cabot Holdings, Inc. 49.86%/CVS Shaw Holdings, Inc. 49.86%

- Omnicare, LLC (continued)
  - NeighborCare Pharmacy Services, LLC (Delaware)
    - APS Acquisition LLC (Delaware)
    - ASCO HealthCare, LLC (Maryland)
    - Badger Acquisition LLC (Delaware)
      - Badger Acquisition of Minnesota LLC (Delaware)
        - Merwin Long Term Care, LLC (Minnesota)
      - Badger Acquisition of Ohio LLC (Delaware)
      - Badger Acquisition of Kentucky LLC (Delaware)
    - Best Care LTC Acquisition Company, LLC (Delaware)
    - Care Pharmaceutical Services, LP (Delaware)
    - CCRx Holdings, LLC (Delaware)
      - Continuing Care Rx, LLC (Pennsylvania)
      - CCRx of North Carolina LLC (Delaware)
    - Compscript, LLC (Florida)
      - Campo's Medical Pharmacy, LLC (Louisiana)
    - D & R Pharmaceutical Services LLC (Kentucky)
    - Enloe Drugs, LLC (Delaware)
    - Evergreen Pharmaceutical, LLC (Washington)
    - Home Care Pharmacy, LLC (Delaware)
    - Interlock Pharmacy Systems, LLC (Missouri)
    - Langsam Health Services, LLC (Delaware)
      - LCPS Acquisition, LLC (Delaware)
        - Omnicare Pharmacy of Tennessee LLC (Delaware)
    - Lobos Acquisition, LLC (Delaware)
    - Lo-Med Prescription Services, LLC (Ohio)
      - ZS Acquisition Company, LLC (Delaware)
    - Main Street Pharmacy, L.L.C. (Maryland)
    - NCS Healthcare of Illinois, LLC (Ohio)
    - NCS Healthcare of Iowa, LLC (Ohio)
      - Martin Health Services, LLC (Delaware)
    - NCS Healthcare of Kansas, LLC (Ohio)
    - NCS Healthcare of Kentucky, LLC (Ohio)
    - NCS Healthcare of Montana, LLC (Ohio)
    - NCS Healthcare of New Mexico, LLC (Ohio)
    - NCS Healthcare of South Carolina, LLC (Ohio)
    - NCS Healthcare of Tennessee, LLC (Ohio)
    - NCS Healthcare of Ohio, LLC (Ohio)
    - NCS Healthcare of Wisconsin, LLC (Ohio)
    - North Shore Pharmacy Services LLC (Delaware)
    - Omnicare Indiana Partnership Holding Company LLC (Delaware)
    - Omnicare of New York, LLC (Delaware)
      - NeighborCare of Indiana, LLC (Indiana)
        - Grandview Pharmacy, LLC (Indiana)
      - NeighborCare of Virginia, LLC (Virginia)
    - Omnicare Pharmacies of Pennsylvania West LLC (Pennsylvania)

        - Omnicare Pharmacy and Supply Services LLC (South Dakota)
        - Omnicare Pharmacy of the Midwest, LLC (Delaware)
        - Omnicare Property Management, LLC (Delaware)
        - Pharmacy Consultants, LLC (South Carolina)
        - PRN Pharmaceutical Services, LP (Delaware)
        - Roeschen's Healthcare LLC (Wisconsin)
            - PP Acquisition Company LLC (Delaware)
        - Specialized Pharmacy Services, LLC (Michigan)
        - Value Health Care Services LLC (Delaware)
        - VAPS Acquisition Company, LLC (Delaware)
        - Westhaven Services Co, LLC (Ohio)
    - Three Forks Apothecary, LLC (Kentucky)
    - UNI-Care Health Services of Maine, LLC (New Hampshire)

- CVS Pharmacy, Inc. (continued)

    - CVS 2948 Henderson, L.L.C. (Nevada)
    - CVS AL Distribution, L.L.C. (Alabama)
    - CVS Albany, L.L.C. (New York)
    - CVS AOC Services, L.L.C. (Delaware)
        - CVS AOC Corporation (California)
    - CVS Care Concierge, LLC (Delaware)
    - CVS Health Applications, LLC (Rhode Island)
    - CVS Health Clinical Trial Services LLC (Connecticut)
    - CVS Health Solutions LLC (Delaware)
    - CVS Health Ventures Management, LLC (Delaware)
    - CVS Health Ventures Fund GP, LLC (Delaware)
        - CVS Health Ventures Fund, LP (Delaware)
    - CVS Indiana, L.L.C. (Indiana)
    - CVS International, L.L.C. (Delaware)
        - CCI Foreign, S.à R.L. (R.C.S. Luxembourg)
            - Beauty Holdings, L.L.C. (Delaware)
            - Pamplona Saúde e Beleza LTDA (Brazil)
    - CVS Kidney Care, LLC (Delaware)
        - CVS Kidney Care Health Services LLC (Delaware)
        - CVS Kidney Care Advanced Technologies LLC (Delaware)
        - CVS Kidney Care Home Dialysis LLC (Delaware)
            - CVS-SHC Kidney Care Home Dialysis of Austin LLC (Delaware)
            - CVS-SHC Kidney Care Home Dialysis of Los Angeles LLC (Delaware)
            - CVS-SHC Kidney Care Home Dialysis of Philadelphia LLC (Delaware)
            - CVS-SHC Renal Holdings LLC (Delaware)
    - CVS Management Support, LLC (Delaware)
    - CVS Manchester NH, L.L.C. (New Hampshire)
    - CVS Media Exchange LLC (Delaware)
    - CVS Michigan, L.L.C. (Michigan)
    - CVS Orlando FL Distribution, L.L.C. (Florida)

- CVS PA Distribution, L.L.C. (Pennsylvania)
- CVS Pharmacy Overseas Online, LLC
- CVS PR Center, Inc. (Delaware)
  - Puerto Rico CVS Pharmacy, L.L.C. (Puerto Rico)
  - Caremark Puerto Rico, L.L.C. (Puerto Rico)
  - Caremark Puerto Rico Specialty Pharmacy, L.L.C. (Puerto Rico)
- CVS RS Arizona, L.L.C. (Arizona)
  - Arizona CVS Stores, L.L.C. (Arizona)
  - CVS 3268 Gilbert, L.L.C. (Arizona)
  - CVS 3745 Peoria, L.L.C. (Arizona)
  - CVS Gilbert 3272, L.L.C. (Arizona)
- CVS Rx Services, Inc. (New York)
  - Busse CVS, L.L.C. (Illinois)
  - Goodyear CVS, L.L.C. (Arizona)
  - Sheffield Avenue CVS, L.L.C. (Illinois)
  - South Wabash CVS, L.L.C. (Illinois)
  - Thomas Phoenix CVS, L.L.C. (Arizona)
  - Washington Lamb CVS, L.L.C. (Nevada)
- CVS SC Distribution, L.L.C. (South Carolina)
- CVS State Capital, L.L.C. (Maine)
- CVS TN Distribution, L.L.C. (Tennessee)
- CVS Transportation, L.L.C. (Indiana)
- CVS Vero FL Distribution, L.L.C. (Florida)
- D.A.W., LLC (Massachusetts)
- Delaware CVS Pharmacy, L.L.C. (Delaware)
- District of Columbia CVS Pharmacy, L.L.C. (District of Columbia)
- Enterprise Patient Safety Organization, LLC (Rhode Island)
- E.T.B., Inc. (Texas)
- Garfield Beach CVS, L.L.C. (California)
- Georgia CVS Pharmacy, L.L.C. (Georgia)
- German Dobson CVS, L.L.C. (Arizona)
- Grand St. Paul CVS, L.L.C. (Minnesota)
- Highland Park CVS, L.L.C. (Illinois)
- Holiday CVS, L.L.C. (Florida)
- Hook-SupeRx, L.L.C. (Delaware)
- Idaho CVS Pharmacy, L.L.C. (Idaho)
- Iowa CVS Pharmacy, L.L.C. (Iowa)
- Kansas CVS Pharmacy, L.L.C. (Kansas)
- Kentucky CVS Pharmacy, L.L.C. (Kentucky)
- Longs Drug Stores California, L.L.C. (California)
- Louisiana CVS Pharmacy, L.L.C. (Louisiana)
- Maryland CVS Pharmacy, L.L.C. (Maryland)
- Melville Realty Company, Inc. (New York)
  - CVS Bellmore Avenue, L.L.C. (New York)
- MinuteClinic, L.L.C. (Delaware)
  - MinuteClinic Diagnostic of Alabama, L.L.C. (Alabama)
  - MinuteClinic Diagnostic of Arkansas, LLC (Arkansas)

- MinuteClinic Diagnostic of Arizona, LLC (Minnesota)
- MinuteClinic Diagnostic of Colorado LLC (Colorado)
- MinuteClinic Diagnostic of Florida, LLC (Minnesota)
- MinuteClinic Diagnostic of Georgia, LLC (Minnesota)
- MinuteClinic Diagnostic of Hawaii, L.L.C. (Hawaii)
- MinuteClinic Diagnostic of Illinois, LLC (Delaware)
- MinuteClinic Diagnostic of Kentucky, L.L.C. (Kentucky)
- MinuteClinic Diagnostic of Louisiana, L.L.C. (Louisiana)
- MinuteClinic Diagnostic of Maine, L.L.C. (Maine)
- MinuteClinic Diagnostic of Maryland, LLC (Minnesota)
- MinuteClinic Diagnostic of Massachusetts, LLC (Massachusetts)
- MinuteClinic Diagnostic of Nebraska, L.L.C. (Nebraska)
- MinuteClinic Diagnostic of New Hampshire, L.L.C. (New Hampshire)
- MinuteClinic Diagnostic of New Mexico, L.L.C. (New Mexico)
- MinuteClinic Diagnostic of Ohio, LLC (Ohio)
- MinuteClinic Diagnostic of Oklahoma, LLC (Oklahoma)
- MinuteClinic Diagnostic of Oregon, LLC (Oregon)
- MinuteClinic Diagnostic of Pennsylvania, LLC (Minnesota)
- MinuteClinic Diagnostic of Rhode Island, LLC (Minnesota)
- MinuteClinic Diagnostic of South Carolina, L.L.C. (South Carolina)
- MinuteClinic Diagnostic of Texas, LLC (Minnesota)
- MinuteClinic Diagnostic of Utah, L.L.C. (Utah)
- MinuteClinic Diagnostic of Virginia, LLC (Virginia)
- MinuteClinic Diagnostic of Washington, LLC (Oregon)
- MinuteClinic Diagnostic of Wisconsin, L.L.C. (Wisconsin)
- MinuteClinic Online Diagnostic Services, LLC (Delaware)
- MinuteClinic Physician Practice of Texas (Texas)
- MinuteClinic Telehealth Services, LLC (Delaware)
- MinuteClinic Telehealth Services of Texas Association (Texas)

- Mississippi CVS Pharmacy, L.L.C. (Mississippi)
- Missouri CVS Pharmacy, L.L.C. (Missouri)
- Montana CVS Pharmacy, L.L.C. (Montana)
- Nebraska CVS Pharmacy, L.L.C. (Nebraska)
- New Jersey CVS Pharmacy, L.L.C. (New Jersey)
- North Carolina CVS Pharmacy, L.L.C. (North Carolina)
- Ohio CVS Stores, L.L.C. (Ohio)
- Oklahoma CVS Pharmacy, L.L.C. (Oklahoma)
- Oregon CVS Pharmacy, L.L.C. (Oregon)
- Pennsylvania CVS Pharmacy, L.L.C. (Pennsylvania)
- ProCare Pharmacy Direct, L.L.C. (Ohio)
- ProCare Pharmacy, L.L.C. (Rhode Island)
- Red Oak Sourcing, LLC (Delaware)
- Rhode Island CVS Pharmacy, L.L.C. (Rhode Island)
- South Carolina CVS Pharmacy, L.L.C. (South Carolina)
- Tennessee CVS Pharmacy, L.L.C. (Tennessee)
- Utah CVS Pharmacy, L.L.C. (Utah)
- Vermont CVS Pharmacy, L.L.C. (Vermont)

- Virginia CVS Pharmacy, L.L.C. (Virginia)
- Warm Springs Road CVS, L.L.C. (Nevada)
- Washington CVS Pharmacy, L.L.C. (Washington)
- Wellpartner, LLC (Delaware)
- West Virginia CVS Pharmacy, L.L.C. (West Virginia)
- Wisconsin CVS Pharmacy, L.L.C. (Wisconsin)
- Woodward Detroit CVS, L.L.C. (Michigan)
- Zinc Health Ventures, LLC (Delaware)
- Zinc Health Services, LLC (Delaware)

Exhibit 23.1

Consent of Independent Registered Public Accounting Firm

We consent to the incorporation by reference in the following Registration Statements:

(1) Registration Statement (Form S-3ASR No. 333-238506) of CVS Health Corporation, and
(2) Registration Statements (Form S-8 Nos. 333-238507, 333-230035, 333-228622, 333-167746, 333-217853, 333-208805, 333-141481, 333-139470, 333-63664, 333-91253, 333-49407, 333-34927, and 333-28043) of CVS Health Corporation;

of our reports dated February 9, 2022, with respect to the consolidated financial statements of CVS Health Corporation and the effectiveness of internal control over financial reporting of CVS Health Corporation included in this Annual Report (Form 10-K) of CVS Health Corporation for the year ended December 31, 2021.

/s/ Ernst & Young LLP

Boston, Massachusetts
February 9, 2022

Exhibit 31.1

Certification

I, Karen S. Lynch, President and Chief Executive Officer of CVS Health Corporation, certify that:

1. I have reviewed this annual report on Form 10-K of CVS Health Corporation;
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(s) 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(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 9, 2022

/s/ KAREN S. LYNCH

Karen S. Lynch
President and Chief Executive Officer

Exhibit 31.2

Certification

I, Shawn M. Guertin, Executive Vice President and Chief Financial Officer of CVS Health Corporation, certify that:

1. I have reviewed this annual report on Form 10-K of CVS Health Corporation;
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(s) 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(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 9, 2022

/s/ SHAWN M. GUERTIN

Shawn M. Guertin
Executive Vice President and Chief Financial Officer

Exhibit 32.1

CERTIFICATION

The certification set forth below is being submitted in connection with the Annual Report of CVS Health Corporation (the "Company") on Form 10-K for the period ended December 31, 2021 (the "Report") solely for the purpose of complying with Rule 13a-14(b) or Rule 15d-14(b) of the Securities Exchange Act of 1934 (the "Exchange Act") and Section 1350 of Chapter 63 of Title 18 of the United States Code.

I, Karen S. Lynch, President and Chief Executive Officer of the Company, certify that, to the best of my knowledge:

1. the Report fully complies with the requirements of Section 13(a) or 15(d) of the Exchange Act; and
2. the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: February 9, 2022

/s/ KAREN S. LYNCH

Karen S. Lynch
President and Chief Executive Officer

Exhibit 32.2

CERTIFICATION

The certification set forth below is being submitted in connection with the Annual Report of CVS Health Corporation (the "Company") on Form 10-K for the period ended December 31, 2021 (the "Report") solely for the purpose of complying with Rule 13a-14(b) or Rule 15d-14(b) of the Securities Exchange Act of 1934 (the "Exchange Act") and Section 1350 of Chapter 63 of Title 18 of the United States Code.

I, Shawn M. Guertin, Executive Vice President and Chief Financial Officer of the Company, certify that, to the best of my knowledge:

1. the Report fully complies with the requirements of Section 13(a) or 15(d) of the Exchange Act; and

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

Date: February 9, 2022

/s/ SHAWN M. GUERTIN

Shawn M. Guertin
Executive Vice President and Chief Financial Officer

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

(Mark One)

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2020

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: 001-01011

CVS HEALTH CORPORATION
(Exact name of registrant as specified in its charter)

Delaware	**05-0494040**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: **(401) 765-1500**

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

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, par value $0.01 per share	CVS	New York Stock Exchange

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

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act.	☑	Yes	☐	No
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.	☐	Yes	☑	No
Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days.	☑	Yes	☐	No
Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files).	☑	Yes	☐	No

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

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

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

The aggregate market value of the registrant's common stock held by non-affiliates was approximately $84,719,366,378 as of June 30, 2020, based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be affiliates of the registrant.

As of February 8, 2021, the registrant had 1,311,354,926 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The following materials are incorporated by reference into this Form 10-K:

Information contained in the definitive proxy statement for CVS Health Corporation's 2021 Annual Meeting of Stockholders, to be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year ended December 31, 2020 (the "Proxy Statement"), is incorporated by reference in Parts III and IV to the extent described therein.

TABLE OF CONTENTS

Unless the context otherwise requires, references to the terms "we," "our" or "us" used throughout this Annual Report on Form 10-K (this "10-K") refer to CVS Health Corporation (a Delaware corporation) ("CVS Health") and its subsidiaries (collectively, the "Company"). References to competitors and other companies throughout this 10-K, including the information incorporated herein by reference, are for illustrative or comparison purposes only and do not indicate that these companies are the Company's or any segment's only competitors or closest competitors.

CAUTIONARY STATEMENT CONCERNING FORWARD-LOOKING STATEMENTS

The Private Securities Litigation Reform Act of 1995 (the "Reform Act") provides a "safe harbor" for forward-looking statements, so long as (1) those statements are identified as forward-looking, and (2) the statements are accompanied by meaningful cautionary statements that identify important factors that could cause actual results to differ materially from those discussed in the statement. We want to take advantage of these safe harbor provisions.

Certain information contained in this 10-K is forward-looking within the meaning of the Reform Act or SEC rules. This information includes, but is not limited to: "Outlook for 2021" of Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A") included in Item 7, "Quantitative and Qualitative Disclosures About Market Risk" included in Item 7A, "Government Regulation" included in Item 1, and "Risk Factors" included in Item 1A. In addition, throughout this 10-K and our other reports and communications, we use the following words or variations or negatives of these words and similar expressions when we intend to identify forward-looking statements:

· *Anticipates*	· *Believes*	· *Can*	· *Continue*	· *Could*
· *Estimates*	· *Evaluate*	· *Expects*	· *Explore*	· *Forecast*
· *Guidance*	· *Intends*	· *Likely*	· *May*	· *Might*
· *Outlook*	· *Plans*	· *Potential*	· *Predict*	· *Probable*
· *Projects*	· *Seeks*	· *Should*	· *View*	· *Will*

All statements addressing the future operating performance of CVS Health or any segment or any subsidiary and/or future events or developments, including statements relating to the projected impact of coronavirus disease 2019 ("COVID-19") on the Company's businesses, investment portfolio, operating results, cash flows and/or financial condition, statements relating to corporate strategy, statements relating to future revenue, operating income or adjusted operating income, earnings per share or adjusted earnings per share, Pharmacy Services segment business, sales results and/or trends and/or operations, Retail/LTC segment business, sales results and/or trends and/or operations, Health Care Benefits segment business, sales results and/or trends, medical cost trends, medical membership, Medicare Part D membership, medical benefit ratios and/or operations, incremental investment spending, interest expense, effective tax rate, weighted-average share count, cash flow from operations, net capital expenditures, cash available for debt repayment, integration synergies, net synergies, integration costs, enterprise modernization, transformation, leverage ratio, cash available for enhancing shareholder value, inventory reduction, turn rate and/or loss rate, debt ratings, the Company's ability to attract or retain customers and clients, store development and/or relocations, new product development, and the impact of industry and regulatory developments, as well as statements expressing optimism or pessimism about future operating results or events, are forward-looking statements within the meaning of the Reform Act.

Forward-looking statements rely on a number of estimates, assumptions and projections concerning future events, and are subject to a number of significant risks and uncertainties and other factors that could cause actual results to differ materially from those statements. Many of these risks and uncertainties and other factors are outside our control. Certain of these risks and uncertainties and other factors are described under "Risk Factors" included in Item 1A of this 10-K; these are not the only risks and uncertainties we face. There can be no assurance that the Company has identified all the risks that affect it. Additional risks and uncertainties not presently known to the Company or that the Company currently believes to be immaterial also may adversely affect the Company's businesses. If any of those risks or uncertainties develops into actual events, those events or circumstances could have a material adverse effect on the Company's businesses, operating results, cash flows, financial condition and/or stock price, among other effects.

You should not put undue reliance on forward-looking statements. Any forward-looking statement speaks only as of the date of this 10-K, and we disclaim any intention or obligation to update or revise forward-looking statements, whether as a result of new information, future events, uncertainties or otherwise.

PART I

Item 1. Business.

Overview

CVS Health Corporation ("CVS Health"), together with its subsidiaries (collectively, the "Company," "we," "our" or "us"), is a diversified health services company united around a common purpose of helping people on their path to better health. In an increasingly connected and digital world, we are meeting people wherever they are and changing health care to meet their needs. The Company has more than 9,900 retail locations, approximately 1,100 walk-in medical clinics, a leading pharmacy benefits manager with approximately 105 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year and expanding specialty pharmacy services. We also serve an estimated 34 million people through traditional, voluntary and consumer-directed health insurance products and related services, including expanding Medicare Advantage offerings and a leading standalone Medicare Part D prescription drug plan ("PDP"). The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

On November 28, 2018 (the "Aetna Acquisition Date"), the Company acquired Aetna Inc. ("Aetna"). As a result of the acquisition of Aetna (the "Aetna Acquisition"), the Company added the Health Care Benefits segment. Certain aspects of Aetna's operations, including products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, are included in the Company's Corporate/Other segment. The consolidated financial statements reflect Aetna's results subsequent to the Aetna Acquisition Date.

The Company has four reportable segments: Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other.

COVID-19

The COVID-19 pandemic has severely impacted the economies of the U.S. and other countries around the world. Beginning in March 2020, the effects of the COVID-19 pandemic began to emerge in the U.S. The Company executed preparedness plans to maintain continuity of its operations, including transitioning many office-based colleagues to a remote work environment and installing protective equipment in our retail pharmacies. The Company also provided enhanced benefits to its colleagues, including bonuses to frontline colleagues, dependent care financial assistance, paid sick leave for part-time colleagues and paid time off to colleagues who test positive or are quarantined due to exposure to COVID-19.

Our strong local presence and scale in communities across the country enabled us to play an indispensable role in the national response to COVID-19, as well as provide seamless support for our customers wherever they needed us: in our CVS locations, in their homes, and virtually. The Company offered COVID-19 diagnostic testing at more than 4,000 CVS Pharmacy® locations as of December 31, 2020 and launched critical diagnostic testing for the vulnerable senior population in long-term care facilities in partnership with three states. The Company was also selected to administer COVID-19 vaccines in both long-term care facilities and its retail pharmacies. The Company began administering COVID-19 vaccinations in long-term care facilities and in certain of its retail pharmacies during December 2020 and February 2021, respectively, and expects to play a significant role in COVID-19 vaccine administration in the future. In the Health Care Benefits segment, the Company also expanded benefit coverage to its members, including cost-sharing waivers for COVID-19 related treatments, as well as assistance to members through premium credits, telehealth cost-sharing waivers and other investments.

The impact of COVID-19 on the Company's businesses, operating results, cash flows and financial condition in the year ended December 31, 2020, as well as information regarding certain expected impacts of COVID-19 on the Company, is discussed throughout this 10-K.

Pharmacy Services Segment

The Pharmacy Services segment provides a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services, mail order pharmacy, specialty pharmacy and infusion services, clinical services, disease management services and medical spend management. The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, PDPs, Medicaid managed care ("Managed Medicaid") plans, plans offered on public health insurance exchanges ("Public Exchanges") and private health insurance exchanges ("Private Exchanges" and together with Public Exchanges, "Insurance Exchanges") and other sponsors of health benefit plans throughout the United States. The

Pharmacy Services segment includes retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services. During the year ended December 31, 2020, the Company's PBM filled or managed 2.1 billion prescriptions on a 30-day equivalent basis.

PBM Services

The Company dispenses prescription drugs directly through its mail order dispensing and specialty mail order pharmacies and through pharmacies in its retail network. All prescriptions processed by the Company are analyzed, processed and documented by the Company's proprietary prescription management systems. These systems provide essential features and functionality to allow plan members to utilize their prescription drug benefits. These systems also streamline the process by which prescriptions are processed by staff and network pharmacists by enhancing review of various items through automation, including plan eligibility, early refills, duplicate dispensing, appropriateness of dosage, drug interactions or allergies, over-utilization and potential fraud.

Plan Design Offerings and Administration
The Company administers pharmacy benefit plans for clients who contract with it to facilitate prescription drug coverage and claims processing for their eligible plan members. The Company assists its PBM clients in designing pharmacy benefit plans that help improve health outcomes while minimizing the costs to the client. The Company also assists PBM clients in monitoring the effectiveness of their plans through frequent, informal communications, the use of proprietary software, as well as through formal annual, quarterly and sometimes monthly performance reviews.

The Company makes recommendations to help PBM clients design benefit plans that promote the use of lower cost, clinically appropriate drugs and helps its PBM clients control costs by recommending plan designs that encourage the use of generic equivalents of brand name drugs when such equivalents are available. Clients also have the option, through plan design, to further lower their pharmacy benefit plan costs by setting different member payment levels for different products on their drug lists or "formularies," which helps guide members to choose lower cost alternatives through appropriate financial incentives.

Formulary Management
The Company utilizes an independent panel of doctors, pharmacists and other medical experts, referred to as the CVS Caremark National Pharmacy and Therapeutics Committee, to review and approve the selection of drugs that meet the Company's standards of safety and efficacy for inclusion on one of the Company's template formularies. The Company's formularies provide recommended products in numerous drug classes to help ensure member access to clinically appropriate drugs with alternatives within a class under the client's pharmacy benefit plan, while helping to drive the lowest net cost for clients that select one of the Company's formularies. To help improve clinical outcomes for members and clients, the Company conducts ongoing, independent reviews of all drugs, including those appearing on the formularies and generic equivalent products. Many of the Company's clients choose to adopt a template formulary offering as part of their plan design. PBM clients are given capabilities to offer real time benefits information for a member's specific plan design, provided digitally at the point of prescribing, at the pharmacy and directly to members.

Retail Pharmacy Network Management Services
The Company maintains a national network of approximately 66,000 retail pharmacies, consisting of approximately 40,000 chain pharmacies (which includes CVS Pharmacy locations) and approximately 26,000 independent pharmacies, in the United States, including Puerto Rico, the District of Columbia, Guam and the U.S. Virgin Islands. When a customer fills a prescription in a retail pharmacy, the pharmacy sends prescription data electronically to the Company from the point-of-sale. This data interfaces with the Company's proprietary prescription management systems, which verify relevant plan member data and eligibility, while also performing a drug utilization review to help evaluate clinical appropriateness and safety and confirming that the pharmacy will receive payment for the prescription. The Company also offers a performance program for non-Medicare customers, which can be implemented with either the Company's broad, national network or with any managed network (as allowed by applicable laws and regulations). Under the program, high performing pharmacies are eligible to receive an incremental positive performance payment. The program aligns with key Healthcare Effectiveness Data Information Set measures utilized by the U.S. Centers for Medicare & Medicaid Services ("CMS") and is funded by client fees.

Mail Order Pharmacy Services
The Pharmacy Services segment operates mail order dispensing pharmacies in the United States. Plan members or their prescribers submit prescriptions or refill requests, primarily for maintenance medications, to these pharmacies, and staff pharmacists review these prescriptions and refill requests with the assistance of the Company's prescription management systems. This review may involve communications with the prescriber and, with the prescriber's approval when required, can result in generic substitution, therapeutic interchange or other actions designed to help reduce cost and/or improve quality of

treatment. The Company's mail order dispensing pharmacies have been awarded Mail Service Pharmacy accreditation from URAC, a health care accrediting organization that establishes quality standards for the health care industry.

Specialty Pharmacy and Infusion Services
The Pharmacy Services segment operates specialty mail order pharmacies, retail specialty pharmacy stores and branches for infusion and enteral nutrition services in the United States. The specialty mail order pharmacies are used for delivery of advanced medications to individuals with chronic or genetic diseases and disorders. The Company's specialty mail order pharmacies also have been awarded Specialty Pharmacy accreditation from URAC. Substantially all of the Company's specialty mail order pharmacies also have been accredited by The Joint Commission, which is an independent, not-for-profit organization that accredits and certifies health care programs and organizations in the United States.

Clinical Services
The Company offers multiple clinical programs and services to help clients manage overall pharmacy and health care costs in a clinically appropriate manner. These programs are primarily designed to promote better health outcomes and to help target inappropriate medication utilization and non-adherence to medication, each of which may result in adverse medical events that negatively affect member health and client pharmacy and medical spend. These programs include utilization management ("UM"), medication management, quality assurance, adherence and counseling programs to complement the client's plan design and clinical strategies. To help address prescription opioid abuse and misuse, the Company introduced an industry-leading UM approach that limits to seven days the supply of opioids dispensed for certain acute prescriptions for patients who are new to therapy, limits the daily dosage of opioids dispensed based on the strength of the opioid and requires the use of immediate-release formulations of opioids before extended-release opioids are dispensed. The Company's Pharmacy Advisor® program facilitates pharmacist counseling, both face-to-face and over the telephone, to help participating plan members with certain chronic diseases, such as diabetes and cardiovascular conditions, to identify gaps in care, adhere to their prescribed medications and manage their health conditions. The Company also has digital connectivity that helps to lower drug costs for patients by providing expanded visibility to lower cost alternatives through enhanced analytics and data sharing.

Disease Management Programs
The Company's clinical programs and services utilize advanced protocols and offer clients convenience in working with health care providers ("providers") and other third parties. The Company's UM program covers diseases such as rheumatoid arthritis, Parkinson's disease, seizure disorders and multiple sclerosis and is accredited by the National Committee for Quality Assurance ("NCQA"), a private, not-for-profit organization that evaluates, accredits and certifies a wide range of health care organizations.

Medical Benefit Management
The Company's NovoLogix® online preauthorization tool helps identify and capture cost savings opportunities for specialty drugs billed under the medical benefit by identifying outliers to appropriate dosages and costs, and helps to ensure clinically appropriate use of specialty drugs.

Group Purchasing Organization Services
The Company operates a group purchasing organization that negotiates pricing for the purchase of pharmaceuticals and rebates with pharmaceutical manufacturers on behalf of its participants. The Company also provides various administrative, management and reporting services to pharmaceutical manufacturers.

Pharmacy Services Information Systems

The Pharmacy Services segment's claim adjudication platform incorporates architecture that centralizes the data generated from filling mail order prescriptions, adjudicating retail pharmacy claims and delivering other solutions to PBM clients. The Health Engagement Engine® technology and proprietary clinical algorithms help connect the various parts of the enterprise and serve an essential role in cost management and health improvement, leveraging cloud-native technologies and practices. This capability transforms pharmacy data into actionable interventions at key points of care, including in retail, mail and specialty pharmacies as well as in customer care call center operations, leveraging our enterprise data platform to improve the quality of care. The technology leverages assisted artificial intelligence to deliver insights to the business and bring automation to otherwise manual tasks. Specialty services also connects with our claim adjudication platform and various health plan adjudication platforms with a centralized architecture servicing many clients and members. Operating services, such as Specialty Expedite®, provide an interconnected onboarding solution for specialty medications and branding solutions ranging from fulfillment to total patient management. These services are managed through our new innovative specialty workflow and web platform.

Pharmacy Services Clients

The Company's Pharmacy Services clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D plans, Managed Medicaid plans and plans offered on Insurance Exchanges and other sponsors of health benefit plans throughout the United States. Pharmaceuticals are provided to eligible members in benefit plans maintained by clients and utilize the Company's information systems, among other things, to help perform safety checks, drug interaction screening and identify opportunities for generic substitution. Substantially all of the Pharmacy Services segment's revenues are generated from dispensing and managing prescription drugs to eligible members in benefit plans maintained by clients. In 2018, revenues from Aetna accounted for approximately 9.8% of the Company's consolidated total revenues. On the Aetna Acquisition Date, Aetna became a wholly-owned subsidiary of CVS Health. Subsequent to the Aetna Acquisition Date, revenues from Aetna continue to be reported in the Pharmacy Services segment; however, these revenues are eliminated in the consolidated financial statements.

Pharmacy Services Seasonality

The majority of Pharmacy Services segment revenues are not seasonal in nature.

Pharmacy Services Competition

The Company believes the primary competitive factors in the pharmacy services industry include: (i) the ability to negotiate favorable discounts from drug manufacturers as well as to negotiate favorable discounts from, and access to, retail pharmacy networks; (ii) the ability to identify and apply effective cost management programs utilizing clinical strategies, including the development and utilization of preferred formularies; (iii) the ability to market PBM products and services; (iv) the commitment to provide flexible, clinically-oriented services to clients and be responsive to clients' needs; (v) the quality, scope and costs of products and services offered to clients and their members; and (vi) operational excellence in delivering services. The Pharmacy Services segment has a significant number of competitors offering PBM services, including large, national PBM companies (e.g., Prime Therapeutics and MedImpact), PBMs owned by large national health plans (e.g., the Express Scripts business of Cigna Corporation and the OptumRx business of UnitedHealth) and smaller standalone PBMs.

Retail/LTC Segment

The Retail/LTC segment sells prescription drugs and a wide assortment of health and wellness products and general merchandise, provides health care services through its MinuteClinic® walk-in medical clinics, provides medical diagnostic testing, administers vaccinations for illnesses such as influenza, COVID-19 and shingles and conducts long-term care pharmacy ("LTC") operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. As of December 31, 2020, the Retail/LTC segment operated more than 9,900 retail locations, approximately 1,100 MinuteClinic locations as well as online retail pharmacy websites, LTC pharmacies and on-site pharmacies. During the year ended December 31, 2020, the Retail/LTC segment filled 1.5 billion prescriptions on a 30-day equivalent basis. For the year ended December 31, 2020, the Company dispensed approximately 27.1% of the total retail pharmacy prescriptions in the United States.

Retail/LTC Products and Services

A typical retail store sells prescription drugs and a wide assortment of high-quality, nationally advertised brand name and proprietary brand merchandise. Front store categories include over-the-counter drugs, consumer health products, beauty products and personal care products. LTC operations include distribution of prescription drugs and related consulting and ancillary services. The Company purchases merchandise from numerous manufacturers and distributors. The Company believes that competitive sources are readily available for substantially all of the products carried in its retail stores and the loss of any one supplier would not likely have a material effect on the Retail/LTC segment. The Company's MinuteClinic locations offer a variety of health care services.

Retail/LTC revenues by major product group are as follows:

	Percentage of Revenues		
	2020	2019	2018
Pharmacy [1]	76.9 %	76.7 %	76.4 %
Front store and other [2]	23.1 %	23.3 %	23.6 %
	100.0 %	100.0 %	100.0 %

(1) Pharmacy includes LTC sales and sales in pharmacies within Target Corporation ("Target") and other retail stores.
(2) "Other" represents less than 10% of the "Front store and other" revenue category.

Pharmacy
Pharmacy revenues represented approximately three-fourths of Retail/LTC segment revenues in each of 2020, 2019 and 2018. The Company believes that retail pharmacy operations will continue to represent a critical part of the Company's business due to industry demographics, e.g., an aging American population consuming a greater number of prescription drugs, prescription drugs being used more often as the first line of defense for managing illness, the introduction of new pharmaceutical products, the need for vaccinations and Medicare Part D growth. The Company believes the retail pharmacy business benefits from investment in both people and technology, as well as innovative collaborations with health plans, PBMs and providers. Given the nature of prescriptions, consumers want their prescriptions filled accurately by professional pharmacists using the latest tools and technology, and ready when promised. Consumers also need medication management programs and better information to help them get the most out of their health care dollars. To assist consumers with these needs, the Company has introduced integrated pharmacy health care services that provide an earlier, easier and more effective approach to engaging consumers in behaviors that can help lower costs, improve health and save lives.

Front Store
Front store revenues reflect the Company's strategy of innovating with new and unique products and services, using innovative personalized marketing and adjusting the mix of merchandise to match customers' needs and preferences. A key component of the front store strategy is the ExtraCare® card program, which is one of the largest and most successful retail loyalty programs in the United States. The ExtraCare program allows the Company to balance marketing efforts so it can reward its best customers by providing them with automatic sale prices, customized coupons, ExtraBucks® rewards and other benefits. The Company also offers a subscription-based membership program, CarePass®, under which members are entitled to a suite of benefits delivered over the course of the subscription period, as well as a promotional reward that can be redeemed for future goods and services. The Company continues to launch and enhance new and exclusive brands to create unmatched offerings in beauty products and deliver other unique product offerings, including a full range of high-quality CVS Health® and other proprietary brand products that are only available through CVS stores. The Company currently carries approximately 6,000 CVS Health and proprietary brand products, which accounted for approximately 24% of front store revenues during 2020.

MinuteClinic
As of December 31, 2020, the Company operated approximately 1,100 MinuteClinic locations in the United States. The clinics are staffed by nurse practitioners and physician assistants who utilize nationally established guidelines to deliver a variety of health care services. Payors value these clinics because they provide convenient, high-quality, cost-effective care, in many cases offering an attractive alternative to more expensive sites of care. MinuteClinic is collaborating with the Pharmacy Services and Health Care Benefits segments to help meet the needs of CVS Caremark's client plan members and the Company's health plan members by offering programs that can improve member health and lower costs. MinuteClinic also maintains relationships with leading hospitals, clinics and physicians in the communities we serve to support and enhance quality, access and continuity of care.

On-site Pharmacies
The Company also operates a limited number of pharmacies located at client sites, which provide certain health plan members and customers with a convenient alternative for filling their prescriptions.

Medical Diagnostic Testing
The Company provides medical diagnostic testing primarily through its COVID-19 testing sites located at CVS Pharmacy locations as well as in long-term care facilities, at community-based testing sites in underserved areas, large-scale rapid test sites in select states, and through its Return Ready℠ solution.

Long-term Care Pharmacy Operations
The Retail/LTC segment provides LTC pharmacy services through the Omnicare® business. Omnicare's customers consist of skilled nursing facilities, assisted living facilities, independent living communities, hospitals, correctional facilities, and other health care service providers. The Company provides pharmacy consulting, including monthly patient drug therapy evaluations, to assist in compliance with state and federal regulations and provide proprietary clinical and health management programs. It also provides pharmaceutical case management services for retirees, employees and dependents who have drug benefits under corporate-sponsored health care programs.

Community Location Development

The addition of new community locations has played, and will continue to play, a key role in the Company's continued growth and success. The Company's community location development program focuses on three areas: entering new service areas, adding locations within existing service areas and relocating to more convenient sites. During 2020, the Company opened approximately 55 new community locations, relocated approximately 20 locations, converted approximately 600 locations into HealthHUB® locations and closed approximately 90 locations.

The Company operated over 650 HealthHUB locations as of December 31, 2020. HealthHUBs have a redesigned format that provide enhanced services, offer a care concierge and focus on health and wellness products. HealthHUBs are designed to meet consumer needs and improve the customer experience by providing care that complements physician practices and hospital systems, enabling improved health outcomes and reducing overall health care costs. The Company expects to continue HealthHUB conversions through 2021 and into 2022.

During the last five years, the Company opened approximately 640 new and relocated retail pharmacies, and acquired approximately 225 locations. The Company believes that continuing to assess the appropriateness of its national footprint and identifying more accessible locations are essential components of competing effectively in the current health care environment. As a result, the Company believes that its community location development program is an integral part of its ability to meet the needs of customers and maintain its leadership position in the pharmacy marketplace given the changing health care landscape.

Retail/LTC Information Systems

The Company has continued to invest in information systems to enable it to deliver exceptional customer service, enhance safety and quality, and expand patient care services while lowering operating costs. The proprietary WeCARE Workflow tool supports pharmacy teams by prioritizing work to meet customer expectations, facilitating prescriber outreach, and seamlessly integrating clinical programs. This solution delivers improved efficiency and enhances customer experience, as well as provides a framework to accommodate the evolution of pharmacy practice and the expansion of clinical programs. Our Health Engagement Engine technology and data science clinical algorithms enable the Company to help identify opportunities for pharmacists to deliver face-to-face counseling regarding patient health and safety matters, including medication adherence issues, gaps in care and management of certain chronic health conditions. The Company's digital strategy is to empower the consumer to navigate their pharmacy experience and manage their condition through integrated online and mobile solutions that offer utility and convenience. The Company's LTC digital technology suite, Omniview®, improves the efficiency of customers' operations with tools that include executive dashboards, pre-admission pricing, electronic ordering of prescription refills, proof-of-delivery tracking, access to patient profiles, receipt and management of facility bills, and real-time validation of Medicare Part D coverage, among other capabilities.

Retail/LTC Customers

The success of the Retail/LTC segment's businesses is dependent upon the Company's ability to establish and maintain contractual relationships with pharmacy benefit managers and other payors on acceptable terms. Substantially all of the Retail/LTC segment's pharmacy revenues are derived from pharmacy benefit managers, managed care organizations ("MCOs"), government funded health care programs, commercial employers and other third-party payors. No single Retail/LTC payor accounted for 10% or more of the Company's consolidated total revenues in 2020, 2019 or 2018.

Retail/LTC Seasonality

The majority of Retail/LTC segment revenues, particularly pharmacy revenues, generally are not seasonal in nature. However, front store revenues tend to be higher during the December holiday season. In addition, both pharmacy and front store revenues are affected by the timing and severity of the cough, cold and flu season. Uncharacteristic or extreme weather conditions also can adversely affect consumer shopping patterns and Retail/LTC revenues, expenses and operating results.

During the year ended December 31, 2020, the quarterly earnings progression was also impacted by COVID-19. During March 2020, the Company experienced greater use of 90-day prescriptions, early refills of maintenance medications and increased front store volume as consumers prepared for the COVID-19 pandemic. Subsequent to March 2020, the Company experienced reduced customer traffic in its retail pharmacies and MinuteClinic locations due to shelter-in-place orders as well as reduced new therapy prescriptions as a result of the COVID-19 pandemic. Beginning in the third quarter, the Company saw an increase in diagnostic testing related to the COVID-19 pandemic and in December 2020, the Company began administering COVID-19 vaccinations in long-term care facilities.

Retail/LTC Competition

The retail pharmacy business is highly competitive. The Company believes that it competes principally on the basis of: (i) store location and convenience, (ii) customer service and satisfaction, (iii) product selection and variety, and (iv) price. In the areas it serves, the Company competes with other drugstore chains (e.g., Walgreens and Rite Aid), supermarkets, discount retailers (e.g., Walmart), independent pharmacies, restrictive pharmacy networks, membership clubs, internet companies (e.g., Amazon), and retail health clinics (including urgent care centers), as well as mail order dispensing pharmacies.

LTC pharmacy services are highly regional or local in nature, and within a given geographic area of operation, highly competitive. The Company's largest LTC pharmacy competitor nationally is PharMerica. The Company also competes with numerous local and regional institutional pharmacies, pharmacies owned by long-term care facilities and local retail pharmacies. Some states have enacted "freedom of choice" or "any willing provider" requirements as part of their state Medicaid programs or in separate legislation, which may increase the competition that the Company faces in providing services to long-term care facility residents in these states.

Health Care Benefits Segment

The Health Care Benefits segment is one of the nation's leading diversified health care benefits providers, serving an estimated 34 million people as of December 31, 2020. The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make more informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental and behavioral health plans, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services and health information technology ("HIT") products and services. The Health Care Benefits segment also provided workers' compensation administrative services through its Coventry Health Care Workers' Compensation business ("Workers' Compensation business") prior to the sale of this business on July 31, 2020. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates. For periods prior to the Aetna Acquisition Date, the Health Care Benefits segment was comprised only of the Company's SilverScript® PDP business.

Health Care Benefits Products and Services

The Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk of medical and dental care costs) as "ASC." Health Care Benefits products and services consist of the following:

- *Commercial Medical*: The Health Care Benefits segment offers point-of-service ("POS"), preferred provider organization ("PPO"), health maintenance organization ("HMO") and indemnity benefit ("Indemnity") plans. Commercial medical products also include health savings accounts ("HSAs") and consumer-directed health plans that combine traditional POS or PPO and/or dental coverage, subject to a deductible, with an accumulating benefit account (which may be funded by the plan sponsor and/or the member in the case of HSAs). Principal products and services are targeted specifically to large multi-site national, mid-sized and small employers, individual insureds and expatriates. The Company offers medical stop loss insurance coverage for certain employers who elect to self-insure their health benefits. Under medical stop loss insurance products, the Company assumes risk for costs associated with large individual claims and/or aggregate loss experience within an employer's plan above a pre-set annual threshold.
- *Government Medical*: In select geographies, the Health Care Benefits segment offers Medicare Advantage plans, Medicare Supplement plans and prescription drug coverage for Medicare beneficiaries; participates in Medicaid and subsidized Children's Health Insurance Programs ("CHIP"); and participates in demonstration projects for members who are eligible for both Medicare and Medicaid ("Duals"). These Government Medical products are further described below:

- *Medicare Advantage:* Through annual contracts with CMS, the Company offers HMO and PPO products for eligible individuals in certain geographic areas through the Medicare Advantage program. Members typically receive enhanced benefits over traditional fee-for-service Medicare coverage ("Original Medicare"), including reduced cost-sharing for preventive care, vision and other services. The Company offered network-based HMO and/or PPO plans in 45 states and Washington, D.C. in 2020. The Company has expanded to 46 states and Washington, D.C. for 2021. For certain qualifying employer groups, the Company offers Medicare PPO products nationally. When combined with the Company's PDP product, these national PPO plans form an integrated national Insured Medicare product for employers that provides medical and pharmacy benefits.
- *Medicare PDP:* The Company is a national provider of drug benefits under the Medicare Part D prescription drug program. All Medicare eligible individuals are eligible to participate in this voluntary prescription drug plan. Members typically receive coverage for certain prescription drugs, usually subject to a deductible, co-insurance and/or co-payment. On November 30, 2018, the Company completed the sale of Aetna's standalone PDPs to WellCare Health Plans, Inc. effective December 31, 2018. The Company provided administrative services to, and retained the financial results of, the divested plans through 2019. Subsequent to 2019, the Company no longer retains the financial results of the divested plans.
- *Medicare Supplement:* For certain Medicare eligible members, the Company offers supplemental coverage for certain health care costs not covered by Original Medicare. The products included in the Medicare Supplement portfolio help to cover some of the gaps in Original Medicare, and include coverage for Medicare deductibles and coinsurance amounts. The Company offered a wide selection of Medicare Supplement products in 49 states and Washington, D.C. in 2020.
- *Medicaid and CHIP:* The Company offers health care management services to individuals eligible for Medicaid and CHIP under multi-year contracts with government agencies in various states that are subject to annual appropriations. CHIP are state-subsidized insurance programs that provide benefits for families with uninsured children. The Company offered these services on an Insured or ASC basis in 16 states in 2020.
- *Duals:* The Company provides health coverage to beneficiaries who are dually eligible for both Medicare and Medicaid coverage. These members must meet certain income and resource requirements in order to qualify for this coverage. The Company coordinates 100% of the care for these members and may provide them with additional services in order to manage their health care costs.

- *Specialty and Strategic Solutions*: The Health Care Benefits segment has a portfolio of additional health products and services that complement its medical products such as dental plans, behavioral health and employee assistance products, provider network access and vision products. The Company also has a portfolio of transformative products and services aimed at creating a holistic and integrated approach to individual health and wellness. These products and services complement the Commercial Medical and Government Medical products and aim to provide innovative solutions, create integrated experience offerings and enable enhanced care delivery to customers.

Health Care Benefits Provider Networks

The Company contracts with physicians, hospitals and other providers for services they provide to the Company's members. The Company uses a variety of techniques designed to help encourage appropriate utilization of medical services ("utilization") and maintain affordability of quality coverage. In addition to contracts with providers for negotiated rates of reimbursement, these techniques include creating risk sharing arrangements that align economic incentives with providers, the development and implementation of guidelines for the appropriate utilization and the provision of data to providers to enable them to improve health care quality. At December 31, 2020, the Company's underlying nationwide provider network had approximately 1.4 million participating providers. Other providers in the Company's provider networks also include laboratory, imaging, urgent care and other freestanding health facilities.

Health Care Benefits Quality Assessment

CMS uses a 5-star rating system to monitor Medicare health care and drug plans and ensure that they meet CMS's quality standards. CMS uses this rating system to provide Medicare beneficiaries with a tool that they can use to compare the overall quality of care and level of customer service of companies that provide Medicare health care and drug plans. The rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management and overall customer satisfaction. See "Health Care Benefits Pricing" below in this Item 1 for further discussion of star ratings. The Company seeks Health Plan accreditation for Aetna HMO plans from the NCQA. Health care plans seeking accreditation must pass a rigorous, comprehensive review and must annually report on their performance.

Aetna Life Insurance Company ("ALIC"), a wholly-owned subsidiary of the Company, has received nationwide NCQA PPO Health Plan accreditation. As of December 31, 2020, all of the Company's Commercial HMO and all of ALIC's PPO members who were eligible participated in HMOs or PPOs that are accredited by the NCQA.

The Company's provider selection and credentialing/re-credentialing policies and procedures are consistent with NCQA and URAC, as well as state and federal, requirements. In addition, the Company is certified under the NCQA Credentials Verification Organization ("CVO") certification program for all certification options and has URAC CVO accreditation.

Quality assessment programs for contracted providers who participate in the Company's networks begin with the initial review of health care practitioners. Practitioners' licenses and education are verified, and their work history is collected by the Company or in some cases by the practitioner's affiliated group or organization. The Company generally requires participating hospitals to be certified by CMS or accredited by The Joint Commission, the American Osteopathic Association, or Det Norske Veritas Healthcare.

The Company also offers quality and outcome measurement programs, quality improvement programs, and health care data analysis systems to providers and purchasers of health care services.

Health Care Benefits Information Systems

The Health Care Benefits segment currently operates and supports an end-to-end suite of information technology platforms to support member engagement, enrollment, health benefit administration, care management, service operations, financial reporting and analytics. The multiple platforms are supported by an integration layer to facilitate the transfer of real-time data. There is continued focus and investment in enterprise data platforms, cloud capabilities, digital products to offer innovative solutions and a seamless experience to the Company's members through mobile and web channels. The Company is making concerted investments in emerging technology capabilities such as voice, artificial intelligence and robotics to further automate, reduce cost and improve the experience for all of its constituents. The Health Care Benefits segment is utilizing the full breadth of the Company's assets to build enterprise technology that will help guide our members through their health care journey, provide them a high level of service, enable healthier outcomes and encourage them to take next best actions to lead healthier lives.

Health Care Benefits Customers

Medical membership is dispersed throughout the United States, and the Company also serves medical members in certain countries outside the United States. The Company offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, many of which are available nationwide. Depending on the product, the Company markets to a range of customers including employer groups, individuals, college students, part-time and hourly workers, health plans, providers, governmental units, government-sponsored plans, labor groups and expatriates. For additional information on medical membership, see "Health Care Benefits Segment" in the Management's Discussion and Analysis of Financial Condition and Results of Operations (the "MD&A") included in Item 7 of this 10-K.

The Company markets both Commercial Insured and ASC products and services primarily to employers that sponsor the Company's products for the benefit of their employees and their employees' dependents. Frequently, larger employers offer employees a choice among coverage options, from which the employee makes his or her selection during a designated annual open enrollment period. Typically, employers pay all of the monthly premiums to the Company and, through payroll deductions, obtain reimbursement from employees for a percentage of the premiums that is determined by each employer. Some Health Care Benefits products are sold directly to employees of employer groups on a fully employee-funded basis. In some cases, the Company bills the covered individual directly.

The Company offers Insured Medicare coverage on an individual basis as well as through employer groups to their retirees. Medicaid and CHIP members are enrolled on an individual basis. The Company also offers Insured health care coverage to members who are dually-eligible for both Medicare and Medicaid.

Health Care Benefits products are sold through: the Company's sales personnel; independent brokers, agents and consultants who assist in the production and servicing of business; and Private Exchanges. For large plan sponsors, independent consultants and brokers are frequently involved in employer health plan selection decisions and sales. In some instances, the Company may pay commissions, fees and other amounts to brokers, agents, consultants and sales representatives who place business with the Company. In certain cases, the customer pays the broker for services rendered, and the Company may facilitate that arrangement by collecting the funds from the customer and transmitting them to the broker. The Company

supports marketing and sales efforts with an advertising program that may include television, radio, billboards, print media and social media, supplemented by market research and direct marketing efforts.

The U.S. federal government is a significant customer of the Health Care Benefits segment through contracts with CMS for coverage of Medicare-eligible individuals and federal employee-related benefit programs. Other than the contracts with CMS, the Health Care Benefits segment is not dependent upon a single customer or a few customers the loss of which would have a significant effect on the earnings of the segment. The loss of business from any one, or a few, independent brokers or agents would not have a material adverse effect on the earnings of the Health Care Benefits segment. In both 2020 and 2019, Health Care Benefits segment revenues from the federal government accounted for 13% of the Company's consolidated total revenues. Contracts with CMS for coverage of Medicare-eligible individuals in the Health Care Benefits segment accounted for approximately 92% of the Company's consolidated revenues from the federal government in both 2020 and 2019. No single Health Care Benefits customer accounted for 10% or more of the Company's consolidated total revenues in 2018.

Health Care Benefits Pricing

For Commercial Insured plans, contracts containing the pricing and other terms of the relationship are generally established in advance of the policy period and typically have a duration of one year. Fees under ASC plans are generally fixed for a period of one year.

Generally, a fixed premium rate is determined at the beginning of the policy period for Commercial Insured plans. The Company typically cannot recover unanticipated increases in health care and other benefit costs in the current policy period; however, it may consider prior experience for a product in the aggregate or for a specific customer, among other factors, in determining premium rates for future policy periods. Where required by state laws, premium rates are filed and approved by state regulators prior to contract inception. Future operating results could be adversely affected if the premium rates requested are not approved or are adjusted downward or their approval is delayed by state or federal regulators.

The Company has Medicare Advantage and PDP contracts with CMS to provide HMO, PPO and prescription drug coverage to Medicare beneficiaries in certain geographic areas. Under these annual contracts, CMS pays the Company a fixed per member (or "capitation") payment and/or a portion of the premium, both of which are based on membership and adjusted for demographic and health risk factors. CMS also considers inflation, changes in utilization patterns and average per capita fee-for-service Medicare costs in the calculation of the fixed capitation payment or premium. PDP contracts also provide a risk-sharing arrangement with CMS to limit the Company's exposure to unfavorable expenses or benefit from favorable expenses. Amounts payable to the Company under the Medicare arrangements are subject to annual revision by CMS, and the Company elects to participate in each Medicare service area or region on an annual basis. Premiums paid to the Company for Medicare products are subject to federal government reviews and audits, which can result, and have resulted, in retroactive and prospective premium adjustments and refunds to the government and/or members. In addition to payments received from CMS, some Medicare Advantage products and all PDP products require a supplemental premium to be paid by the member or sponsoring employer. In some cases these supplemental premiums are adjusted based on the member's income and asset levels. Compared to Commercial Medical products, Medicare contracts generate higher per member per month revenues and higher health care and other benefit costs.

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA") ties a portion of each Medicare Advantage plan's reimbursement to the plan's "star ratings." Plans must have a star rating of four or higher (out of five) to qualify for bonus payments. CMS released the Company's 2021 star ratings in October 2020. The Company's 2021 star ratings will be used to determine which of the Company's Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2022. Based on the Company's membership at December 31, 2020, 83% of the Company's Medicare Advantage members were in plans with 2021 star ratings of at least 4.0 stars, consistent with 83% of the Company's Medicare Advantage members being in plans with 2020 star ratings of at least 4.0 stars based on the Company's membership at December 31, 2019.

Rates for Medicare Supplement products are regulated at the state level and vary by state and plan.

Under Insured Medicaid contracts, state government agencies pay the Company fixed monthly rates per member that vary by state, line of business and demographics; and the Company arranges, pays for and manages the health care services provided to Medicaid beneficiaries. These rates are subject to change by each state, and, in some instances, provide for adjustment for health risk factors. CMS requires these rates to be actuarially sound. The Company also receives fees from customers where it provides services under ASC Medicaid contracts. ASC Medicaid contracts generally are for periods of more than one year, and certain of them contain performance incentives and limited financial risk sharing with respect to certain medical, financial

and operational metrics. Under these arrangements, performance is evaluated annually, with associated financial incentive opportunities, and financial risk share obligations are typically limited to a percentage of the fees otherwise payable to the Company. Payments to the Company under Medicaid contracts are subject to the annual appropriation process in the applicable state.

Under Duals contracts, the rate setting process is generally established by CMS in partnership with the state government agency participating in the demonstration project. Both CMS and the state government agency may seek premium and other refunds under certain circumstances, including if the Company fails to comply with CMS regulations or other contractual requirements.

The Company offers HMO and consumer-directed medical and dental plans to federal employees under the Federal Employees Health Benefits ("FEHB") Program and the Federal Employees Dental and Vision Insurance Program. Premium rates and fees for those plans are subject to federal government review and audit, which can result, and have resulted, in retroactive and prospective premium and fee adjustments and refunds to the government and/or members.

Beginning in 2014, the ACA imposed significant new industry-wide fees, assessments and taxes, including an annual levy known as the health insurer fee (the "HIF"). The HIF applies for both 2020 and 2018 and was temporarily suspended for 2019. In December 2019, the HIF was repealed for calendar years after 2020. For additional information on the ACA fees, assessments and taxes, see Note 1 ''Significant Accounting Policies'' included in Item 8 of this 10-K. The Company's goal is to collect premiums and fees where possible, or solve for, all of the ACA-related fees, assessments and taxes.

Health Care Benefits Seasonality

For periods prior to the Aetna Acquisition Date, the Health Care Benefits segment was comprised only of the Company's SilverScript PDP business. The quarterly earnings and operating cash flows of the PDP business are impacted by the Medicare Part D benefit design and changes in the composition of PDP membership. The Medicare Part D standard benefit design results in coverage that varies with a member's cumulative annual out-of-pocket costs. The benefit design generally results in employers or other entities that sponsor the Company's products ("plan sponsors") sharing a greater portion of the responsibility for total prescription drug costs in the early part of the year. As a result, the PDP pay percentage or benefit ratio generally decreases and operating income generally increases as the year progresses. For periods subsequent to the Aetna Acquisition, the Health Care Benefits segment's quarterly operating income progression is also impacted by (i) the seasonality of benefit costs which generally increase during the year as Insured members progress through their annual deductibles and out-of-pocket expense limits and (ii) the seasonality of operating expenses, which are generally the highest during the fourth quarter due primarily to spending to support readiness for the start of the upcoming plan year and marketing associated with Medicare annual enrollment.

During the year ended December 31, 2020, the quarterly earnings progression was also impacted by COVID-19. Beginning in mid-March, the health care system experienced a significant reduction in utilization that is discretionary and the cancellation of elective medical procedures. Utilization remained below historical levels through April, began to recover in May and June and reached more normal levels in the third and fourth quarters, with select geographies impacted by COVID-19 waves. The impact of the deferral of non-essential care was partially offset by COVID-19 testing and treatment costs, as well as planned COVID-19 related investments.

Health Care Benefits Competition

The health care benefits industry is highly competitive, primarily due to a large number of for-profit and not-for-profit competitors, competitors' marketing and pricing and a proliferation of competing products, including new products that are continually being introduced into the marketplace. New entrants into the marketplace, as well as consolidation within the industry, have contributed to and are expected to intensify the competitive environment. In addition, the rapid pace of change as the industry evolves towards a consumer-focused retail marketplace, including Insurance Exchanges, and the increased use of technology to interact with members, providers and customers, increase the risks the Company currently faces from new entrants and disruptive actions by existing competitors compared to prior periods.

The Company believes that the significant factors that distinguish competing health plans include the perceived overall quality (including accreditation status), quality of service, comprehensiveness of coverage, cost (including premium rates, provider discounts and member out-of-pocket costs), product design, financial stability and ratings, breadth and quality of provider networks, ability to offer different provider network options, providers available in such networks, and quality of member support and care management programs. The Company believes that it is competitive on each of these factors. The

Company's ability to increase the number of persons covered by its health plans or to increase Health Care Benefits segment revenues is affected by its ability to differentiate itself from its competitors on these factors. Competition may also affect the availability of services from providers, including primary care physicians, specialists and hospitals.

Insured products compete with local and regional health care benefits plans, health care benefits and other plans sponsored by other large commercial health care benefit insurance companies, health system owned health plans, new entrants into the marketplace and numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association. The largest competitor in Medicare products is Original Medicare. Additional Health Care Benefits segment competitors include other types of medical and dental provider organizations, various specialty service providers (including PBM services providers), health care consultants, financial services companies, integrated health care delivery organizations (networks of providers who also coordinate administrative services for and assume insurance risk of their members), third party administrators ("TPAs"), HIT companies and, for certain plans, programs sponsored by the federal or state governments. Emerging competitors include start up health care benefits plans, technology companies, provider-owned health plans, new joint ventures (including not-for-profit joint ventures among firms from multiple industries), technology firms, financial services firms that are distributing competing products on their proprietary Private Exchanges, and consulting firms that are distributing competing products on their proprietary Private Exchanges, as well as non-traditional distributors such as retail companies. The Company's ability to increase the number of persons enrolled in Insured Commercial Medical products also is affected by the desire and ability of employers to self-fund their health coverage.

The Health Care Benefits segment's ASC plans compete primarily with other large commercial health care benefit companies, numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association and TPAs.

The Health Care Benefits segment's international products compete with local, global and U.S.-based health plans and commercial health care benefit insurance companies, many of whom are licensed in more geographies and have a longer operating history, better brand recognition and greater marketplace presence in one or more geographies.

The provider solutions and HIT marketplaces and products are evolving rapidly. The Company competes for provider solutions and HIT business with other large health plans and commercial health care benefit insurance companies as well as information technology companies and companies that specialize in provider solutions and HIT. Many information technology product competitors have longer operating histories, better brand recognition, greater marketplace presence and more experience in developing innovative products.

In addition to competitive pressures affecting the Company's ability to obtain new customers or retain existing customers, the Health Care Benefits segment's medical membership has been and may continue to be adversely affected by adverse and/or uncertain economic conditions and reductions in workforce by existing customers due to adverse and/or uncertain general economic conditions, especially in the United States and industries where such membership is concentrated.

Health Care Benefits Reinsurance

The Company currently has several reinsurance agreements with non-affiliated insurers that relate to Health Care Benefits insurance policies. The Company entered into these contracts to reduce the risk of catastrophic losses which in turn reduces capital and surplus requirements. The Company frequently evaluates reinsurance opportunities and refines its reinsurance and risk management strategies on a regular basis.

Corporate/Other Segment

The Company presents the remainder of its financial results in the Corporate/Other segment, which primarily consists of:

- Management and administrative expenses to support the Company's overall operations, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments, expenses associated with the Company's investments in its transformation and enterprise modernization programs and acquisition-related transaction and integration costs; and
- Products for which the Company no longer solicits or accepts new customers such as large case pensions and long-term care insurance products.

Business Strategy

CVS Health is a different kind of health care company. As a diversified health services company, CVS Health is focused on its purpose of helping people on their path to better health. In an increasingly connected and digital world, the Company is meeting people wherever they are and changing health care to meet their needs. Built on a foundation of unmatched community presence, our diversified model engages one in three Americans each year. This broad reach differentiates CVS Health and fosters an increased level of engagement with customers across the country. Through our innovative new products and services that help manage chronic conditions, our HealthHUB care destinations, and our digital solutions, we are making health care more accessible, more affordable and simply better. The Company believes its strategy oriented around the consumer and being present for all the meaningful moments in health will drive long-term sustainable value and place the Company at the forefront of the evolution of health care.

Generic Sourcing Venture

The Company and Cardinal Health, Inc. ("Cardinal") each have a 50% ownership in Red Oak Sourcing, LLC ("Red Oak"), a generic pharmaceutical sourcing entity. Under this arrangement, the Company and Cardinal contributed their sourcing and supply chain expertise to Red Oak and agreed to source and negotiate generic pharmaceutical supply contracts for both companies through Red Oak. Red Oak does not own or hold inventory on behalf of either company.

Working Capital Practices

The Company funds the growth of its businesses through a combination of cash flow from operations, commercial paper and other short-term borrowings, proceeds from sale-leaseback transactions and long-term borrowings. For additional information on the Company's working capital practices, see "Liquidity and Capital Resources" in the MD&A included in Item 7 of this 10-K. The majority of the Retail/LTC segment non-pharmacy revenues are paid in cash, or with debit or credit cards. Managed care organizations, pharmacy benefit managers, government funded health care programs, commercial employers and other third party insurance programs, which represent the vast majority of the Company's consolidated pharmacy revenues, typically settle in less than 30 days. The remainder of the Company's consolidated pharmacy revenues are paid in cash, or with debit or credit cards. Employer groups, individuals, college students, part-time and hourly workers, health plans, providers, governmental units, government-sponsored plans (with the exception of Medicare Part D services, which are described below), labor groups and expatriates, which represent the vast majority of Health Care Benefits segment revenues, typically settle in less than 30 days. As a provider of Medicare Part D services, the Company contracts annually with CMS. Utilization of services each plan year results in the accumulation of either a receivable from or a payable to CMS. The timing of settlement of the receivable or payable with CMS takes several quarters, which impacts working capital from year to year.

Human Capital

Overview

At CVS Health, we share a single, clear purpose: helping people on their path to better health. We devote significant time and attention to the attraction, development and retention of colleagues to deliver high levels of service to our customers. Our commitment to them includes a competitive rewards package and programs that support our diverse range of colleagues in rewarding and fulfilling careers. As of December 31, 2020, we employed nearly 300,000 colleagues primarily in the United States including in all 50 states, the District of Columbia and Puerto Rico, approximately 71% of whom were full-time.

We believe engaged colleagues produce stronger business results and are more likely to build a career with the Company. Each year we conduct an internal engagement survey that provides colleagues with an opportunity to share their opinions and experiences with respect to their role, their team and the enterprise to help our Board of Directors (the "Board") and our management identify areas where we can improve colleague experience. The survey covers a broad range of topics including development and opportunities, diversity management, recognition, performance, well-being, compliance and continuous improvement. In 2020, greater than 80% of our colleagues participated in the engagement survey, of which greater than 80% responded that they were actively engaged.

The Board and our chief executive officer ("CEO") provide oversight of our human capital strategy, which consists of the following categories: total rewards; diversity, equity and inclusion; colleague development; and health and safety.

Total Rewards

We recognize how vital our colleagues are to our success and strive to offer comprehensive and competitive wages and benefits to meet the varying needs of our colleagues and their families. The benefits and programs include annual bonuses, 401(k) plans, stock awards, an employee stock purchase plan, health care and insurance benefits, paid time off, flexible work schedules, family leave, dependent care resources, colleague assistance programs and tuition assistance, among many others, depending on eligibility.

In response to the COVID-19 pandemic, we provided enhanced pay and benefits, including bonuses to frontline colleagues, dependent care financial assistance, paid sick leave for part-time colleagues and paid time off to colleagues who test positive or are quarantined due to exposure.

Diversity, Equity & Inclusion

We believe that a diverse workforce creates a healthier, stronger and more sustainable company. We aim to attract, retain and support a diverse workforce that reflects the many customers, patients, members and communities we serve. Our Diversity Management Leadership Council, a cross-functional group of senior leaders appointed by our CEO, works with our Strategic Diversity Management leadership team to intentionally embed diversity across all facets of our business. For our efforts, we have been recognized as a DiversityInc Top 50 Company, named to Bloomberg's 2019 Gender-Equality Index and earned a 100 percent score on the Disability Equality Index, meaning the company is recognized as a "Best Place to Work for Disability Inclusion." The Company discloses information on our diversity, equity and inclusion strategy, programs and progress in our annual Corporate Social Responsibility ("CSR") Report.

As a foundation of equity, we continuously focus on increasing underrepresented populations across our business. In 2020, 70% of our total colleague population and 52% of our colleagues at the manager level and above self-reported as female. In addition, in 2020 our colleagues reported their race/ethnicity as: White (53%), Black/African American (16%), Hispanic/Latino (15%), Asian (11%) and Other (5%). The appendix to our CSR Report includes additional data on the diversity of our workforce.

Our diversity management strategy emphasizes workplace representation, inclusion and belonging, talent acquisition and management and a diverse marketplace. We support 15 Colleague Resource Groups ("CRGs") that include more than 22,000 colleagues across the enterprise. These groups represent a wide range of professional, cultural, ethical and personal affinities and interests, as well as formal mentoring programs. Our CRGs provide our colleagues with an opportunity to connect and network with one another through a particular affinity, culture or interest. Each of our CRGs is sponsored by a senior leader.

Colleague Development

The Company offers a number of resources and programs that attract, engage, develop, advance and retain colleagues. Training and development provides colleagues the support they need to perform well in their current role while planning and preparing for future roles. We offer an online orientation program that pairs new hires with seasoned colleagues and the training continues throughout a colleague's career through in-person, virtual and self-paced learning at all levels. We also provide mentoring, tools and workshops for colleagues to manage their career development. We offer a variety of management and leadership programs that develop incumbent diverse and other high potential colleagues. Our broad training practices include updated, tech-enabled tools and keep our colleagues informed of new developments in our industry that are relevant to their roles. During the year ended December 31, 2020, our colleagues completed nearly 12 million training courses.

Our colleague development program also promotes the importance of compliance across our business. Our colleagues demonstrate this commitment through our annual Code of Conduct training, which 100% of active colleagues completed in 2020. In 2020, we launched more than 75 different training courses as part of our annual Enterprise Compliance Training Program.

Health & Safety

We have a strong commitment to providing a safe working environment.

We utilize Safety Service Plans to analyze data and concentrate on key areas of risk to reduce the chance of workplace incidents. We focus on identifying causes and improving performance when workplace incidents occur. We also engage leaders in promoting a culture of safety. With safety task forces in place at each distribution center, we empower leaders and safety business partners to identify policies, procedures and processes that could improve their own operations.

In addition, from the outset of the COVID-19 pandemic, we took a comprehensive approach to managing occupational health and safety challenges presented by the pandemic. We implemented social distancing practices and enhanced cleaning protocols at all of our locations. We launched a COVID-19 command center to coordinate responsive actions to reports of COVID-positivity among colleagues, including contact tracing, sanitizing and collaborating with public health officials. We distributed personal protective equipment based on our safety professionals' assessment of various activities our colleagues perform. We added engineering controls and enhanced safety features in our retail locations, including protective panels at pharmacy counters and front store checkout stations. We developed travel, work from home, self-quarantine, wellness check, and other HR-related guidance to help colleagues maintain their health and safety while continuing to support the essential operations of the Company.

Intellectual Property

The Company has registered and/or applied to register a variety of trademarks and service marks used throughout its businesses, as well as domain names, and relies on a combination of copyright, patent, trademark and trade secret laws, in addition to contractual restrictions, to establish and protect the Company's proprietary rights. The Company regards its intellectual property as having significant value in the Pharmacy Services, Retail/LTC and Health Care Benefits segments. The Company is not aware of any facts that could materially impact the continuing use of any of its intellectual property.

Government Regulation

Overview

The Company's operations are subject to comprehensive federal, state and local laws and regulations and comparable multiple levels of international regulation in the jurisdictions in which it does business. There also continues to be a heightened level of review and/or audit by federal, state and international regulators of the health and related benefits industry's business and reporting practices. In addition, many of the Company's PBM clients and the Company's payors in the Retail/LTC segment, including insurers, Medicare plans, Managed Medicaid plans and MCOs, are themselves subject to extensive regulations that affect the design and implementation of prescription drug benefit plans that they sponsor. Similarly, the Company's LTC clients, such as skilled nursing facilities, are subject to government regulations, including many of the same government regulations to which the Company is subject.

The laws and rules governing the Company's businesses and interpretations of those laws and rules continue to expand and become more restrictive each year and are subject to frequent change. The application of these complex legal and regulatory requirements to the detailed operation of the Company's businesses creates areas of uncertainty. Further, there are numerous proposed health care, financial services and other laws and regulations at the federal, state and international levels, some of which could adversely affect the Company's businesses if they are enacted. The Company cannot predict whether pending or future federal or state legislation or court proceedings, including fundamental changes to the dynamics of one or more of the industries in which it competes, such as the federal or one or more state governments fundamentally restructuring the Commercial, Medicare or Medicaid marketplace or reducing payments to the Company under or financing for Medicare, Medicaid, dual eligible or special needs programs, increasing its involvement in drug reimbursement, pricing, purchasing, and/or importation or changing the laws governing PBMs, will change various aspects of the industries in which it competes or the health care industry generally or the impact those changes will have on the Company's businesses, operating results, cash flows and/or stock price, but the effects could be materially adverse. The Company has internal control policies and procedures and conducts training and compliance programs for its employees to deter prohibited practices. However, if the Company's employees or agents fail to comply with applicable laws governing its international or other operations, it may face investigations, prosecutions and other legal proceedings and actions which could result in civil penalties, administrative remedies and criminal sanctions. Any failure or alleged failure to comply with applicable laws and regulations summarized below, or any adverse applications or interpretations of, or changes in, the laws and regulations affecting the Company and/or its businesses, could have a material adverse effect on the Company's operating results, financial condition, cash flows and/or stock price. See Item 3 of this 10-K, "Legal Proceedings," for further information.

The Company can give no assurance that its businesses, financial condition, operating results and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations, including the laws and regulations described in this Government Regulation section, as they may relate to one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iii) pending or future federal or state governmental investigations of one or more of the Company's

businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting one or more of the industries in which the Company competes and/or the health care industry generally.

Laws and Regulations Related to COVID-19

The Families First Coronavirus Response Act (the "Families First Act") and the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") were enacted in March 2020. Each of the Families First Act and the CARES Act requires the Company to provide coverage for COVID-19 related medical services, in many cases without member cost-sharing, in its Insured Health Care Benefits products.

The CARES Act also provides relief funding to providers to reimburse them for health care related expenses incurred in preventing, preparing for and/or responding to COVID-19 (provided no other source is obligated to reimburse those expenses) or lost health care related revenues that are attributable to COVID-19. Under the CARES Act, the Company receives reimbursement for uninsured patients in connection with COVID-19 testing and vaccination as well as monoclonal antibody treatment. Aside from such reimbursement, the Company did not request any funding under the CARES Act. However, in the second quarter of 2020, the Company received $43 million from the CARES Act provider relief fund, all of which was returned to the U.S. Department of Health and Human Services ("HHS") during the second quarter of 2020.

The CARES Act also allows for the deferral of the payment of the employer share of Social Security taxes effective March 27, 2020. The Company has elected to defer its Social Security tax payments in accordance with this provision, and will remit the associated payments in two equal installments on or about December 31, 2021 and December 31, 2022, as required under the CARES Act. The Company deferred approximately $670 million of its Social Security tax payments during the year ended December 31, 2020.

In addition to the Families First Act and the CARES Act, the Company is experiencing an unprecedented level of new laws, regulations, directives and orders from federal, state, county and municipal authorities related to the COVID-19 pandemic, most of which have been issued on an emergency basis with immediate, or in some instances retroactive, effect. These governmental actions include, but are not limited to, requirements to waive member cost-sharing associated with COVID-19 testing and treatment, provide coverage for additional COVID-19-related services, expand the use of telemedicine, suspend precertification or other UM mechanisms (including review of claims for medical necessity), allow earlier or longer renewal of prescriptions, extend grace periods for payments of premiums or limit coverage termination based on non-payment of premiums or fees, modify health benefits coverage eligibility rules to help maintain employee eligibility, and facilitate, accelerate or advance payments to providers. For example, in December 2020, as part of a COVID-19 relief package, Congress enacted a 3.75% payment increase to providers through the Medicare Physician Fee Schedule, which Medicare Advantage plans often use as a benchmark for provider contracts. As a result, in many instances the Company will be contractually required to pass on this payment to its providers, which was not anticipated at the time of bidding.

Related governmental actions have required the Company to close or significantly limit operations at traditional office worksites and affected the hours of operation of MinuteClinic locations and the Company's pharmacies. In some instances, the Company has taken permitted proactive actions consistent with more general regulatory directives, such as expanding home delivery of prescription medications, extending hours of operation for member assistance lines and liberalizing certain other terms of coverage. Similar directives have affected the Company's international operations. The Company anticipates additional mandates and directives from domestic and foreign federal, state, county and local authorities throughout the continuation of the COVID-19 pandemic and for some time thereafter, some of which may result in permanent changes in the Company's operations or the health care and other benefits cost and other risks assumed by the Company. Further, although the Company has seen regulators relax certain requirements in light of the COVID-19 pandemic, such as temporary suspension of certain audits and extensions of certain filing deadlines, failure to provide regulatory relief or accommodations in other areas may result in increased costs or reduced revenue for the Company.

The impact of this governmental activity on the U.S. economy, consumer, customer and health care provider behavior and health care utilization patterns is beyond our knowledge and control. As a result, the financial and/or operational impact these COVID-19 related governmental actions and inactions will have on our businesses, operating results, cash flows and/or financial condition is uncertain, but the collective impact could be material and adverse.

Laws and Regulations Related to Multiple Segments of the Company's Business

Laws Related to Reimbursement by Government Programs - The Company is subject to various federal and state laws concerning its submission of claims and other information to Medicare, Medicaid and other federal and state government-sponsored health care programs. Potential sanctions for violating these laws include recoupment or reduction of government reimbursement amounts, civil penalties, treble damages, and exclusion from participation in government health care programs. Such laws include the federal False Claims Act (the "False Claims Act"), the federal anti-kickback statute (the "AKS"), state false claims acts and anti-kickback statutes in most states, the federal "Stark Law" and related state laws. In particular, the False Claims Act prohibits intentionally submitting, conspiring to submit, or causing to be submitted, false claims, records, or statements to the federal government, or intentionally failing to return overpayments, in connection with reimbursement by federal government programs. In addition, any claim for government reimbursement also violates the False Claims Act where it results from a violation of the AKS.

Both federal and state false claims laws permit private individuals to file *qui tam* or "whistleblower" lawsuits on behalf of the federal or state government. Participants in the health and related benefits industry, including the Company, frequently are subject to actions under the False Claims Act or similar state laws. The federal Stark Law generally prohibits physicians from referring Medicare or Medicaid beneficiaries for certain services, including outpatient prescription drugs, to any entity with which the physician, or an immediate family member of the physician, has a financial relationship. The Stark Law further prohibits the entity receiving a prohibited referral from presenting a claim for reimbursement by Medicare or Medicaid for services furnished pursuant to the prohibited referral. Various states have enacted similar laws.

The ACA - The United States Supreme Court is expected to rule on the constitutionality of the ACA by June 2021. If the ACA is deemed unconstitutional, there will likely be significant changes to the laws and rules that govern the Company's businesses. If the ACA is deemed constitutional, there may nevertheless be continued efforts to invalidate, modify, repeal or replace it or portions of it, and the Company expects aspects of the ACA to continue to significantly impact its business operations and operating results, including pricing, medical benefit ratios ("MBRs") and the geographies in which the Company's products are available.

The ACA made broad-based changes to the U.S. health care system. While most of the significant aspects of the ACA became effective during or prior to 2014, parts of the ACA continue to evolve through the promulgation of executive orders, legislation, regulations and guidance as well as ongoing litigation. Additional changes to the ACA and those regulations and guidance at the federal and/or state level are likely, and those changes are likely to be significant. Growing federal and state budgetary pressures make it more likely that any changes, including changes at the state level in response to changes to, or invalidation, repeal or replacement of, the ACA and/or changes in the funding levels and/or payment mechanisms of federally supported benefit programs, will be adverse to us. For example, if any elements of the ACA are invalidated or repealed at the federal level, the Company expects that some states would seek to enact similar requirements, such as prohibiting pre-existing condition exclusions, prohibiting rescission of insurance coverage, requiring coverage for dependents up to age 26, requiring guaranteed renewability of insurance coverage and prohibiting lifetime limits on insurance coverage.

The Company filed a lawsuit in August 2019 to recover the $313 million it was owed under the ACA's risk corridor program, which had been stayed pending the Supreme Court decision. In April 2020, the U.S. Supreme Court ruled that health insurance companies may sue the federal government for amounts owed as calculated under the ACA's temporary risk corridor program. In October 2020, the Company received the $313 million in funds it was owed under the ACA's risk corridor program.

The expansion of health care coverage contemplated by the ACA is being funded in part by reductions to the reimbursements the Company and other health plans are paid by the federal government for Medicare members, among other sources. While not all-inclusive, the following are some of the recent key funding changes related to the ACA (assuming it continues to be implemented in its current form). The Company continues to evaluate these provisions and the related regulations and regulatory guidance to determine the impact that they will have on its business operations and operating results:

- The repeal of the annual non-tax deductible industry-wide HIF for calendar years after 2020. The HIF was $15.5 billion and $14.3 billion for 2020 and 2018, respectively, and suspended for 2019.
- The repeal of the non-tax deductible 40% excise tax on employer-sponsored health care benefits above a certain threshold that was scheduled to begin in 2022.
- Reduced federal matching funds for Medicaid expansion. Starting in 2017, the federal matching rate declined slightly each year until it reached 90 percent in 2020, and will remain there.

The ACA also specifies minimum medical loss ratios ("MLRs") for Commercial and Medicare Insured products, specifies features required to be included in commercial benefit designs, limits commercial individual and small group rating and pricing practices, encourages additional competition (including potential incentives for new participants to enter the marketplace) and significantly increases federal and state oversight of health plans, including regulations and processes that could delay or limit the Company's ability to appropriately increase its health plan premium rates. This in turn could adversely affect the Company's ability to continue to participate in certain product lines and/or geographies that it serves today.

Potential repeal of the ACA, ongoing legislative, regulatory and administrative policy changes to the ACA, the results of federal and state level elections, pending litigation challenging the constitutionality of the ACA or funding for the law and federal budget negotiations continue to create uncertainty about the ultimate impact of the ACA. Given the inherent difficulty of foreseeing the nature and scope of future changes to the ACA and how states, businesses and individuals will respond to those changes, the Company cannot predict the impact on it of future changes to the ACA. It is reasonably possible that invalidation, repeal or replacement of or other changes to the ACA and/or states' responses to such changes, in the aggregate, could have a significant adverse effect on the Company's businesses, operating results and cash flows.

Medicare Regulation - The Company's Medicare Advantage products compete directly with Original Medicare and Medicare Advantage products offered by other Medicare Advantage organizations and Medicare Supplement products offered by other insurers. The Company's Medicare PDP and Medicare Supplement products are products that Medicare beneficiaries who are enrolled in Original Medicare purchase to enhance their Original Medicare coverage.

The Company continues to expand the number of counties in which it offers Medicare products. The Company has expanded its Medicare service area and products in 2021 and is seeking to substantially grow its Medicare membership, revenue and operating results over the next several years, including through growth in Medicare Supplement products. The anticipated organic expansion of the Medicare service area and Medicare products offered and the Medicare-related provisions of the ACA significantly increase the Company's exposure to funding and regulation of, and changes in government policy with respect to and/or funding or regulation of, the various Medicare programs in which the Company participates, including changes in the amounts payable to us under those programs and/or new reforms or surcharges on existing programs. For example, the ACA requires minimum MLRs for Medicare Advantage and Medicare Part D plans of 85%. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS. Due to potential lower utilization of medical services by Medicare beneficiaries during the COVID-19 pandemic, it is possible certain Medicare Advantage contracts may not meet the 85% MLR for consecutive years.

The Company's Medicare Advantage and PDP products are heavily regulated by CMS. The regulations and contractual requirements applicable to the Company and other private participants in Medicare programs are complex, expensive to comply with and subject to change. For example, in the second quarter of 2014, CMS issued a final rule implementing the ACA requirements that Medicare Advantage and PDP plans report and refund to CMS overpayments that those plans receive from CMS. The precise interpretation, impact and legality of this rule are not clear and are subject to pending litigation. Payments the Company receives from CMS for its Medicare Advantage and Part D businesses also are subject to risk adjustment based on the health status of the individuals enrolled. Elements of that risk adjustment mechanism continue to be challenged by the U.S. Department of Justice (the "DOJ"), the Office of the Inspector General of the HHS (the "OIG") and CMS itself. Substantial changes in the risk adjustment mechanism, including changes that result from enforcement or audit actions, could materially affect the amount of the Company's Medicare reimbursement, require the Company to raise prices or reduce the benefits offered to Medicare beneficiaries, and potentially limit the Company's (and the industry's) participation in the Medicare program.

The Company has invested significant resources to comply with Medicare standards, and its Medicare compliance efforts will continue to require significant resources. CMS may seek premium and other refunds, prohibit the Company from continuing to market and/or enroll members in or refuse to passively enroll members in one or more of the Company's Medicare or Medicare-Medicaid demonstration (historically known as "dual eligible") plans, exclude us from participating in one or more Medicare, dual eligible or dual eligible special needs plan programs and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with CMS regulations or its Medicare contractual requirements. The Company's Medicare Supplement products are regulated at the state level and subject to similar significant compliance requirements and risks.

CMS regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare Advantage and PDP beneficiaries. For example, CMS conducts risk adjustment data validation ("RADV") audits of a subset of Medicare Advantage contracts for each contract year.

Since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various years for RADV audit, and the number of RADV audits continues to increase. The OIG also is auditing the Company's risk adjustment data and that of other companies, and the Company expects CMS and the OIG to continue auditing risk adjustment data. The Company also has received Civil Investigative Demands ("CIDs") from, and provided documents and information to, the Civil Division of the DOJ in connection with a current investigation of its patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

On October 26, 2018, CMS issued proposed rules related to, among other things, changes to the RADV audit methodology established by CMS in 2012. CMS projects that the changes to the RADV audit methodology would increase its recoveries from Medicare Advantage plans as a result of RADV audits. CMS has requested comments on the proposed rules, including whether the proposed RADV rule change should apply retroactively to audits of Medicare Advantage plans for contract year 2011 and forward. The Company is evaluating the potential adverse effect, which could be material, on the Company's operating results, financial condition, and cash flows if the proposed RADV rule change were adopted as proposed. CMS also has announced that its goal is to subject all Medicare Advantage contracts to either a comprehensive or a targeted RADV audit for each contract year.

A portion of each Medicare Advantage plan's reimbursement is tied to the plan's "star ratings." The star rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management, compliance and overall customer satisfaction. Only Medicare Advantage plans with an overall star rating of four or more stars (out of five stars) are eligible for a quality bonus in their basic premium rates. As a result, the Company's Medicare Advantage plans' operating results in 2021 and going forward will be significantly affected by their star ratings. The Company's star ratings and past performance scores are adversely affected by the compliance issues that arise each year in its Medicare operations. CMS released the Company's 2021 star ratings in October 2020. The Company's 2021 star ratings will be used to determine which of its Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2022. Based on the Company's membership at December 31, 2020, 83% of the Company's Medicare Advantage members were in plans with 2021 star ratings of at least 4.0 stars. CMS also gives PDPs star ratings which affect each PDP's enrollment. Medicare Advantage and PDP plans that are rated less than three stars for three consecutive years are subject to contract termination by CMS. CMS continues to revise its star ratings system to make it harder to achieve four stars or more. Despite the Company's success in achieving high 2021 star ratings and other quality measures and the continuation of its improvement efforts, there can be no assurances that it will be successful in maintaining or improving its star ratings in future years. Accordingly, the Company's Medicare Advantage plans may not be eligible for full level quality bonuses, which could adversely affect the benefits such plans can offer, reduce membership and/or reduce profit margins.

Overall, the Company projects the benchmark payment rates in CMS's April 2020 final notice detailing final Medicare Advantage benchmark payment rates for 2021 will increase funding for the Company's Medicare Advantage business, excluding the impact of the HIF in 2020, by approximately 1.8% in 2021 compared to 2020. This 2021 rate increase only partially offsets the challenge the Company faces from the impact of the increasing cost of medical care (including prescription medications) and CMS local and national coverage decisions that require the Company to pay for services and supplies that are not factored into the Company's bids. The federal government may seek to impose restrictions on the configuration of pharmacy or other provider networks for Medicare Advantage and/or PDP plans, or otherwise restrict the ability of these plans to alter benefits, negotiate prices or establish other terms to improve affordability or maintain viability of products. The Company currently believes that the payments it has received and will receive in the near term are adequate to justify the Company's continued participation in the Medicare Advantage and PDP programs, although there are economic and political pressures to continue to reduce spending on the program, and this outlook could change. In January 2021, CMS issued its final notice detailing final 2022 Medicare Advantage benchmark payment rates. Final 2022 Medicare Advantage rates resulted in an increase in industry benchmark rates of approximately 4.1%.

Going forward, the Company expects CMS, the OIG, the DOJ, other federal agencies and the U.S. Congress to continue to scrutinize closely each component of the Medicare program (including Medicare Advantage, PDPs, demonstration projects such as Medicare-Medicaid plans and provider network access and adequacy), modify the terms and requirements of the program and possibly seek to recast or limit private insurers' roles. It is not possible to predict the outcome of this Congressional or regulatory activity, any of which could materially and adversely affect the Company.

In addition, in November 2020, the HHS released the final Rebate Rule (the "Rebate Rule"), which eliminates the regulatory safe harbor from prosecution under the AKS for rebates from pharmaceutical companies to PBMs in Medicare Part D, replacing it with two far narrower safe harbors designed to directly benefit patients with high out-of-pocket costs and to change the way PBMs are compensated. The new safe harbors are (i) for rebates which are passed on to the patient at the point of sale and (ii) for flat service fee payments made to PBMs which cannot be tied to the list prices of drugs. The Pharmaceutical Care

Management Association (the "PCMA"), which represents PBMs, has filed a suit in an effort to block the Rebate Rule, claiming that the Rebate Rule would lead to higher premiums in Medicare Part D and was adopted in an unlawful manner. It is unclear whether the Rebate Rule will be enforceable, whether pharmaceutical companies will respond by reducing list prices, whether list prices in the private market may also be reduced, and what the resulting impact will be to PBMs or the Company.

340B Drug Pricing Program – The 340B Drug Pricing Program allows eligible covered entities to purchase prescription drugs from manufacturers at a steep discount, and is overseen by the HHS and the Health Resources and Services Administration ("HRSA"). In 2020, a number of pharmaceutical manufacturers began programs that limited covered entities' participation in the program through contract pharmacies arrangements, which the Company has with some covered entities. Enforcement from HHS and HRSA to curb these manufacturer practices will significantly impact the Company's participation in the program in the future.

Anti-Remuneration Laws - Federal law prohibits, among other things, an entity from knowingly and willfully offering, paying, soliciting or receiving, subject to certain exceptions and "safe harbors," any remuneration to induce the referral of individuals or the purchase, lease or order of items or services for which payment may be made under Medicare, Medicaid or certain other federal and state health care programs. A number of states have similar laws, some of which are not limited to services paid for with government funds. Sanctions for violating these federal and state anti-remuneration laws may include imprisonment, criminal and civil fines, and exclusion from participation in Medicare, Medicaid and other federal and state government-sponsored health care programs. Companies involved in public health care programs such as Medicare and/or Medicaid are required to maintain compliance programs to detect and deter fraud, waste and abuse, and are often the subject of fraud, waste and abuse investigations and audits. The Company has invested significant resources to comply with Medicare and Medicaid program standards. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that the Company's compliance efforts in this area will continue to require significant resources.

Antitrust and Unfair Competition - The U.S. Federal Trade Commission ("FTC") investigates and prosecutes practices that are "unfair trade practices" or "unfair methods of competition." Numerous lawsuits have been filed throughout the United States against pharmaceutical manufacturers, retail pharmacies and/or PBMs under various federal and state antitrust and unfair competition laws challenging, among other things: (i) brand name drug pricing and rebate practices of pharmaceutical manufacturers, (ii) the maintenance of retail or specialty pharmacy networks by PBMs, and (iii) various other business practices of PBMs and retail pharmacies. To the extent that the Company appears to have actual or potential market power in a relevant market or CVS Pharmacy, CVS Specialty or MinuteClinic plays a unique or expanded role in a Pharmacy Services or Health Care Benefits segment product offering, the Company's business arrangements and uses of confidential information may be subject to heightened scrutiny from an anti-competitive perspective and possible challenge by state and/or federal regulators and/or private parties.

Privacy and Confidentiality Requirements - Many of the Company's activities involve the receipt, use and disclosure by the Company of personally identifiable information ("PII") as permitted in accordance with applicable federal and state privacy and data security laws, which require organizations to provide appropriate privacy and security safeguards for such information. In addition to PII, the Company uses and discloses de-identified data for analytical and other purposes when permitted. Additionally, there are industry standards for handling credit card data known as the Payment Card Industry Data Security Standard, which are a set of requirements designed to help ensure that entities that process, store or transmit credit card information maintain a secure environment. Certain states have incorporated these requirements into state laws or enacted other requirements relating to the use and/or disclosure of PII.

The federal Health Insurance Portability and Accountability Act of 1996 and the regulations issued thereunder (collectively, "HIPAA"), as further modified by the American Recovery and Reinvestment Act of 2009 ("ARRA") impose extensive requirements on the way in which health plans, providers, health care clearinghouses (known as "covered entities") and their business associates use, disclose and safeguard protected health information ("PHI"). Further, ARRA requires the Company and other covered entities to report any breaches of PHI to impacted individuals and to the HHS and to notify the media in any states where 500 or more people are impacted by the unauthorized release or use of or access to PHI. Criminal penalties and civil sanctions may be imposed for failing to comply with HIPAA standards. The Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), enacted as part of ARRA, amended HIPAA to impose additional restrictions on third-party funded communications using PHI and the receipt of remuneration in exchange for PHI. The HITECH Act also extended HIPAA privacy and security requirements and penalties directly to business associates. HHS has begun to audit health plans, providers and other parties to enforce HIPAA compliance, including with respect to data security.

In addition to HIPAA, state health privacy laws apply to the extent they are more protective of individual privacy than is HIPAA, including laws that place stricter controls on the release of information relating to specific diseases or conditions and

requirements to notify members of unauthorized release or use of or access to PHI. States also have adopted regulations to implement provisions of the Financial Modernization Act of 1999 (also known as the Gramm-Leach-Bliley Act ("GLBA")) which generally require insurers, including health insurers, to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a non-affiliated third party. Like HIPAA, GLBA sets a "floor" standard, allowing states to adopt more stringent requirements governing privacy protection. Complying with additional state requirements requires us to make additional investments beyond those the Company has made to comply with HIPAA and GLBA.

The Cybersecurity Information Sharing Act of 2015 encourages organizations to share cyber threat indicators with the federal government and, among other things, directs HHS to develop a set of voluntary cybersecurity best practices for organizations in the health care industry. In addition, states have begun to enact more comprehensive privacy laws and regulations addressing consumer rights to data access, deletion, protection or transparency, such as the California Consumer Privacy Act ("CCPA"). States also are starting to issue regulations and proposed regulations specifically related to cybersecurity, such as the regulations issued by the New York Department of Financial Services. Complying with conflicting cybersecurity regulations, which may differ from state to state, requires significant resources. In addition, differing approaches to state privacy and/or cyber-security regulation and varying enforcement philosophies may materially and adversely affect the Company's ability to standardize its products and services across state lines. Widely-reported large scale commercial data breaches in the United States and abroad increase the likelihood that additional data security legislation will be considered by additional states. These legislative and regulatory developments will impact the design and operation of the Company's businesses, its privacy and security strategy and its web-based and mobile assets.

Finally, each Public Exchange is required to adhere to privacy and security standards with respect to PII, and to impose privacy and security standards that are at least as protective of PII as those the Public Exchange has implemented for itself or non-Public Exchange entities, which include insurers offering plans through the Public Exchange and their designated downstream entities, including PBMs and other business associates. These standards may differ from, and be more stringent than, HIPAA.

Consumer Protection Laws - The federal government has many consumer protection laws, such as the Federal Trade Commission Act, the Federal Postal Service Act and the Consumer Product Safety Act. Most states also have similar consumer protection laws and a growing number of states regulate subscription programs. In addition, the federal government and most states have adopted laws and/or regulations requiring places of public accommodation, health care services and other goods and services to be accessible to people with disabilities. These consumer protection and accessibility laws and regulations have been the basis for investigations, lawsuits and multistate settlements relating to, among other matters, the marketing of loyalty programs, and health care products and services, pricing accuracy, expired front store products, financial incentives provided by drug manufacturers to pharmacies in connection with therapeutic interchange programs, disclosures related to how personal data is used and protected and the accessibility of goods and services to people with disabilities. As a result of the Company's direct-to-consumer activities, including mobile and web-based solutions offered to members and to other consumers, the Company also is subject to federal and state regulations applicable to electronic communications and to other general consumer protection laws and regulations. For example, the CCPA became effective in 2020, and additional federal and state regulation of consumer privacy protection may be proposed or enacted in 2020. The Company expects these new laws and regulations to impact the design of its products and services and the management and operation of its businesses and to increase its compliance costs.

Transparency in Coverage Rule - In October 2020, the HHS released a final rule requiring health insurers to disclose negotiated prices of drugs, medical services, supplies and other covered items to the public. The rule requires group health plans and health insurance issuers in the individual and group markets to disclose cost-sharing information upon request, to a participant, beneficiary, or enrollee, which, unless otherwise indicated, for the purpose of the final rules includes an authorized representative, and require plans and issuers to disclose in-network provider rates, historical out-of-network allowed amounts and the associated billed charges, and negotiated rates for prescription drugs. Disclosure of data in a machine readable file is required beginning in January 2022, and insurers are required to have a consumer tool in place by January 2023. The public disclosure of insurer- or PBM-negotiated price concessions may result in drug manufacturers lowering discounts or rebates, resulting in higher drug costs for patients and impacting the ability of the Company to negotiate drug prices and provide competitive products and services to consumers.

Telemarketing and Other Outbound Contacts - Certain federal and state laws, such as the Telephone Consumer Protection Act and the Telemarketing Sales Rule, give the FTC, the Federal Communications Commission and state attorneys general the ability to regulate, and bring enforcement actions relating to, telemarketing practices and certain automated outbound contacts such as phone calls, texts or emails. Under certain circumstances, these laws provide consumers with a private right of action. Violations of these laws could result in substantial statutory penalties and other sanctions.

Pharmacy and Professional Licensure and Regulation - The Company is subject to a variety of intersecting federal and state statutes and regulations that govern the wholesale distribution of drugs; operation of retail, specialty, infusion, LTC and mail order pharmacies; licensure of facilities and professionals, including pharmacists, technicians, nurses and other health care professionals; registration of facilities with the U.S. Drug Enforcement Administration (the "DEA") and analogous state agencies that regulate controlled substances; packaging, storing, shipping and tracking of pharmaceuticals; repackaging of drug products; labeling, medication guides and other consumer disclosures; interactions with prescribers and health care professionals; compounding of prescription medications; dispensing of controlled and non-controlled substances; counseling of patients; transfers of prescriptions; advertisement of prescription products and pharmacy services; security; inventory control; recordkeeping; reporting to Boards of Pharmacy, the U.S. Food and Drug Administration (the "FDA"), the U.S. Consumer Product Safety Commission, the DEA and related state agencies; and other elements of pharmacy practice. Pharmacies are highly regulated and have contact with a wide variety of federal, state and local agencies with various powers to investigate, inspect, audit or solicit information, including Boards of Pharmacy and Nursing, the DEA, the FDA, the DOJ, HHS and others. Many of these agencies have broad enforcement powers, conduct audits on a regular basis, can impose substantial fines and penalties, and may revoke the license, registration or program enrollment of a facility or professional.

State Insurance, HMO and Insurance Holding Company Regulation - A number of states regulate affiliated groups of insurers and HMOs such as the Company under holding company statutes. These laws may, among other things, require prior regulatory approval of dividends and material intercompany transfers of assets and transactions between the regulated companies and their affiliates, including their parent holding companies. The Company expects the states in which its insurance and HMO subsidiaries are licensed to continue to expand their regulation of the corporate governance and internal control activities of its insurance companies and HMOs. Changes to state insurance, HMO and/or insurance holding company laws or regulations or changes to the interpretation of those laws or regulations, including due to regulators' increasing concerns regarding insurance company and/or HMO solvency due, among other things, to past and expected payor insolvencies, could negatively affect the Company's businesses in various ways, including through increases in solvency fund assessments, requirements that the Company hold greater levels of capital and/or delays in approving dividends from regulated subsidiaries.

PBM offerings of prescription drug coverage under certain risk arrangements may be subject to laws and regulations in various states. Such laws may require that the party at risk become licensed as an insurer, establish reserves or otherwise demonstrate financial viability. Laws that may apply in such cases include insurance laws and laws governing MCOs and limited prepaid health service plans.

The states of domicile of the Company's regulated subsidiaries have statutory risk-based capital ("RBC") requirements for health and other insurance companies and HMOs based on the National Association of Insurance Commissioners' Risk-Based Capital for Insurers Model Act (the "RBC 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. The RBC Model Act sets forth the formula for calculating 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 company's business. 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. At December 31, 2020, the RBC level of each of the Company's insurance and HMO subsidiaries was above the level that would require regulatory action.

For information regarding restrictions on certain payments of dividends or other distributions by the Company's HMO and insurance company subsidiaries, see Note 12 ''Shareholders' Equity'' included in Item 8 of this 10-K.

The holding company laws for the states of domicile of certain of the Company's subsidiaries also restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes, without such approval (or an exemption), no person may acquire any voting security of an insurance holding company (such as the Company's ultimate parent company, CVS Health) that controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would control the insurance holding company. 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.

Certain states have laws that prohibit submitting a false claim or making a false record or statement in order to secure reimbursement from an insurance company. These state laws vary, and violation of them may lead to the imposition of civil or criminal penalties.

Government Agreements and Mandates - The Company and/or its various affiliates are subject to certain consent decrees, settlement and other agreements, corrective action plans and corporate integrity agreements with various federal, state and local authorities relating to such matters as privacy practices, controlled substances, PDPs, expired products, environmental and safety matters, marketing and advertising practices, PBM, LTC and other pharmacy operations and various other business practices. Certain of these agreements contain ongoing reporting, monitoring and/or other compliance requirements for the Company. Failure to meet the Company's obligations under these agreements could result in civil or criminal remedies, financial penalties, administrative remedies, and/or exclusion from participation in federal health care programs.

Environmental and Safety Regulation - The Company's businesses are subject to various federal, state and local laws, regulations and other requirements pertaining to protection of the environment, public health and employee safety, including, for example, regulations governing the management of hazardous substances, the cleaning up of contaminated sites, and the maintenance of safe working conditions in the Company's retail locations, distribution centers and other facilities. Governmental agencies at the federal, state and local levels continue to focus on the retail and health care sectors' compliance with such laws and regulations, and have at times pursued enforcement activities. Any failure to comply with these regulations could result in fines or other sanctions by government authorities.

ERISA Regulation - The Employee Retirement Income Security Act of 1974 ("ERISA"), provides for comprehensive federal regulation of certain employee pension and benefit plans, including private employer and union sponsored health plans and certain other plans that contract with us to provide PBM services. In general, the Company assists plan sponsors in the administration of their health benefit plans, including the prescription drug benefit portion of those plans, in accordance with the plan designs adopted by the plan sponsors. In addition, the Company may have fiduciary duties where it has specifically contracted with a plan sponsor to accept limited fiduciary responsibility, such as for the adjudication of initial prescription drug benefit claims and/or the appeals of denied claims under a plan. In addition to its fiduciary provisions, ERISA imposes civil and criminal liability on service providers to health plans and certain other persons if certain forms of illegal remuneration are made or received. These provisions of ERISA are broadly written and their application to specific business practices is often uncertain.

Some of the Company's health and related benefits and large case pensions products and services and related fees also are subject to potential issues raised by judicial interpretations relating to ERISA. Under those interpretations, together with U.S. Department of Labor ("DOL") regulations, the Company may have ERISA fiduciary duties with respect to PBM members and/or certain general account assets held under contracts that are not guaranteed benefit policies. As a result, certain transactions related to those general account assets are subject to conflict of interest and other restrictions, and the Company must provide certain disclosures to policyholders annually. The Company must comply with these restrictions or face substantial penalties.

In addition, ERISA generally preempts all state and local laws that relate to employee benefit plans, but the extent of the pre-emption continues to be reviewed by courts, including the U.S. Supreme Court. For example, in December 2020, the U.S. Supreme Court upheld an Arkansas law that, among other things, mandates a particular pricing methodology, establishes an appeals process for a pharmacy when the reimbursement is below the pharmacy's acquisition cost, permits a pharmacy to reverse and rebill if they cannot procure the drug from its wholesaler at a price equal to or less than the reimbursement rate, prohibits a PBM from reimbursing a pharmacy less than the amount it reimburses an affiliate on a per unit basis, and permits a pharmacy to decline to dispense if the reimbursement is lower than the pharmacy's acquisition cost.

Other Legislative Initiatives and Regulatory Initiatives - The U.S. federal and state governments, as well as governments in other countries where the Company does business, continue to enact and seriously consider many broad-based legislative and regulatory proposals that have had a material impact on or could materially impact various aspects of the health care and related benefits system and the Company's businesses, operating results and/or cash flows. For example:

- Under the Budget Control Act of 2011 and the American Taxpayer Relief Act of 2012 significant, automatic across-the-board budget cuts (known as sequestration) began in March 2013, including Medicare spending cuts of not more than 2% of total program costs per year through 2024. Since then, Congress has extended and modified sequestration a number of times. Currently, the CARES Act suspended Medicare sequestration from May 2020 to the end of December 2020 and extended mandatory sequestration to 2030. The Consolidated Appropriations Act of 2021 extended the temporary suspension of Medicare sequestration through the end of March 2021. Significant uncertainty remains as to whether and how the U.S. Congress will proceed with actions that create additional federal revenue and/or with entitlement reform. The Company cannot predict future federal Medicare or federal or state Medicaid funding levels or the impact that future federal or state budget actions or entitlement program reform, if it occurs, will have on the Company's businesses, operations or operating results, but the effects could be materially adverse, particularly on the Company's Medicare and/or Medicaid revenues, MBRs and operating results.

- The European Union's ("EU's") General Data Protection Regulation ("GDPR") began to apply across the EU during 2018.
- Other significant legislative and/or regulatory measures which are or recently have been under consideration include the following:
    - Eliminating payment of manufacturer's rebates on prescription drugs to PBMs, PDPs and Managed Medicaid organizations in connection with federally funded health care programs.
    - Imposing requirements and restrictions on the design and/or administration of pharmacy benefit plans offered by the Company's and its clients' health plans and/or its PBM clients and/or the services the Company provides to those clients, including prohibiting "differential" or "spread" pricing in PBM contracts; restricting or eliminating the use of formularies for prescription drugs; restricting the Company's ability to require members to obtain drugs through a home delivery or specialty pharmacy; restricting the Company's ability to place certain specialty or other drugs in the higher cost tiers of its pharmacy formularies; restricting the Company's ability to make changes to drug formularies and/or clinical programs; limiting or eliminating rebates on pharmaceuticals; requiring the use of up front purchase price discounts on pharmaceuticals in lieu of rebates; restricting the Company's ability to configure its health plan and retail pharmacy provider networks, including use of CVS Pharmacy locations; and restricting or eliminating the use of certain drug pricing methodologies.
    - Increasing federal or state government regulation of, or involvement in, the pricing and/or purchasing of drugs.
    - Restricting the Company's ability to limit providers' participation in its networks and/or remove providers from its networks by imposing network adequacy requirements or otherwise (including in its Medicare and Commercial Health Care Benefits products).
    - Imposing assessments on (or to be collected by) health plans or health carriers that may or may not be passed through to their customers. These assessments may include assessments for insolvency, the uninsured, uncompensated care, Medicaid funding or defraying health care provider medical malpractice insurance costs.
    - Mandating coverage by the Company's and its clients' health plans for additional conditions and/or specified procedures, drugs or devices (e.g., high cost pharmaceuticals, experimental pharmaceuticals and oral chemotherapy regimens).
    - Regulating electronic connectivity.
    - Mandating or regulating the disclosure of provider fee schedules, manufacturer's rebates and other data about the Company's payments to providers and/or payments the Company receives from pharmaceutical manufacturers.
    - Mandating or regulating disclosure of provider outcome and/or efficiency information.
    - Prescribing or limiting members' financial responsibility for health care or other covered services they utilize, including restricting "surprise" bills by providers and by specifying procedures for resolving "surprise" bills.
    - Prescribing payment levels for health care and other covered services rendered to the Company's members by providers who do not have contracts with the Company.
    - Assessing the medical device status of HIT products and/or solutions, mobile consumer wellness tools and clinical decision support tools, which may require compliance with FDA requirements in relation to some of these products, solutions and/or tools.
    - Restricting the ability of employers and/or health plans to establish or impose member financial responsibility.
    - Amending or supplementing ERISA to impose greater requirements on PBMs or the administration of employer-funded benefit plans or limit the scope of current ERISA pre-emption, which would among other things expose the Company and other health plans to expanded liability for punitive and other extra-contractual damages and additional state regulation.

It is uncertain whether the Company can counter the potential adverse effects of such potential legislation or regulation on its operating results or cash flows, including whether it can recoup, through higher premium rates, expanded membership or other measures, the increased costs of mandated coverage or benefits, assessments, fees, taxes or other increased costs, including the cost of modifying its systems to implement any enacted legislation or regulations.

The Company's businesses also may be affected by other legislation and regulations. The Dodd-Frank Wall Street Reform and Consumer Protection Act creates incentives for whistleblowers to speak directly to the government rather than utilizing internal compliance programs and reduces the burden of proof under the Foreign Corrupt Practices Act of 1977 (the "FCPA"). There also are laws and regulations that set standards for the escheatment of funds to states.

Health savings accounts, health reimbursement arrangements and flexible spending accounts and certain of the tax, fee and subsidy provisions of the ACA also are regulated by the U.S. Department of the Treasury and the Internal Revenue Service.

The Company also may be adversely affected by court and regulatory decisions that expand or revise the interpretations of existing statutes and regulations or impose medical malpractice or bad faith liability. Federal and state courts, including the U.S. Supreme Court, continue to consider cases, and federal and state regulators continue to issue regulations and interpretations, addressing bad faith liability for denial of medical claims, the scope of ERISA's fiduciary duty requirements, the scope of the False Claims Act and the pre-emptive effect of ERISA on state laws.

Contract Audits - The Company is subject to audits of many of its contracts, including its PBM client contracts, its PBM rebate contracts, its PBM network contracts, its contracts relating to Medicare Advantage and/or Medicare Part D, the agreements the Company's pharmacies enter into with other payors, its Medicaid contracts and its customer contracts. Because some of the Company's contracts are with state or federal governments or with entities contracted with state or federal agencies, audits of these contracts are often regulated by the federal or state agencies responsible for administering federal or state benefits programs, including those which operate Medicaid fee for service plans, Managed Medicaid plans, Medicare Part D plans or Medicare Advantage organizations.

Federal Employee Health Benefits Program - The Company's subsidiaries contract with the Office of Personnel Management (the "OPM") to provide managed health care services under the FEHB program in their service areas. These contracts with the OPM and applicable government regulations establish premium rating arrangements for this program. OPM regulations require that community-rated FEHB plans meet a FEHB program-specific minimum MLR by plan code and market. Managing to these rules is complicated by the simultaneous application of the minimum MLR standards and associated premium rebate requirements of the ACA. The Company also has a contractual arrangement with carriers for the FEHB program, such as the BlueCross BlueShield Association, to provide pharmacy services to federal employees, postal workers, annuitants, and their dependents under the Government-wide Service Benefit Plan, as authorized by the FEHB Act and as part of the FEHB program. Additionally, the Company manages certain FEHB plans on a "cost-plus" basis. These arrangements subject the Company to certain aspects of the FEHB Act, and other federal regulations, such as the FEHB Acquisition Regulation, that otherwise would not be applicable to the Company. The OPM also is auditing the Company and its other contractors to, among other things, verify that plans meet their applicable FEHB program-specific MLR and the premiums established under the OPM's Insured contracts and costs allocated pursuant to the OPM's cost-based contracts are in compliance with the requirements of the applicable FEHB program. The OPM may seek premium refunds or institute other sanctions against the Company if it fails to comply with the FEHB program requirements.

Clinical Services Regulation - The Company provides clinical services to health plans, PBMs and providers for a variety of complex and common medical conditions, including arranging for certain members to participate in disease management programs. State laws regulate the practice of medicine, the practice of pharmacy, the practice of nursing and certain other clinical activities. Clinicians engaged in a professional practice in connection with the provision of clinical services must satisfy applicable state licensing requirements and must act within their scope of practice.

Third Party Administration and Other State Licensure Laws - Many states have licensure or registration laws governing certain types of administrative organizations, such as PPOs, TPAs and companies that provide utilization review services. Several states also have licensure or registration laws governing the organizations that provide or administer consumer card programs (also known as cash card or discount card programs).

International Regulation - The Company has insurance licenses in several foreign jurisdictions and does business directly or through local affiliations in numerous countries around the world. The Company has taken steps to be able to continue to serve customers in the European Economic Area following the United Kingdom's exit from the EU ("Brexit"). However, the impact of Brexit on the Company's international business and operating results is uncertain.

The Company's international operations are subject to different, and sometimes more stringent, legal and regulatory requirements, which vary widely by jurisdiction, including anti-corruption laws; economic sanctions laws; various privacy, insurance, tax, tariff and trade laws and regulations; corporate governance, privacy, data protection (including the EU's General Data Protection Regulation which began to apply across the EU during 2018), data mining, data transfer, labor and employment, intellectual property, consumer protection and investment laws and regulations; discriminatory licensing procedures; compulsory cessions of reinsurance; required localization of records and funds; higher premium and income taxes; limitations on dividends and repatriation of capital; and requirements for local participation in an insurer's ownership. In addition, the expansion of the Company's operations into foreign countries increases the Company's exposure to the anti-bribery, anti-corruption and anti-money laundering provisions of U.S. law, including the FCPA, and corresponding foreign laws, including the U.K. Bribery Act 2010 (the "UK Bribery Act").

Anti-Corruption Laws - The FCPA prohibits offering, promising or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage. The Company also is subject to applicable anti-corruption laws of the jurisdictions in which it operates. In many countries outside the United States, health care professionals are employed by the government. Therefore, the Company's dealings with them are subject to regulation under the FCPA. Violations of the FCPA and other anti-corruption laws may result in severe criminal and civil sanctions as well as other penalties, and there continues to be a heightened level of FCPA enforcement activity by the U.S. Securities and Exchange Commission (the "SEC") and the DOJ. The UK Bribery Act is an anti-corruption law that is broader in scope than the FCPA and applies to all companies with a nexus to the United Kingdom. Disclosures of FCPA violations may be shared with the UK authorities, thus potentially exposing companies to liability and potential penalties in multiple jurisdictions.

Anti-Money Laundering Regulations - Certain lines of the Company's businesses are subject to Treasury anti-money laundering regulations. Those lines of business have implemented anti-money laundering policies designed to ensure their compliance with the regulations. The Company also is subject to anti-money laundering laws in non-U.S. jurisdictions where it operates.

Office of Foreign Assets Control - The Company also is subject to regulation by the Office of Foreign Assets Control of the U.S. Department of Treasury ("OFAC"). OFAC administers and enforces economic and trade sanctions based on U.S. foreign policy and national security goals against targeted foreign countries and regimes, terrorists, international narcotics traffickers, those engaged in activities related to the proliferation of weapons of mass destruction, and other threats to the national security, foreign policy or economy of the United States. In addition, the Company is subject to similar regulations in the non-U.S. jurisdictions in which it operates.

FDA Regulation - The FDA regulates the Company's compounding pharmacy and clinical research operations. The FDA also generally has authority to, among other things, regulate the manufacture, distribution, sale and labeling of medical devices (including hemodialysis devices such as the device the Company is developing and mobile medical devices) and many products sold through retail pharmacies, including prescription drugs, over-the-counter medications, cosmetics, dietary supplements and certain food items. In addition, the FDA regulates the Company's activities as a distributor of store brand products.

Laws and Regulations Related to the Pharmacy Services Segment

In addition to the laws and regulations discussed above that may affect multiple segments of the Company's business, the Company is subject to federal, state and local statutes and regulations governing the operation of its Pharmacy Services segment specifically. Among these are the following:

PBM Laws and Regulation - Legislation and/or regulations seeking to regulate PBM activities in a comprehensive manner have been proposed or enacted in a number of states. This legislation could adversely affect the Company's ability to conduct business on commercially reasonable terms in states where the legislation is in effect and the Company's ability to standardize its PBM products and services across state lines. In addition, certain quasi-regulatory organizations, including the National Association of Boards of Pharmacy and the National Association of Insurance Commissioners ("NAIC") and the National Council of Insurance Legislators, have issued model regulations or may propose future regulations concerning PBMs and/or PBM activities. Similarly, credentialing organizations such as NCQA and URAC may establish voluntary standards regarding PBM, mail order pharmacy and/or specialty pharmacy activities. While the actions of these quasi-regulatory or standard-setting organizations do not have the force of law, they may influence states to adopt their requirements or recommendations and influence client requirements for PBM, mail order pharmacy and/or specialty pharmacy services. Moreover, any standards established by these organizations could also impact the Company's health plan clients and/or the services provided to those clients and/or the Company's health plans.

The Company's PBM activities also are regulated directly and indirectly at the federal and state levels, including being subject to the False Claims Act and state false claims acts and the AKS and state anti-kickback laws. These laws and regulations govern, and proposed legislation and regulations may govern and/or further restrict, critical PBM practices, including disclosure, receipt and retention of rebates and other payments received from pharmaceutical manufacturers; use of, administration of and/or changes to drug formularies, maximum allowable cost ("MAC") list pricing, average wholesale prices ("AWP") and/or clinical programs; the offering to plan sponsors of pricing that includes retail network "differential" or "spread" (i.e., a difference between the drug price charged to the plan sponsor by a PBM and the price paid by the PBM to the dispensing provider); disclosure of data to third parties; drug UM practices; the level of duty a PBM owes its customers; configuration of pharmacy networks; the operations of the Company's pharmacies (including audits of its pharmacies); disclosure of negotiated provider reimbursement rates; disclosure of fees associated with administrative service agreements and patient care programs that are attributable to members' drug utilization; and registration or licensing of PBMs. Failure by the

Company or one of its PBM services suppliers to comply with these laws or regulations could result in material fines and/or sanctions and could have a material adverse effect on the Company's operating results and/or cash flows.

The Company's PBM service contracts, including those in which the Company assumes certain risks under performance guarantees or similar arrangements, are generally not subject to insurance regulation by the states. However, state departments of insurance are increasing their oversight of PBM activities due to legislation passing in a number of states requiring PBMs to register or obtain a license with the department. Rulemaking is either underway or has already taken place in a number of states with the areas of focus on licensure requirements, pharmacy reimbursement for generics (MAC reimbursement) and pharmacy audits - most of which fall under the state insurance code.

Most-Favored-Nations Rule - In November 2020, HHS released the Most-Favored-Nations Rule (the "MFN Rule"), which requires CMS to take a most-favored-nation approach in calculating payment for Medicare Part B drugs. The MFN Rule will test paying Part B drugs at comparable amounts to the lowest adjusted price paid by any country in the Organization for Economic Co-operation and Development that has a Gross Domestic Product ("GDP") per capita that is at least 60% of the U.S. GDP per capita. The MFN Rule will also test a redesign of the percentage add-on payment structure under Medicare Part B to remove incentives for use of higher-cost drugs through a flat per-dose add-on payment, and will include a financial hardship exemption for participants. The mandatory MFN Rule will operate for seven years, from January 1, 2021 to December 31, 2027. Over the course of the model, CMS will monitor and evaluate the impact of the MFN Rule on beneficiary access to drugs, program costs, and the quality of care for beneficiaries. Further, CMS commits to assess initial impacts of the MFN Rule on quality of care, including access to drugs, prior to beginning performance year 5. Multiple pharmaceutical manufacturers have sued HHS over the rule, and it is currently delayed due to a temporary restraining order prohibiting CMS from implementing it. If implemented, the MFN Rule may impact the ability of the Company to negotiate drug prices and provide competitive products and services to consumers.

Pharmacy Network Access Legislation - Medicare Part D and a majority of states now have some form of legislation affecting the Company's (and its health plans' and its health plan clients') ability to limit access to a pharmacy provider network or remove pharmacy network providers. For example, certain "any willing provider" legislation may require the Company or its clients to admit a nonparticipating pharmacy if such pharmacy is willing and able to meet the plan's price and other applicable terms and conditions for network participation. These laws could negatively affect the services and economic benefits achievable through a limited pharmacy provider network. Also, a majority of states now have some form of legislation affecting the Company's ability (and the Company's and its client health plans' ability) to conduct audits of network pharmacies regarding claims submitted to the Company for payment. These laws could negatively affect the Company's ability to recover overpayments of claims submitted by network pharmacies that the Company identifies through pharmacy audits.

Pharmacy Pricing Legislation - A number of states have passed legislation regulating the Company's ability to manage and establish MACs for generic prescription drugs. MAC methodology is a common cost management practice used by private and public payors (including CMS) to pay pharmacies for dispensing generic prescription drugs. MAC prices specify the allowable reimbursement by a PBM for a particular strength and dosage of a generic drug that is available from multiple manufacturers but sold at different prices. State legislation can regulate the disclosure of MAC prices and MAC price methodologies, the kinds of drugs that a PBM can pay for at a MAC price, and the rights of pharmacies to appeal a MAC price established by a PBM. These laws could negatively affect the Company's ability to establish MAC prices for generic drugs.

Formulary and Plan Design Regulation - A number of government entities regulate the administration of prescription drug benefits. HHS regulates how Medicare Part D formularies are developed and administered, including requiring the inclusion of all drugs in certain classes and categories, subject to limited exceptions. Under the ACA, CMS imposes drug coverage requirements for health plans required to cover essential health benefits, including plans offered through federal or state Public Exchanges. Additionally, the NAIC and health care accreditation agencies like NCQA and URAC have developed model acts and standards for formulary development that are often incorporated into government requirements. Many states regulate the scope of prescription drug coverage, as well as the delivery channels to receive prescriptions, for insurers, MCOs and Medicaid managed care plans. The increasing government regulation of formularies could significantly affect the Company's ability to develop and administer formularies, pharmacy networks and other plan design features on behalf of its insurer, MCO and other clients. Similarly, some states prohibit health plan sponsors from implementing certain restrictive pharmacy benefit plan design features. This regulation could limit or preclude (i) limited networks, (ii) a requirement to use particular providers, (iii) copayment differentials among providers and (iv) formulary tiering practices.

Laws and Regulations Related to the Retail/LTC Segment

In addition to the laws and regulations discussed above that may affect multiple segments of the Company's business, the Company is subject to federal, state and local statutes and regulations governing the operation of its Retail/LTC segment specifically. Among these are the following:

Retail Medical Clinics - States regulate retail medical clinics operated by nurse practitioners or physician assistants through physician oversight, clinic and lab licensure requirements and the prohibition of the corporate practice of medicine. A number of states have implemented or proposed laws or regulations that impact certain components of retail medical clinic operations such as physician oversight, signage, third party contracting requirements, bathroom facilities, and scope of services. These laws and regulations may affect the operation and expansion of the Company's owned and managed retail medical clinics.

Other Laws - Other federal, state and local laws and regulations also impact the Company's retail operations, including laws and regulations governing the practice of optometry, the practice of audiology, the provision of dietician services and the sale of durable medical equipment, contact lenses, eyeglasses, hearing aids and alcohol.

Laws and Regulations Related to the Health Care Benefits Segment

In addition to the laws and regulations discussed above that may affect multiple segments of the Company's business, the Company is subject to federal, state, local and international statutes and regulations governing its Health Care Benefits segment specifically.

Overview - Differing approaches to state insurance regulation and varying enforcement philosophies may materially and adversely affect the Company's ability to standardize its Health Care Benefits products and services across state lines. These laws and regulations, including the ACA, restrict how the Company conducts its business and result in additional burdens and costs to the Company. Significant areas of governmental regulation include premium rates and rating methodologies, underwriting rules and procedures, required benefits, sales and marketing activities, provider rates of payment, restrictions on health plans' ability to limit providers' participation in their networks and/or remove providers from their networks and financial condition (including reserves and minimum capital or risk based capital requirements). These laws and regulations are different in each jurisdiction and vary from product to product.

Each health insurer and HMO must file periodic financial and operating reports with the states in which it does business. In addition, health insurers and HMOs are subject to state examination and periodic license renewal. Applicable laws also restrict the ability of the Company's regulated subsidiaries to pay dividends, and certain dividends require prior regulatory approval. In addition, some of the Company's businesses and related activities may be subject to PPO, MCO, utilization review or TPA-related licensure requirements and regulations. These licensure requirements and regulations differ from state to state, but may contain provider network, contracting, product and rate, financial and reporting requirements. There also are laws and regulations that set specific standards for the Company's delivery of services, payment of claims, fraud prevention, protection of consumer health information, and payment for covered benefits and services.

Required Regulatory Approvals - The Company must obtain and maintain regulatory approvals to price, market and administer many of its Health Care Benefits products. Supervisory agencies, including CMS, the Center for Consumer Information and Insurance Oversight and the DOL, as well as state health, insurance, managed care and Medicaid agencies, have broad authority to take one or more of the following actions:

- Grant, suspend and revoke the Company's licenses to transact business;
- Suspend or exclude the Company from participation in government programs;
- Suspend or limit the Company's authority to market products;
- Regulate many aspects of the products and services the Company offers, including the pricing and underwriting of many of its products and services;
- Assess damages, fines and/or penalties;
- Terminate the Company's contract with the government agency and/or withhold payments from the government agency to the Company;
- Impose retroactive adjustments to premiums and require the Company to pay refunds to the government, customers and/or members;
- Restrict the Company's ability to conduct acquisitions or dispositions;

- Require the Company to maintain minimum capital levels in its subsidiaries and monitor its solvency and reserve adequacy;
- Regulate the Company's investment activities on the basis of quality, diversification and other quantitative criteria; and/or
- Exclude the Company's plans from participating in Public Exchanges if they are deemed to have a history of "unreasonable" premium rate increases or fail to meet other criteria set by HHS or the applicable state.

The Company's operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time the Company receives subpoenas and other requests for information from, federal, state and international supervisory and enforcement agencies, attorneys general and other state, federal and international governmental authorities and legislators.

Commercial Product Pricing and Underwriting Restrictions - Pricing and underwriting regulation by states limits the Company's underwriting and rating practices and those of other health insurers, particularly for small employer groups, and varies by state. In general, these limitations apply to certain customer segments and limit the Company's ability to set prices for new or renewing groups, or both, based on specific characteristics of the group or the group's prior claim experience. In some states, these laws and regulations restrict the Company's ability to price for the risk it assumes and/or reflect reasonable costs in the Company's pricing.

The ACA expanded the premium rate review process by, among other things, requiring the Company's Commercial Insured rates to be reviewed for "reasonableness" at either the state or the federal level. HHS established a federal premium rate review process that generally applies to proposed premium rate increases equal to or exceeding a federally (or lower state) specified threshold. HHS's rate review process imposes additional public disclosure requirements as well as additional review on filings requesting premium rate increases equal to or exceeding this "reasonableness" threshold. These combined state and federal review requirements may prevent, further delay or otherwise affect the Company's ability to price for the risk it assumes, which could adversely affect its MBRs and operating results, particularly during periods of increased utilization of medical services and/or medical cost trend or when such utilization and/or trend exceeds the Company's projections.

The ACA also specifies minimum MLRs of 85% for large group Commercial products and 80% for individual and small group Commercial products. Because the ACA minimum MLRs are structured as "floors" for many of their requirements, states have the latitude to enact more stringent rules governing these restrictions. For Commercial products, states have and may adopt higher minimum MLR requirements, use more stringent definitions of "medical loss ratio," incorporate minimum MLR requirements into prospective premium rate filings, require prior approval of premium rates or impose other requirements related to minimum MLR. Minimum MLR requirements and similar actions further limit the level of margin the Company can earn in its Insured Commercial products while leaving the Company exposed to medical costs that are higher than those reflected in its pricing. The Company also may be subject to significant fines, penalties, premium refunds and litigation if it fails to comply with minimum MLR laws and regulations.

In addition, the Company requested increases in its premium rates in its Commercial Health Care Benefits business for 2020 (including as a result of the reinstatement of the HIF for 2020 following the temporary suspension of the HIF for 2019) and expects to continue to request increases in those rates for 2021 and beyond in order to adequately price for projected medical cost trends, required expansions of coverage and rating limits, and significant assessments, fees and taxes imposed by the federal and state governments, including as a result of the ACA. The Company's rates also must be adequate to reflect adverse selection in its products, particularly in small group Commercial products. These rate increases may be significant and thus heighten the risks of adverse publicity, adverse regulatory action and adverse selection and the likelihood that the Company's requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.

Many of the laws and regulations governing the Company's pricing and underwriting practices also limit the differentials in premium rates insurers and other carriers may charge between new and renewal business, and/or between groups based on differing characteristics. They may also require that carriers disclose to customers the basis on which the carrier establishes new business and renewal premium rates and limit the ability of a carrier to terminate customers' coverage.

Medicaid Regulation - The Company is seeking to substantially grow its Medicaid, dual eligible and dual eligible special needs plan businesses over the next several years. As a result, the Company also is increasing its exposure to changes in government policy with respect to and/or regulation of the various Medicaid, dual eligible and dual eligible special needs plan programs in which the Company participates, including changes in the amounts payable to the Company under those programs.

Since 2017, Managed Medicaid products, including those the Company offers, are subject to a minimum federal MLR of 85%. A Medicaid managed care quality rating system and provider network adequacy requirements also apply to Medicaid products. Because the federal minimum MLR is structured as a "floor," states have the latitude to enact more stringent rules governing these restrictions. For Managed Medicaid products, states may adopt higher minimum MLR requirements, use more stringent definitions of "medical loss ratio" or impose other requirements related to minimum MLR. Minimum MLR requirements and similar actions further limit the level of margin the Company can earn in its Insured Medicaid products while leaving the Company exposed to medical costs that are higher than those reflected in its pricing. The Company also may be subject to significant fines, penalties, premium refunds and litigation if it fails to comply with minimum MLR laws and regulations.

The future of the ACA, and the impact of Medicaid expansion under the ACA, are uncertain. States may opt out of the elements of the ACA requiring expansion of Medicaid coverage without losing their current federal Medicaid funding. To date, a number of states and the District of Columbia have expanded Medicaid coverage to the higher eligibility levels contemplated by the ACA. In addition, the election of new governors and/or state legislatures may impact states' previous decisions regarding Medicaid expansion. Proposals for substantial changes to federal funding of state Medicaid programs are likely to be considered in 2020 and beyond, including the possibility of converting federal Medicaid support to block grants (such as the block grant option outlined by CMS on January 30, 2020) and per capita caps on federal funding. Uncertainty regarding federal funding is causing and will continue to cause states to re-evaluate their Medicaid expansions and consider new assessments, fees and/or taxes on health plans. That re-evaluation and any changes to federal funding of state Medicaid programs may adversely affect Medicaid payment rates, the Company's revenues and its Medicaid membership.

The economic aspects of the Medicaid, dual eligible and dual eligible special needs plan business vary from state to state and are subject to frequent change. Medicaid premiums are paid by each state and differ from state to state. The federal government and certain states also are considering proposals and legislation for Medicaid and dual eligible program reforms or redesigns, including restrictions on the collection of manufacturer's rebates on pharmaceuticals by Medicaid MCOs and their contracted PBMs, further program, population and/or geographic expansions of risk-based managed care, increasing beneficiary cost-sharing or payment levels, and changes to benefits, reimbursement, eligibility criteria, provider network adequacy requirements (including requiring the inclusion of specified high cost providers in the Company's networks) and program structure. In some states, current Medicaid and dual eligible funding and premium revenue may not be adequate for the Company to continue program participation. The Company's Medicaid and dual eligible contracts with states (or sponsors of Medicaid managed care plans) are subject to cancellation by the state (or the sponsors of the managed care plans) after a short notice period without cause (e.g., when a state discontinues a managed care program) or in the event of insufficient state funding.

The Company's Medicaid, dual eligible and dual eligible special needs plan products also are heavily regulated by CMS and state Medicaid agencies, which have the right to audit the Company's performance to determine compliance with CMS contracts and regulations. The Company's Medicaid products, dual eligible products and CHIP contracts also are subject to complex federal and state regulations and oversight by state Medicaid agencies regarding the services provided to Medicaid enrollees, payment for those services, network requirements (including mandatory inclusion of specified high-cost providers), and other aspects of these programs, and by external review organizations which audit Medicaid plans on behalf of state Medicaid agencies. The laws, regulations and contractual requirements applicable to the Company and other participants in Medicaid and dual eligible programs, including requirements that the Company submit encounter data to the applicable state agency, are extensive, complex and subject to change. The Company has invested significant resources to comply with these standards, and its Medicaid and dual eligible program compliance efforts will continue to require significant resources. CMS and/or state Medicaid agencies may fine the Company, withhold payments to the Company, seek premium and other refunds, terminate the Company's existing contracts, elect not to award the Company new contracts or not to renew the Company's existing contracts, prohibit the Company from continuing to market and/or enroll members in or refuse to automatically assign members to one or more of the Company's Medicaid or dual eligible products, exclude the Company from participating in one or more Medicaid or dual eligible programs and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with CMS or state regulations or contractual requirements.

The Company cannot predict whether pending or future federal or state legislation or court proceedings will change various aspects of the Medicaid program, nor can it predict the impact those changes will have on its business operations or operating results, but the effects could be materially adverse.

Federal and State Reporting - The Company is subject to extensive financial and business reporting requirements, including penalties for inaccuracies and/or omissions, at both the federal and state level. The Company's ability to comply with certain of these requirements depends on receipt of information from third parties that may not be readily available or reliably provided in all instances. The Company is and will continue to be required to modify its information systems, dedicate significant resources

and incur significant expenses to comply with these requirements. However, the Company cannot eliminate the risks of unavailability of or errors in its reports.

Product Design and Administration and Sales Practices - State and/or federal regulatory scrutiny of health care benefit product design and administration and marketing and advertising practices, including the filing of insurance policy forms, the adequacy of provider networks, the accuracy of provider directories, and the adequacy of disclosure regarding products and their administration, is increasing as are the penalties being imposed for inappropriate practices. Medicare, Medicaid and dual eligible products and products offering more limited benefits in particular continue to attract increased regulatory scrutiny.

Guaranty Fund Assessments/Solvency Protection - Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. The Company's assessments generally are based on a formula relating to the Company's health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer governed health plans established under the ACA. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that limit future offsets.

Available Information

CVS Health Corporation was incorporated in Delaware in 1996. The corporate office is located at One CVS Drive, Woonsocket, Rhode Island 02895, telephone (401) 765-1500. CVS Health's common stock is listed on the New York Stock Exchange under the trading symbol "CVS." General information about the Company is available through the Company's website at *http://www.cvshealth.com*. The Company's financial press releases and filings with the SEC are available free of charge within the Investors section of the Company's website at *http://investors.cvshealth.com*. In addition, the SEC maintains an internet site that contains reports, proxy and information statements and other information regarding issuers, such as the Company, that file electronically with the SEC. The address of that website is *http://www.sec.gov.* The information on or linked to the Company's website is neither a part of nor incorporated by reference in this 10-K or any of the Company's other SEC filings.

In accordance with guidance provided by the SEC regarding use by a company of its websites and social media channels as a means to disclose material information to investors and to comply with its disclosure obligations under SEC Regulation FD, CVS Health Corporation (the "Registrant") hereby notifies investors, the media and other interested parties that it intends to continue to use its media and investor relations website (*http://investors.cvshealth.com/*) and its Twitter feed (@CVSHealthIR) to publish important information about the Registrant, including information that may be deemed material to investors. The list of social media channels that the Registrant uses may be updated on its media and investor relations website from time to time. The Registrant encourages investors, the media, and other interested parties to review the information the Registrant posts on its website and social media channels as described above, in addition to information announced by the Registrant through its SEC filings, press releases and public conference calls and webcasts.

Item 1A. Risk Factors.

You should carefully consider each of the following risks and uncertainties and all of the other information set forth in this 10-K. These risks and uncertainties and other factors may affect forward-looking statements, including those we make in this 10-K or elsewhere, such as in news releases or investor or analyst calls, meetings or presentations, on our websites or through our social media channels. The risks and uncertainties described below are not the only ones we face. There can be no assurance that we have identified all the risks that affect us. Additional risks and uncertainties not presently known to us or that we currently believe to be immaterial also may adversely affect our businesses. Any of these risks or uncertainties could cause our actual results to differ materially from our expectations and the expected results discussed in our forward-looking statements. You should not consider past results to be an indication of future performance.

If any of the following risks or uncertainties develops into actual events or if the circumstances described in the risks or uncertainties occur or continue to occur, those events or circumstances could have a material adverse effect on our businesses, operating results, cash flows, financial condition and/or stock price, among other effects on us. You should read the following section in conjunction with the MD&A, included in Item 7 of this 10-K, our consolidated financial statements and the related notes, included in Item 8 of this 10-K, and our "Cautionary Statement Concerning Forward-Looking Statements" in this 10-K.

Summary

The following is a summary of the principal risks we face:

Risks Related to COVID-19

- The impact of COVID-19 on our businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be material and adverse.
- The impact of COVID-19 and the related testing and vaccination may result in us not being able to accurately forecast health care and other benefit costs, and we are uncertain that future health care and other benefits costs will not exceed our projections.

Risks Relating to Our Businesses

- Each of our segments operates in a highly competitive and evolving business environment.
- A change in our Health Care Benefits product mix may adversely affect our profit margins.
- Negative public perception of the industries in which we operate can adversely affect our businesses, operating results, cash flows and prospects.
- Failure to maintain or improve our relationships with our retail and specialty pharmacy customers may adversely affect our operating results.
- We face risks relating to the availability, pricing and safety profiles of prescription drugs that we purchase and sell.
- We may not be able to accurately forecast health care and other benefit costs.
- If actual claims in our Insured Health Care Benefits products exceed our estimates, our operating results could be materially adversely affected, and our ability to take timely corrective actions to limit future costs may be limited.
- We are exposed to risks relating to the solvency of other insurers.

Risks From Changes in Public Policy and Other Legal and Regulatory Risks

- We are subject to potential changes in public policy, laws and regulations, including reform of the U.S. health care system, which can adversely affect our businesses.
- If we fail to comply with applicable laws and regulations, we could be subject to significant adverse regulatory actions or suffer brand and reputational harm.
- If our compliance or other systems and processes fail or are deemed inadequate, we may suffer brand and reputational harm and become subject to regulatory actions and/or litigation.
- The litigation and other adverse legal proceedings that we face are costly to defend, may result in changes in our business practices, harm our brand and reputation and adversely affect our businesses and operating results.
- The governmental audits, investigations and reviews to which we are subject could result in changes to our business practices and also could result in material refunds, fines, penalties, civil and/or criminal liabilities and other sanctions.
- Our litigation and regulatory risk profile are changing as we offer new products and services.
- We face unique regulatory and other challenges in our Medicare and Medicaid businesses.
- Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues, and we expect that percentage to increase.
- We may not be able to obtain adequate premium rate increases in our Insured Health Care Benefits products, which would have an adverse effect on our revenues, MBRs and operating results.
- Minimum MLR rebate requirements limit the level of margin we can earn in our Insured Health Care Benefits products while leaving us exposed to higher than expected medical costs.
- Our operating results may be adversely affected by changes in laws and policies governing employers and by union organizing activity.

Risks Associated with Mergers, Acquisitions, and Divestitures

- We may be unable to successfully integrate companies we acquire.

- The acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities we pursue may be unsuccessful.
- In order to complete a proposed acquisition, we may be required to divest certain portions of our business, for which we may not be able to obtain favorable pricing.

Risks Related to Our Operations

- Failure to meet customer expectations may harm our brand and reputation, our ability to retain and grow our customer base and membership and our operating results and cash flows.
- We can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of cyber attacks or other information security (including cybersecurity) risks or threats in the future.
- Our use and disclosure of members', customers' and other constituents' sensitive information is subject to complex regulations at multiple levels, and we would be adversely affected if we or our business associates or other vendors fail to adequately protect members', customers' or other constituents' sensitive information.
- Product liability, product recall or personal injury issues could damage our reputation and have a significant adverse effect on our businesses, operating results, cash flows and/or financial condition.
- We face significant competition in attracting and retaining talented employees, and managing succession for, and retention of, key executives is critical to our success.
- Sales of our products and services are dependent on our ability to attract and motivate internal sales personnel and independent third-party brokers, consultants and agents.
- Failure of our businesses to effectively collaborate could prevent us from maximizing our operating results.
- The failure or disruption of our information technology systems or infrastructure to support our businesses could adversely affect our reputation, businesses, operating results and cash flows.
- Pursuing multiple initiatives simultaneously presents challenges to maintaining, continuing to develop and improve an effective information technology system.
- We are subject to payment-related risks that could increase our operating costs, expose us to fraud or theft, subject us to potential liability and disrupt our business operations.
- Both our and our vendors' operations are subject to a variety of business continuity hazards and risks.

Financial Risks

- We would be adversely affected if we do not effectively deploy our capital. Downgrades or potential downgrades in our credit ratings could adversely affect our brand and reputation, businesses, operating results, cash flows and financial condition.
- Goodwill and other intangible assets could, in the future, become impaired.
- Adverse conditions in the U.S. and global capital markets can significantly and adversely affect the value of our investments.
- Our significant indebtedness has increased our consolidated interest expense and could adversely affect our business flexibility and increase our borrowing costs.

Risks Related to Our Relationships with Manufacturers, Providers, Suppliers and Vendors

- We face risks relating to the market availability, pricing, suppliers and safety profiles of prescription drugs and other products that we purchase and sell.
- Our operating results may be adversely affected if we are unable to contract with providers on competitive terms and develop and maintain attractive networks with high quality providers.
- If our service providers fail to meet their contractual obligations to us or to comply with applicable laws or regulations, we may be exposed to brand and reputational harm, litigation and/or regulatory action.
- We may experience increased medical and other benefit costs, litigation risk and customer and member dissatisfaction when providers that do not have contracts with us render services to our Health Care Benefits members.
- Continuing consolidation and integration among providers and other suppliers may increase our medical and other covered benefits costs, make it difficult for us to compete in certain geographies and create new competitors.

Risks Related to COVID-19

The spread of, impact of and response to COVID-19 underscores and amplifies certain risks we face. The impact COVID-19 will have on our businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be material and adverse.

COVID-19 has spread to every state in the U.S., has been declared a pandemic by the World Health Organization and has severely impacted, and is expected to continue to severely impact, the economies of the U.S. and other countries around the world.

The legislative and regulatory environment governing our businesses is dynamic and changing frequently, including the Families First Act, the CARES Act and mandated increases to the medical services we must pay for without a corresponding increase in the premiums we receive in our Health Care Benefits Insured products. As a result of COVID-19, including legislative and/or regulatory responses to COVID-19, the premiums we charge in our Insured Health Care Benefits products may prove to be insufficient to cover the cost of medical services delivered to our Insured medical members, which may increase significantly as a result of higher utilization rates of medical facilities and services and other increases in associated hospital and pharmaceutical costs.

Federal, state and local governmental policies and initiatives to reduce the transmission of COVID-19, including shelter-in-place orders and social distancing directives, may not effectively combat the severity and/or duration of the COVID-19 pandemic and have resulted in, among other things, a reduction in utilization that is discretionary, the cancellation of elective medical procedures, reduced customer traffic and front store sales in our retail pharmacies, our customers being ordered to close or severely curtail their operations, the adoption of work-from-home policies and a reduction in diagnostic reporting due to reductions in health care provider visits and restrictions on our access to providers' medical records, all of which impact our businesses. Among other impacts of these policies and initiatives on our businesses, we expect changes in medical claims submission patterns and an adverse impact on (i) drug utilization due to the reduction in discretionary visits with providers; (ii) front store sales as a result of reduced customer traffic in our retail pharmacies due to shelter-in-place orders and COVID-19 related unemployment; (iii) medical membership in our Health Care Benefits segment and covered lives in our PBM clients due to reductions in workforce at our existing customers (including due to business failures) as well as reduced willingness to change benefits providers by prospective customers; (iv) benefit costs due to COVID-19 related support programs we have put in place for our medical members and mandated increases to the medical services we must pay for without a corresponding increase in the premiums we receive in our Insured Health Care Benefits products; and (v) the amount, timing and collectability of payments to the Company from customers, clients, government payers and members as a result of the impact of COVID-19 on them. Over time, these policies and initiatives also may cause us to experience increased benefit costs and/or decreased revenues in our Health Care Benefits segment if, as a result of our medical members not seeing their providers as a result of COVID-19, we are unable to implement clinical initiatives to manage benefit costs and chronic conditions of our medical members and appropriately document their risk profiles.

In addition, in response to COVID-19, during the first half of 2020, we began to offer our medical members expanded benefit coverage and became obligated by governmental action to provide other additional coverage. This expanded benefit coverage is being provided without a corresponding increase in the premiums we receive in our Insured Health Care Benefits products. We also are taking actions designed to help provide financial and administrative relief for the health care provider community. Such measures and any further steps we take or are required to take to expand or otherwise modify the services delivered to our Health Care Benefits members, provide relief for the health care provider community, or in connection with the relaxation of shelter-in-place orders and social distancing directives and other restrictions on movement and economic activity intended to reduce the spread of COVID-19, including the potential for widespread testing and vaccination, as a component of lifting those measures, could adversely impact our benefit costs, MBR and operating results.

The various initiatives we have implemented to slow and/or reduce the impact of COVID-19, such as colleagues working remotely and installing protective equipment in our retail pharmacies, and the COVID-19-related support programs we have put in place for our customers, medical members and colleagues have increased our operating expenses and reduced the efficiency of our operations. Our operating results will continue to be adversely affected so long as these initiatives continue or if they are expanded. In addition, the adverse economic conditions in the U.S. and abroad caused by COVID-19 have had, and may continue to have, an adverse impact on our net investment income and the value of our investment portfolio.

The spread of COVID-19, or actions taken to mitigate its spread, could have material and adverse effects on our ability to operate our businesses effectively, including as a result of the complete or partial closure of facilities, labor shortages and/or financial difficulties experienced by third-party service providers. Disruptions in our supply chains, our distribution chains and/

or public and private infrastructure, including communications and financial services, could materially and adversely impact our business operations. We have transitioned a significant subset of our colleagues to a remote work environment in an effort to mitigate the spread of COVID-19, as have a significant number of our third-party service providers, which may amplify certain risks to our businesses, including an increased demand for information technology resources, increased risk of phishing and other cybersecurity attacks, increased risk of unauthorized dissemination of sensitive personal information or proprietary or confidential information about us or our medical members or other third-parties and increased risk of business interruptions.

While the FDA has authorized some COVID-19 vaccines for emergency use, the COVID-19 pandemic continues to evolve and the severity and duration of the pandemic and scope and intensity of the governmental response to it are unknown at this time. We believe COVID-19's impact on our businesses, operating results, cash flows and/or financial condition primarily will be driven by the geographies impacted and the severity and duration of the pandemic; the pandemic's impact on the U.S. and global economies and consumer behavior and health care utilization patterns; and the timing, scope and impact of stimulus legislation as well as other federal, state and local governmental responses to the pandemic. Those primary drivers are beyond our knowledge and control. As a result, the impact COVID-19 will have on our businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be adverse and material. COVID-19 also may result in legal and regulatory proceedings, investigations and claims against us.

A number of factors, many of which are beyond our control, including COVID-19 and related testing and vaccination, contribute to rising health care and other benefit costs. We may not be able to accurately forecast health care and other benefit costs, which could adversely affect our Health Care Benefits segment's operating results. There can be no assurance that future health care and other benefits costs will not exceed our projections.

As a result of COVID-19, the current economic environment is adverse and less predictable than recently experienced, which has caused and may continue to cause unanticipated and significant volatility in our health care and other benefits costs, including COVID-19 related testing and vaccination and post-acute care skilled nursing facility and behavioral health costs. On January 21, 2021, the President of the United States issued an executive order to support government efforts to expand access, availability and use of COVID-19 diagnostic, screening and surveillance and addressed the cost of COVID-19 testing by facilitating COVID-19 testing free of charge to those who lack comprehensive health insurance and clarifying group health plans' and health insurance issuers' obligations to provide coverage for COVID-19 testing. In addition, the timing of vaccine administration to the general public and related costs as well as the identification of new, more infectious strains of the COVID-19 virus and whether the vaccines will be effective against such new strains are uncertain and may impact our MBR. Premiums for our Insured Health Care Benefits products, which comprised 92% of our Health Care Benefits revenues for 2020, are priced in advance based on our forecasts of health care and other benefit costs during a fixed premium period, which is generally twelve months. These forecasts are typically developed several months before the fixed premium period begins, are influenced by historical data (and recent historical data in particular), are dependent on our ability to anticipate and detect medical cost trends and changes in our members' behavior and health care utilization patterns and medical claim submission patterns and require a significant degree of judgment. For example, our revenue on Medicare policies is based on bids submitted in June of the year before the contract year. Cost increases in excess of our projections cannot be recovered in the fixed premium period through higher premiums. As a result, our profits are particularly sensitive to the accuracy of our forecasts of the increases in health care and other benefit costs that we expect to occur and our ability to anticipate and detect medical cost trends. For 2021, those forecasts include adjustments made to pricing based on prospective expectations for liabilities due to testing, vaccines, direct COVID-19 treatment and deferred care. Risk-adjusted revenue has been adjusted for deferred care, and forecasted enrollment considers assumptions about the economic environment, though COVID-19 related impacts remain uncertain. During periods such as 2020 and 2021 when health care and other benefit costs, utilization and/or medical costs trends experience significant volatility and medical claim submission patterns are changing rapidly as a result of COVID-19, accurately detecting, forecasting, managing, reserving and pricing for our (and our self-insured customers') medical cost trends and incurred and future health care and other benefits costs is more challenging. There can be no assurance regarding the accuracy of the health care or other benefit cost projections reflected in our pricing, and our health care and other benefit costs (including COVID-19 related testing and vaccination and post-acute care skilled nursing facility and behavioral health costs) are affected by COVID-19 and other external events over which we have no control. Even relatively small differences between predicted and actual health care and other benefit costs as a percentage of premium revenues can result in significant adverse changes in our Health Care Benefits segment's operating results.

A number of factors contribute to rising health care and other benefit costs, including COVID-19, previously uninsured members entering the health care system, changes in members' behavior and health care utilization patterns, turnover in our membership, additional government mandated benefits or other regulatory changes (including under the Families First Act and the CARES Act), changes in the health status of our members, the aging of the population and other changing demographic characteristics, advances in medical technology, increases in the number and cost of prescription drugs (including specialty

pharmacy drugs and ultra-high cost drugs and therapies), direct-to-consumer marketing by drug manufacturers, the increasing influence of social media on our members' health care utilization and other behaviors, changes in health care practices and general economic conditions (such as inflation and employment levels). In addition, government-imposed limitations on Medicare and Medicaid reimbursements to health plans and providers have caused the private sector to bear a greater share of increasing health care and other benefits costs over time, and future amendments or repeal or replacement of the ACA that increase the uninsured population may amplify this problem. Other factors that affect our health care and other benefit costs include epidemics or other pandemics, changes as a result of the ACA, changes to or the discontinuation of the ACA and other changes in the regulatory environment, the evolution toward a consumer driven business model, new technologies, influenza-related health care costs (which may be substantial), clusters of high-cost cases, health care provider and member fraud, and numerous other factors that are or may be beyond our control.

Furthermore, if we are not able to accurately and promptly anticipate and detect medical cost trends or accurately estimate the cost of incurred but not yet reported claims or reported claims that have not been paid, our ability to take timely corrective actions to limit future health care costs and reflect our current benefit cost experience in our pricing process may be limited, which would further amplify the extent of any adverse impact on our operating results. These risks are particularly acute during periods such as 2020 and 2021 when health care and other benefit costs, utilization and/or medical cost trends experience significant volatility and medical claim submission patterns are changing rapidly as a result of COVID-19. Such risks are further magnified by the ACA and other existing and future legislation and regulations that limit our ability to price for our projected and/or experienced increases in utilization and/or medical cost trends.

There can be no assurance that future health care and other benefits costs will not exceed our projections.

Adverse economic conditions in the U.S. and abroad can materially and adversely impact our businesses, operating results, cash flows and financial condition, and we do not expect these conditions to improve in the near future.

The COVID-19 pandemic, the availability and cost of credit and other capital, higher unemployment rates and other factors have contributed to adverse conditions in the global economy and significantly diminished expectations for the global economy, and particularly the U.S. economy, at least through the end of 2020 and possibly longer. Our customers, medical providers and the other companies with which we do business are generally headquartered in the U.S.; however, many of our largest customers are global companies with operations around the world. As a result, adverse economic conditions in the U.S. and abroad, including those caused by COVID-19, can materially and adversely impact our businesses, operating results, cash flows and financial condition, including:

- In our Pharmacy Services segment, by causing drug utilization to decline, reducing demand for PBM services and adversely affecting the financial health of our PBM clients.
- In our Retail/LTC segment, by causing drug utilization to decline, changing consumer purchasing power, preferences and/or spending patterns leading to reduced consumer demand for products sold in our stores and adversely affecting the financial health of our LTC pharmacy customers.
- By causing our existing customers to reduce workforces (including due to business failures), which would reduce our revenues, the number of covered lives in our PBM clients and/or the number of members our Health Care Benefits segment serves.
- By causing our clients and customers and potential clients and customers, particularly those with the most employees or members, and state and local governments, to force us to compete more vigorously on factors such as price and service, including service, discount and other performance guarantees, to retain or obtain their business.
- By causing customers and potential customers of our Retail/LTC and Health Care Benefits segments to purchase fewer products and/or products that generate less profit for us than the ones they currently purchase or otherwise would have purchased.
- By causing customers and potential customers of our Health Care Benefits segment, particularly smaller employers and individuals, to forego obtaining or renewing their health and other coverage with us.
- In our Health Care Benefits segment, by causing unanticipated increases and volatility in utilization of medical and other covered services, including COVID-19 related testing, vaccination and behavioral health services, by our medical members, changes in medical claim submission patterns and/or increases in medical unit costs and/or provider behavior, each of which would increase our costs and limit our ability to accurately detect, forecast, manage, reserve and price for our (and our self-insured customers') medical cost trends and incurred and future health care and other benefits costs.

- By increasing medical unit costs and causing changes in provider behavior in our Health Care Benefits segment as hospitals and other providers attempt to maintain revenue levels in their efforts to adjust to their own COVID-19-related and other economic challenges.
- By weakening the ability or perceived ability of the issuers and/or guarantors of the debt or other securities we hold in our investment portfolio to perform on their obligations to us, which could result in defaults in those securities and has reduced, and may further reduce, the value of those securities and has created, and may continue to create, net realized capital losses for us that reduce our operating results.
- By weakening the ability of our customers, including self-insured customers in our Health Care Benefits segment, medical providers and the other companies with which we do business as well as our medical members to perform their obligations to us or causing them not to perform those obligations, either of which could reduce our operating results.
- By weakening the ability of our former subsidiaries and/or their purchasers to satisfy their lease obligations that we have guaranteed and causing the Company to be required to satisfy those obligations.
- By weakening the financial condition of other insurers, including long-term care insurers and life insurers, which increases the risk that we will receive significant assessments for obligations of insolvent insurers to policyholders and claimants.
- By causing, over time, inflation that could cause interest rates to increase and thereby increase our interest expense and reduce our operating results, as well as decrease the value of the debt securities we hold in our investment portfolio, which would reduce our operating results and/or adversely affect our financial condition.

Furthermore, reductions in workforce by our customers can cause unanticipated increases in the health care and other benefits costs of our Health Care Benefits segment. For example, our business associated with members who have elected to receive benefits under Consolidated Omnibus Budget Reconciliation Act (known as "COBRA") typically has an MBR that is significantly higher than our overall Commercial MBR.

Risks Relating to Our Businesses

Each of our segments operates in a highly competitive and evolving business environment; and gross margins in the industries in which we compete may decline.

Each of our segments, Pharmacy Services, which includes our pharmacy benefit management ("PBM") business, Retail/LTC, and Health Care Benefits, operates in a highly competitive and evolving business environment. Specifically:

- As competition increases in the geographies in which we operate, including competition from new entrants, a significant increase in price compression and/or reimbursement pressures could occur, and this could require us to reevaluate our pricing structures to remain competitive.
- The competitive success of our Pharmacy Services segment is dependent on our ability to establish and maintain contractual relationships with network pharmacies as PBM clients evaluate adopting narrow or restricted retail pharmacy networks.
- The competitive success of our Retail/LTC segment and our specialty pharmacy operations is dependent on our ability to establish and maintain contractual relationships with PBMs and other payors on acceptable terms as the payors' clients evaluate adopting narrow or restricted retail pharmacy networks.
- In our PBM business, we maintain contractual relationships with brand name drug manufacturers that provide for purchase discounts and/or rebates on drugs dispensed by pharmacies in our retail network and by our specialty and mail order pharmacies (all or a portion of which may be passed on to clients). Manufacturer's rebates often depend on a PBM's ability to meet contractual requirements, including the placement of a manufacturer's products on the PBM's formularies. If we lose our relationship with one or more drug manufacturers, or if the discounts or rebates provided by drug manufacturers decline, our operating results, cash flows and/or prospects could be adversely affected.
- The PBM industry has been experiencing price compression as a result of competitive pressures and increased client demands for lower prices, increased revenue sharing, including sharing in a larger portion of rebates received from drug manufacturers, enhanced service offerings and/or higher service levels. Marketplace dynamics and regulatory changes also have adversely affected our ability to offer plan sponsors pricing that includes the use of retail "differential" or "spread," which could adversely affect our future profitability, and we expect these trends to continue.
- Our retail pharmacy, specialty pharmacy and LTC pharmacy operations have been affected by reimbursement pressure caused by competition, including client demands for lower prices, generic drug pricing, earlier than expected generic drug introductions and network reimbursement pressure. If we are unable to increase our prices to reflect, or otherwise mitigate

the impact of, increasing costs, our profitability will be adversely affected. If we are unable to limit our price increases, we may lose customers to competitors with more favorable pricing, adversely affecting our revenues and operating results.

- A shift in the mix of our pharmacy prescription volume towards programs offering lower reimbursement rates as a result of competition or otherwise could adversely affect our margins, including the ongoing shift in pharmacy mix towards 90-day prescriptions at retail and the ongoing shift in pharmacy mix towards Medicare Part D prescriptions.
- PBM client contracts often are for a period of approximately three years. However, PBM clients may require early or periodic re-negotiation of pricing prior to contract expiration. PBM clients are generally well informed, can move between us and our competitors and often seek competing bids prior to expiration of their contracts. We are therefore under pressure to contain price increases despite being faced with increasing drug costs and increasing operating costs. If we are unable to increase our prices to reflect, or otherwise mitigate the impact of, increasing costs, our profitability will be adversely affected. If we are unable to limit our price increases, we may lose customers to competitors with more favorable pricing, adversely affecting our revenues and operating results.
- The operating results and margins of our LTC business are further affected by the increased efforts of health care payors to negotiate reduced or capitated pricing arrangements and by the financial health of, and purchases and sales of, our LTC customers.
- In our Health Care Benefits segment we are seeking to substantially grow our Medicaid, dual eligible and dual eligible special needs plan membership over the next several years. In many instances, to acquire and retain our government customers' business, we must bid against our competitors in a highly competitive environment. Winning bids often are challenged successfully by unsuccessful bidders, and may also be withdrawn or cancelled by the issuing agency.
- Customer contracts in our Health Care Benefits segment are generally for a period of one year, and our customers have considerable flexibility in moving between us and our competitors. One of the key factors on which we compete for customers, especially in uncertain economic environments, is overall cost. We are therefore under pressure to contain premium price increases despite being faced with increasing health care and other benefit costs and increasing operating costs. If we are unable to increase our prices to reflect, or otherwise mitigate the impact of, increasing costs, our profitability will be adversely affected. If we are unable to limit our price increases, we may lose members to competitors with more favorable pricing, adversely affecting our revenues and operating results. In response to rising prices, our customers may elect to self-insure or to reduce benefits in order to limit increases in their benefit costs. Alternatively, our customers may purchase different types of products from us that are less profitable. Such elections may result in reduced membership in our more profitable Insured products and/or lower premiums for our Insured products, which may adversely affect our revenues and operating results, although such elections also may reduce our health care and other benefit costs. In addition, our Medicare, Medicaid and CHIP products are subject to termination without cause, periodic re-bid, rate adjustment and program redesign, as customers seek to contain their benefit costs, particularly in an uncertain economy, and our exposure to this risk is increasing as we grow our Government products membership. These actions may adversely affect our membership, revenues and operating results.
- We requested increases in our premium rates in our Commercial Health Care Benefits business for 2021 and expect to continue to request increases in those rates for 2022 and beyond in order to adequately price for projected medical cost trends, required expansions of coverage and rating limits, and significant assessments, fees and taxes imposed by federal and state governments, including as a result of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA"). Our rates also must be adequate to reflect the risk that our products will be selected by people with a higher risk profile or utilization rate than the pool of participants we anticipated when we established pricing for the applicable products (also known as "adverse selection"), particularly in small group Commercial products. These rate increases may be significant and thus heighten the risks of adverse publicity, adverse regulatory action and adverse selection and the likelihood that our requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.

In addition, competitors in each of our businesses may offer services and pricing terms that we may not be willing or able to offer. Competition also may come from new entrants and other sources in the future. Unless we can demonstrate enhanced value to our clients through innovative product and service offerings in the rapidly changing health care industry, we may be unable to remain competitive.

Disruptive innovation by existing or new competitors could alter the competitive landscape in the future and require us to accurately identify and assess such alterations and make timely and effective changes to our strategies and business model to compete effectively. For example, decisions to buy our Pharmacy Services and Health Care Benefits products and services increasingly are made or influenced by consumers, either through direct purchasing (e.g., Medicare Advantage plans and PDPs) or through public health insurance exchanges ("Public Exchanges") and private health insurance exchanges (together with Public Exchanges, collectively, "Insurance Exchanges") that allow individual choice. Consumers also are increasingly seeking to access consumer goods and health care products and services locally and through other direct channels such as mobile

devices and websites. To compete effectively in the consumer-driven marketplace, we will be required to develop or acquire new capabilities, attract new talent and develop new service and distribution relationships that respond to consumer needs and preferences.

Changes in marketplace dynamics or the actions of competitors or manufacturers, including industry consolidation, the emergence of new competitors and strategic alliances, and decisions to exclude us from new narrow or restricted retail pharmacy networks could materially and adversely affect our businesses, operating results, cash flows and/or prospects.

A change in our Health Care Benefits product mix may adversely affect our profit margins.

Our Insured Health Care Benefits products that involve greater potential risk generally tend to be more profitable than our ASC products. Historically, smaller employer groups have been more likely to purchase Insured Health Care Benefits products because such purchasers are generally unable or unwilling to bear greater liability for health care expenditures, although over the last several years even relatively small employers have moved to ASC products. We also serve, and expect to grow our business with, government-sponsored programs, including Medicare and Medicaid, that are subject to competitive bids and have lower profit margins than our Commercial Insured Health Care Benefits products. A shift of enrollees from more profitable products to less profitable products could have a material adverse effect on the Health Care Benefits segment's operating results.

Negative public perception of the industries in which we operate, or of our industries' or our practices, can adversely affect our businesses, operating results, cash flows and prospects.

Our brand and reputation are two of our most important assets, and the industries in which we operate have been and are negatively perceived by the public from time to time. Negative publicity may come as a result of adverse media coverage, litigation against us and other industry participants, the ongoing public debates over drug pricing, PBMs, government involvement in drug pricing and purchasing, the future of the ACA, "surprise" medical bills, governmental hearings and/or investigations, actual or perceived shortfalls regarding our industries' or our own products and/or business practices (including PBM operations, drug pricing and insurance coverage determinations) and social media and other media relations activities. Negative publicity also may come from a failure to meet customer expectations for consistent, high quality and accessible care. This risk may increase as we continue to offer products and services that make greater use of data and as our business model becomes more focused on delivering health care to consumers.

In addition, by working with the U.S. government in the distribution and administration of the COVID-19 vaccine, the Company may be subject to negative publicity related to the government's actions in response to COVID-19 that are outside of the ability of the Company to control.

Negative public perception and/or publicity of our industries in general, or of us or our key vendors, brokers or product distribution networks in particular, can further increase our costs of doing business and adversely affect our operating results and our stock price by:

- adversely affecting our brand and reputation;
- adversely affecting our ability to market and sell our products and/or services and/or retain our existing customers and members;
- requiring us to change our products and/or services;
- reducing or restricting the revenue we can receive for our products and/or services; and/or
- increasing or significantly changing the regulatory and legislative requirements with which we must comply.

We must maintain and improve our relationships with our retail and specialty pharmacy customers and increase the demand for our products and services, including proprietary brands.

The success of our businesses depends in part on customer loyalty, superior customer service and our ability to persuade customers to frequent our retail stores and online sites and to purchase products in additional categories and our proprietary brands. Failure to timely identify or effectively respond to changing consumer preferences and spending patterns, and evolving demographic mixes in the communities we serve, an inability to expand the products being purchased by our clients and customers, or the failure or inability to obtain or offer particular categories of products could adversely affect our relationship with our customers and clients and the demand for our products and services and could result in excess inventories of products.

We offer our retail customers proprietary brand products that are available exclusively at our retail stores and through our online retail sites. The sale of proprietary products subjects us to unique risks including potential product liability risks, mandatory or voluntary product recalls, potential supply chain and distribution chain disruptions for raw materials and finished products, our ability to successfully protect our intellectual property rights and the rights of applicable third parties, and other risks generally encountered by entities that source, market and sell private-label products. We also face similar risks for the other products we sell in our retail operations, including supply chain and distribution chain disruption risk. Any failure to adequately address some or all of these risks could have an adverse effect on our retail business, operating results, cash flows and/or financial condition. Additionally, an increase in the sales of our proprietary brands may adversely affect our sales of products owned by our suppliers and adversely impact certain of our supplier relationships. Our ability to locate qualified, economically stable suppliers who satisfy our requirements, and to acquire sufficient products in a timely and effective manner, is critical to ensuring, among other things, that customer confidence is not diminished. Any failure to develop sourcing relationships with a broad and deep supplier base could adversely affect our operating results and erode customer loyalty.

We also could be adversely affected if we fail to identify or effectively respond to changes in marketplace dynamics. For example, specialty pharmacy represents a significant and growing proportion of prescription drug spending in the U.S., a significant portion of which is dispensed outside of traditional retail pharmacies. Because our specialty pharmacy business focuses on complex and high-cost medications, many of which are made available by manufacturers to a limited number of pharmacies (so-called limited distribution drugs) that serve a relatively limited universe of patients, the future growth of our specialty pharmacy business depends largely upon expanding our access to key drugs and penetration in certain treatment categories. Any contraction of our base of patients or reduction in demand for the prescriptions we currently dispense could have an adverse effect on our specialty pharmacy business, operating results and cash flows.

We face risks relating to the availability, pricing and safety profiles of prescription drugs that we purchase and sell.

The profitability of our Retail/LTC and Pharmacy Services segments is dependent upon the utilization of prescription drug products. We dispense significant volumes of brand name and generic drugs from our retail, LTC, specialty and mail order pharmacies, and the retail pharmacies in our PBM's network also dispense significant volumes of brand name and generic drugs. Our revenues, operating results and cash flows may decline if physicians cease writing prescriptions for drugs or the utilization of drugs is reduced, including due to:

- increased safety risk profiles or regulatory restrictions;
- manufacturing or other supply issues;
- certain products being withdrawn by their manufacturers or transitioned to over-the-counter products;
- future FDA rulings restricting the supply or increasing the cost of products;
- the introduction of new and successful prescription drugs or lower-priced generic alternatives to existing brand name products; or
- inflation in the price of brand name drugs.

In addition, increased utilization of generic drugs (which normally yield a higher gross profit rate than equivalent brand name drugs) has resulted in pressure to decrease reimbursement payments to retail, mail order, specialty and LTC pharmacies for generic drugs, causing a reduction in our margins on sales of generic drugs. Consolidation within the generic drug manufacturing industry and other external factors may enhance the ability of manufacturers to sustain or increase pricing of generic drugs and diminish our ability to negotiate reduced generic drug acquisition costs. Any inability to offset increased brand name or generic prescription drug acquisition costs or to modify our activities to lessen the financial impact of such increased costs could have a significant adverse effect on our operating results.

A number of factors, many of which are beyond our control, contribute to rising health care and other benefit costs. We may not be able to accurately forecast health care and other benefit costs, which could adversely affect our Health Care Benefits segment's operating results.

Premiums for our Insured Health Care Benefits products, which comprised 92% of our Health Care Benefits revenues for 2020, are priced in advance based on our forecasts of health care and other benefit costs during a fixed premium period, which is generally one year. These forecasts are typically developed several months before the fixed premium period begins, are influenced by historical data (and recent historical data in particular), are dependent on our ability to anticipate and detect medical cost trends and changes in our members' behavior and health care utilization patterns and require a significant degree of judgment. For example, our revenue on Medicare policies is based on bids submitted in June of the year before the contract year. Cost increases in excess of our projections cannot be recovered in the fixed premium period through higher premiums. As

a result, our profits are particularly sensitive to the accuracy of our forecasts and our ability to anticipate and detect medical cost trends. Even relatively small differences between predicted and actual health care and other benefit costs as a percentage of premium revenues can result in significant adverse changes in our operating results.

A number of factors contribute to rising health care and other benefit costs, including previously uninsured members entering the health care system, changes in members' behavior and health care utilization patterns, turnover in our membership, additional government mandated benefits or other regulatory changes, changes in the health status of our members, the aging of the population and other changing demographic characteristics, advances in medical technology, increases in the number and cost of prescription drugs (including specialty pharmacy drugs and ultra-high cost drugs and therapies), direct-to-consumer marketing by drug manufacturers, the increasing influence of social media on our members' health care utilization and other behaviors, changes in health care practices and general economic conditions (such as inflation and employment levels). In addition, government-imposed limitations on Medicare and Medicaid reimbursements to health plans and providers have caused the private sector to bear a greater share of increasing health care and other benefits costs over time, and future amendments or repeal or replacement of the ACA that increase the uninsured population may exacerbate this problem. Other factors that affect our health care and other benefit costs include changes as a result of the ACA, changes to the ACA and other changes in the regulatory environment, the evolution toward a consumer driven business model, new technologies, influenza related health care costs (which may be substantial and higher than we project), clusters of high-cost cases, epidemics or pandemics, health care provider and member fraud, and numerous other factors that are or may be beyond our control. For example, the 2020-2021 influenza season was impacted by efforts taken to reduce the spread of COVID-19; and the 2019-2020 influenza season had an earlier than average start and had a higher incidence of influenza than the 2018-2019 influenza season.

Our Health Care Benefits segment's operating results and competitiveness depend in large part on our ability to appropriately manage future health care and other benefit costs through underwriting criteria, product design, provider network configuration, negotiation of favorable provider contracts and medical management programs. Our medical cost management programs may not be successful and may have a smaller impact on health care and benefit costs than we expect. The factors described above may adversely affect our ability to predict and manage health care and other benefit costs, which can adversely affect our competitiveness and operating results.

The reserves we hold for expected claims in our Insured Health Care Benefits products are based on estimates that involve an extensive degree of judgment and are inherently variable. Any reserve, including a premium deficiency reserve, may be insufficient. If actual claims exceed our estimates, our operating results could be materially adversely affected, and our ability to take timely corrective actions to limit future costs may be limited.

A large portion of health care claims are not submitted to us until after the end of the quarter in which services are rendered by providers to our members. Our reported health care costs payable for any particular period reflect our estimates of the ultimate cost of such claims as well as claims that have been reported to us but not yet paid. We also must estimate the amount of rebates payable under the MLR rules of the ACA, CMS and the OPM and the amounts payable by us to, and receivable by us from, the United States federal government under the ACA's remaining premium stabilization program.

Our estimates of health care costs payable are based on a number of factors, including those derived from historical claim experience, but this estimation process also makes use of extensive judgment. Considerable variability is inherent in such estimates, and the accuracy of the estimates is highly sensitive to changes in medical claims submission and processing patterns and/or procedures, turnover and other changes in membership, changes in product mix, changes in the utilization of medical and/or other covered services, including prescription drugs, changes in medical cost trends, changes in our medical management practices and the introduction of new benefits and products. We estimate health care costs payable periodically, and any resulting adjustments, including premium deficiency reserves, are reflected in current-period operating results within benefit costs. For example, as of December 31, 2020 and 2019, we established a premium deficiency reserve of $11 million and $4 million, respectively, related to Medicaid products in the Health Care Benefits segment. A worsening (or improvement) of health care cost trend rates or changes in claim payment patterns from those that we assumed in estimating health care costs payable as of December 31, 2020 would cause these estimates to change in the near term, and such a change could be material.

Furthermore, if we are not able to accurately and promptly anticipate and detect medical cost trends or accurately estimate the cost of incurred but not yet reported claims or reported claims that have not been paid, our ability to take timely corrective actions to limit future health care costs and reflect our current benefit cost experience in our pricing process may be limited, which would further exacerbate the extent of any adverse impact on our operating results. These risks are particularly acute during and following periods when utilization of medical and/or other covered services and/or medical cost trends are below recent historical levels and in products where there is significant turnover in our membership each year, and such risks are

further magnified by the ACA and other legislation and regulations that limit our ability to price for our projected and/or experienced increases in utilization and/or medical cost trends.

Our operating results are affected by the health of the economy in general and in the geographies we serve.

Our businesses are affected by the U.S. economy and consumer confidence in general and in the geographies we serve, including various economic factors, including inflation and changes in consumer purchasing power, preferences and/or spending patterns. An unfavorable, uncertain or volatile economic environment could cause a decline in drug utilization, an increase in health care utilization and dampen demand for PBM services as well as consumer demand for products sold in our retail stores.

If our customers' operating and financial performance deteriorates, or they are unable to make scheduled payments or obtain adequate financing, our customers may not be able to pay timely, or may delay payment of, amounts owed to us. Any inability of our customers to pay us for our products and services may adversely affect our businesses, operating results and cash flows. In addition, both state and federal government sponsored payers, as a result of budget deficits or spending reductions, may suspend payments or seek to reduce their health care expenditures resulting in our customers delaying payments to us or renegotiating their contracts with us.

Further, economic conditions including interest rate fluctuations, changes in capital market conditions and regulatory changes may affect our ability to obtain necessary financing on acceptable terms, our ability to secure suitable store locations under acceptable terms, our ability to execute sale-leaseback transactions under acceptable terms and the value of our investment portfolio. Adverse changes in the U.S. economy, consumer confidence and economic conditions could have an adverse effect on our businesses and financial results. This adverse effect could be further exacerbated by the increasing prevalence of high deductible health plans and health plan designs favoring co-insurance over co-payments as members and other consumers may decide to postpone, or not to seek, medical treatment which may lead them to incur more expensive medical treatment in the future and/or decrease our prescription volumes.

In addition, our Health Care Benefits membership remains concentrated in certain U.S. geographies and in certain industries. Unfavorable changes in health care or other benefit costs or reimbursement rates or increased competition in those geographic areas where our membership is concentrated could therefore have a disproportionately adverse effect on our Health Care Benefits segment's operating results. Our Health Care Benefits membership has been and may continue to be affected by workforce reductions by our customers due to adverse and/or uncertain general economic conditions, especially in the U.S. geographies and industries where our membership is concentrated. As a result, we may not be able to profitably grow and diversify our Health Care Benefits membership geographically, by product type or by customer industry, and our revenues and operating results may be disproportionately affected by adverse changes affecting our customers.

We are exposed to risks relating to the solvency of other insurers.

We are subject to assessments under guaranty fund laws existing in all states for obligations of insolvent insurance companies (including long-term care insurers), HMOs, ACA co-ops and other payors to policyholders and claimants. For example, in the first quarter of 2017, Aetna recorded a discounted estimated liability expense of $231 million pretax for our estimated share of future assessments for long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries. Guaranty funds are maintained by state insurance commissioners to protect policyholders and claimants in the event that an insurer, HMO, ACA co-op and/or other payor becomes insolvent or is unable to meet its financial obligations. These funds are usually financed by assessments against insurers regulated by a state. Future assessments may have an adverse effect on our operating results and cash flows.

Extreme events, or the threat of extreme events, could materially increase our health care (including behavioral health) costs.

Nuclear, biological or other attacks, whether as a result of war or terrorism, other man-made disasters, natural disasters, epidemics, pandemics and other extreme events can affect the U.S. economy in general, our industries and us specifically. In particular, such extreme events or the threat of such extreme events could result in significant health care (including behavioral health) costs, which also would be affected by the government's actions and the responsiveness of public health agencies and other insurers. Such extreme events or the threat of such extreme events also could disrupt our supply chains and/or our distribution chains for the products we sell. In addition, our employees and those of our vendors are concentrated in certain large, metropolitan areas which may be particularly exposed to these events. Such events could adversely affect our businesses,

operating results and cash flows, and, in the event of extreme circumstances, our financial condition or viability, particularly if our responses to such events are less adequate than those of our competitors.

Risks From Changes in Public Policy and Other Legal and Regulatory Risks

We are subject to potential changes in public policy, laws and regulations, including reform of the U.S. health care system, which can adversely affect our businesses. Entitlement program reform, if it occurs, could have a material adverse effect on our businesses, operations and/or operating results.

The political environment in which we operate remains uncertain. It is reasonably possible that our business operations and operating results could be materially adversely affected by legislative, regulatory and public policy changes at the federal or state level, increased government involvement in drug reimbursement, pricing, purchasing and/or importation and/or increased regulation of PBMs, including: changes to the Medicare or Medicaid programs (including the block grant option outlined by CMS on January 30, 2020, the "block grant option") or the regulatory environment for health care and related benefits, including the ACA; changes to laws or regulations governing drug reimbursement and/or pricing; changes to the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs; changes to laws and/or regulations governing drug manufacturers' rebates; changes to laws and/or regulations governing reimbursements paid to pharmacists by and/or reporting required by PBMs; changes to immigration policies and/or other public policy initiatives. It is not possible to predict whether or when any such changes will occur or what form any such changes may take (including through the use of U.S. Presidential Executive Orders). Other significant changes to health care and related benefits system legislation or regulation as well as changes with respect to tax and trade policies, tariffs and other government regulations affecting trade between the United States and other countries also are possible and could adversely affect our businesses. If we fail to respond adequately to such changes, including by implementing strategic and operational initiatives, or do not respond as effectively as our competitors, our businesses, operations and operating results may be materially adversely affected.

In addition to efforts to amend, repeal or replace the ACA and related regulations, we expect the federal and state governments to continue to enact and seriously consider many broad-based legislative and regulatory proposals that will or could materially impact various aspects of the health care and related benefits system and our businesses. Potential modification to the ACA, including changes in enforcement and/or funding that further destabilize the Public Exchanges, as well as significant changes to Medicaid funding (including the block grant option) could impact the number of Americans with health insurance and, consequently, prescription drug coverage. Further changes to federal health care and related benefits laws, including the ACA, drug reimbursement and pricing laws, laws governing PBMs and/or laws governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, are probable. We cannot predict the effect, if any, that new health care and related benefits legislation, future changes to the ACA or the implementation of or failure to implement the outstanding provisions of ACA, may have on our Pharmacy Services, retail pharmacy, LTC pharmacy and/or Health Care Benefits operations and/or operating results. The federal and many state governments also are considering changes in the interpretation, enforcement and/or application of existing programs, laws and regulations, including changes to payments under and funding of Medicare and Medicaid programs and increased regulation of PBMs.

Further, changes in existing federal or state laws or regulations or the adoption of new laws or regulations relating to additional regulation of PBMs (including formulary management or other PBM services), drug pricing or purchasing, patent term extensions and/or purchase discount and/or rebate arrangements with drug manufacturers also could reduce the discounts or rebates we receive. Changes in existing federal or state laws or regulations or the adoption of new laws or regulations relating to claims processing and billing, including our ability to use MAC lists and collect transmission fees, also could adversely affect our profitability. For example, on October 29, 2020, the HHS released a final rule requiring health insurers to disclose drug pricing and cost-sharing information. The final rule requires group health plans and health insurance issuers in the individual and group markets to disclose cost-sharing information upon request, to a participant, beneficiary, or enrollee, which, unless otherwise indicated, for the purpose of the final rules includes an authorized representative, and requires plans and issuers to disclose in-network provider rates, historical out-of-network allowed amounts and the associated billed charges, and negotiated rates for prescription drugs. The public disclosure of insurer- or PBM-negotiated price concessions may result in drug manufacturers lowering discounts or rebates, resulting in higher drug costs for patients and impacting the ability of the Company to negotiate drug prices and provide competitive products and services to consumers.

In addition, in November 2020, the HHS released the Rebate Rule, which eliminates the regulatory safe harbor from prosecution under the AKS for rebates from pharmaceutical companies to PBMs in Medicare Part D and in Medicaid MCOs, replacing it with two far narrower safe harbors designed to directly benefit patients with high out-of-pocket costs and to change the way PBMs are compensated. The new safe harbors are (i) for rebates which are passed on to the patient at the point of sale

and (ii) for flat service fee payments made to PBMs which cannot be tied to the list prices of drugs. The PCMA, which represents PBMs, has filed a suit in an effort to block the Rebate Rule, claiming that the Rebate Rule would lead to higher premiums in Medicare Part D and was adopted in an unlawful manner. It is unclear whether the Rebate Rule will be enforceable, whether pharmaceutical companies will respond by reducing list prices, whether list prices in the private market may also be reduced, and what the resulting impact will be to PBMs or the Company.

We cannot predict the enactment or content of new legislation or regulations or changes to existing laws or regulations or their enforcement, interpretation or application, or the effect they will have on our business operations or operating results, which could be materially adverse. Even if we could predict such matters, it is not possible to eliminate the adverse impact of public policy changes that would fundamentally change the dynamics of one or more of the industries in which we compete. Examples of such changes include: the federal or one or more state governments fundamentally restructuring or reducing the funding available for Medicare, Medicaid, dual eligible or dual eligible special needs plan programs, increasing its involvement in drug reimbursement, pricing, purchasing and/or importation, changing the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, changing the tax treatment of health or related benefits, or repealing or otherwise significantly altering the ACA. The likelihood of adverse changes remains high due to state and federal budgetary pressures, and our businesses and operating results could be materially and adversely affected by such changes, even if we correctly predict their occurrence.

For more information on these matters, see "Government Regulation" included in Item 1 of this 10-K.

If we fail to comply with applicable laws and regulations, many of which are highly complex, we could be subject to significant adverse regulatory actions or suffer brand and reputational harm.

Our businesses are subject to extensive regulation and oversight by state, federal and international governmental authorities. The laws and regulations governing our operations and interpretations of those laws and regulations are increasing in number and complexity, change frequently and can be inconsistent or conflict with one another. In general, these laws and regulations are designed to benefit and protect customers, members and providers rather than us or our investors. In addition, the governmental authorities that regulate our businesses have broad latitude to make, interpret and enforce the laws and regulations that govern us and continue to interpret and enforce those laws and regulations more strictly and more aggressively each year. We also must follow various restrictions on certain of our businesses and the payment of dividends by certain of our subsidiaries put in place by certain state regulators.

Certain of our Pharmacy Services and Retail/LTC operations, products and services are subject to:

- the clinical quality, patient safety and other risks inherent in the dispensing, packaging and distribution of drugs and other health care products and services, including claims related to purported dispensing and other operational errors (any failure by our Pharmacy Services and/or Retail/LTC operations to adhere to the laws and regulations applicable to the dispensing of drugs could subject us to civil and criminal penalties);
- federal and state anti-kickback and other laws that govern our relationship with drug manufacturers, customers and consumers;
- compliance requirements under ERISA, including fiduciary obligations in connection with the development and implementation of items such as drug formularies and preferred drug listings; and
- federal and state legislative proposals and/or regulatory activity that could adversely affect pharmacy benefit industry practices.

Our Health Care Benefits products are highly regulated, particularly those that serve Medicare, Medicaid, dual eligible, dual eligible special needs and small group Commercial customers and members. The laws and regulations governing participation in Medicare Advantage, Medicare Part D, Medicaid, dual eligible and dual eligible special needs plan programs are complex, are subject to interpretation and can expose us to penalties for non-compliance.

The scope of the practices and activities that are prohibited by federal and state false claims acts is the subject of pending litigation. Claims under federal and state false claims acts can be brought by the government or by private individuals on behalf of the government through a *qui tam* or "whistleblower" suit, and we are a defendant in a number of such proceedings. If we are convicted of fraud or other criminal conduct in the performance of a government program or if there is an adverse decision against us under the False Claims Act, we may be temporarily or permanently suspended from participating in government health care programs, including Medicare Advantage, Medicare Part D, Medicaid, dual eligible and dual eligible special needs plan programs, and we also may be required to pay significant fines and/or other monetary penalties. Whistleblower suits have

resulted in significant settlements between governmental agencies and health care companies. The significant incentives and protections provided to whistleblowers under applicable law increase the risk of whistleblower suits.

If we fail to comply with laws and regulations that apply to government programs, we could be subject to criminal fines, civil penalties, premium refunds, prohibitions on marketing or active or passive enrollment of members, corrective actions, termination of our contracts or other sanctions which could have a material adverse effect on our ability to participate in Medicare Advantage, Medicare Part D, Medicaid, dual eligible, dual eligible special needs plan and other programs and on our operating results, cash flows and financial condition.

Our businesses, profitability and growth also may be adversely affected by (i) judicial and regulatory decisions that change and/or expand the interpretations of existing statutes and regulations, impose medical or bad faith liability, increase our responsibilities under ERISA or the remedies available under ERISA, or reduce the scope of ERISA pre-emption of state law claims or (ii) other legislation and regulations. For example, in December 2020, the U.S. Supreme Court upheld an Arkansas law that, among other things, mandates a particular pricing methodology, establishes an appeals process for a pharmacy when the reimbursement is below the pharmacy's acquisition cost, permits a pharmacy to reverse and rebill if they cannot procure the drug from its wholesaler at a price equal to or less than the reimbursement rate, prohibits a PBM from reimbursing a pharmacy less than the amount it reimburses an affiliate on a per unit basis, and permits a pharmacy to decline to dispense if the reimbursement is lower than the pharmacy's acquisition cost.

If our compliance or other systems and processes fail or are deemed inadequate, we may suffer brand and reputational harm and become subject to regulatory actions and/or litigation.

In addition to being subject to extensive and complex regulations, many of our contracts with customers include detailed requirements. In order to be eligible to offer certain products or bid on certain contracts, we must demonstrate that we have robust systems and processes in place that are designed to maintain compliance with all applicable legal, regulatory and contractual requirements. These systems and processes frequently are reviewed and audited by our customers and regulators. If our systems and processes designed to maintain compliance with applicable legal and contractual requirements, and to prevent and detect instances of, or the potential for, non-compliance fail or are deemed inadequate, we may suffer brand and reputational harm and be subject to regulatory actions, litigation and other proceedings which may result in damages, fines, suspension or loss of licensure, suspension or exclusion from participation in government programs and/or other penalties, any of which could adversely affect our businesses, operating results, cash flows and/or financial condition.

We routinely are subject to litigation and other adverse legal proceedings, including class actions and qui tam actions. Many of these proceedings seek substantial damages which may not be covered by insurance. These proceedings are costly to defend, may result in changes in our business practices, harm our brand and reputation and adversely affect our businesses and operating results.

PBM, retail pharmacy, mail order pharmacy, specialty pharmacy, LTC pharmacy and health care and related benefits are highly regulated industries whose participants frequently are subject to litigation and other adverse legal proceedings. We are currently subject to various litigation and arbitration matters, investigations, regulatory audits, inspections, government inquiries, and regulatory and other legal proceedings, both inside and outside the U.S. Outside the U.S., contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the U.S. Litigation related to our provision of professional services in our medical clinics, pharmacies and LTC operations is increasing as we expand our services along the continuum of health care.

Litigation, and particularly securities, derivative, collective or class action and *qui tam* litigation, is often expensive and disruptive. Many of the legal proceedings against us seek substantial damages (including non-economic or punitive damages and treble damages), and certain of these proceedings also seek changes in our business practices. While we currently have insurance coverage for some potential liabilities, other potential liabilities may not be covered by insurance, insurers may dispute coverage and/or the amount of our insurance may not be enough to cover the damages awarded or costs incurred. In addition, some types of damages, like punitive damages, may not be covered by insurance, and in some jurisdictions the coverage of punitive damages is prohibited. Insurance coverage for all or some forms of liability also may become unavailable or prohibitively expensive in the future.

The outcome of litigation and other adverse legal proceedings is always uncertain, and outcomes that are not justifiable by the evidence or existing law or regulation can and do occur, and the costs incurred frequently are substantial regardless of the outcome. Litigation and other adverse legal proceedings could materially adversely affect our businesses, operating results and/or cash flows because of brand and reputational harm to us caused by such proceedings, the cost of defending such proceedings,

the cost of settlement or judgments against us, or the changes in our operations that could result from such proceedings. See Item 3 of this 10-K for additional information.

We frequently are subject to regular and special governmental audits, investigations and reviews that could result in changes to our business practices and also could result in material refunds, fines, penalties, civil liabilities, criminal liabilities and other sanctions.

As one of the largest national retail, mail order, specialty and LTC pharmacy, PBM and health care and related benefits providers, we frequently are subject to regular and special governmental market conduct and other audits, investigations and reviews by, and we receive subpoenas and other requests for information from, various federal and state agencies, regulatory authorities, attorneys general, committees, subcommittees and members of the U.S. Congress and other state, federal and international governmental authorities. For example, we have received CIDs from, and provided documents and information to, the Civil Division of the DOJ in connection with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. CMS and the OIG also are auditing the risk adjustment-related data of certain of our Medicare Advantage plans, and the number of such audits continues to increase. Several such audits, investigations and reviews by governmental authorities currently are pending, some of which may be resolved in 2021, the results of which may be adverse to us.

Federal and state governments have made investigating and prosecuting health care and other insurance fraud, waste and abuse a priority. Fraud, waste and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical and/or other covered services, improper marketing and violations of patient privacy rights. The regulations and contractual requirements applicable to us and other industry participants are complex and subject to change, making it necessary for us to invest significant resources in complying with our regulatory and contractual requirements. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that our compliance efforts in this area will continue to require significant resources. In addition, our medical costs and the medical expenses of our Health Care Benefits ASC customers may be adversely affected if we do not prevent or detect fraudulent activity by providers and/or members.

Regular and special governmental audits, investigations and reviews by federal, state and international regulators could result in changes to our business practices, and also could result in significant or material premium refunds, fines, penalties, civil liabilities, criminal liabilities or other sanctions, including suspension or exclusion from participation in government programs and suspension or loss of licensure. Any of these audits, investigations or reviews could have a material adverse effect on our businesses, operating results, cash flows and/or financial condition or result in significant liabilities and negative publicity for us.

See “Legal and Regulatory Proceedings” in Note 16 ‘‘Commitments and Contingencies’’ included in Item 8 of this 10-K for additional information.

Our litigation and regulatory risk profile are changing as we offer new products and services and expand in business areas beyond our historical core businesses of Pharmacy Services, Retail/LTC and Health Care Benefits.

Historically, we focused primarily on providing Pharmacy Services, Retail/LTC and Health Care Benefits products and services. As a result of our transformation program and other innovation initiatives, we are expanding our presence in the health care space and plan to offer new products and services (such as the home hemodialysis device we are developing) which present a different litigation and regulatory risk profile than the products and services that we historically have offered.

The increased volume of business in areas beyond our historical core businesses and new products and services subject us to litigation and regulatory risks that are different from the risks of providing Pharmacy Services, Retail/LTC and Health Care Benefits products and services and increase significantly our exposure to other risks.

We face unique regulatory and other challenges in our Medicare and Medicaid businesses.

We are seeking to substantially grow the Medicare and Medicaid membership in our Health Care Benefits segment in 2020 and over the next several years. We face unique regulatory and other challenges that may inhibit the growth and profitability of those businesses.

- In April 2020, CMS issued a final notice detailing final Medicare Advantage benchmark payment rates for 2021 (the “Final Notice”). Overall, we project the benchmark rates in the Final Notice will increase funding for our Medicare Advantage

business, excluding the impact of the HIF in 2020, by approximately 1.8% in 2021 compared to 2020. This 2021 rate increase only partially offsets the challenge we face from the impact of the increasing cost of medical care (including prescription medications) and CMS local and national coverage decisions that require us to pay for services and supplies that are not factored into our bids and creates continued pressure on our Medicare Advantage operating results. In January 2021, CMS issued its final notice detailing final 2022 Medicare Advantage benchmark payment rates. Final 2022 Medicare Advantage rates resulted in an increase in industry benchmark rates of approximately 4.1%. We cannot predict future Medicare funding levels, the impact of future federal budget actions or ensure that such changes or actions will not have an adverse effect on our Medicare operating results.

- The organic expansion of our Medicare Advantage and Medicare Part D service area is subject to the ability of CMS to process our requests for service area expansions and our ability to build cost competitive provider networks in the expanded service areas that meet applicable network adequacy requirements. CMS' decisions on our requests for service area expansions also may be affected adversely by compliance issues that arise each year in our Medicare operations.
- CMS regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of the services we provide to our Medicare members. As a result of these audits, we may be subject to significant or material retroactive adjustments to and/or withholding of certain premiums and fees, fines, criminal liability, civil monetary penalties, CMS imposed sanctions (including suspension or exclusion from participation in government programs) or other restrictions on our Medicare, Medicaid and other businesses, including suspension or loss of licensure.
- "Star ratings" from CMS for our Medicare Advantage plans will continue to have a significant effect on our plans' operating results. Since 2015, only Medicare Advantage plans with a star rating of four or higher (out of five) are eligible for a quality bonus in their basic premium rates. CMS continues to change its rating system to make achieving and maintaining a four or higher star rating more difficult. Our star ratings and past performance scores are adversely affected by the compliance issues that arise each year in our Medicare operations. If our star ratings fall below four for a significant portion of our Medicare Advantage membership or do not match the performance of our competitors or the star rating quality bonuses are reduced or eliminated, our revenues, operating results and cash flows may be significantly adversely affected.
- Payments we receive from CMS for our Medicare Advantage and Part D businesses also are subject to risk adjustment based on the health status of the individuals we enroll. Elements of that risk adjustment mechanism continue to be challenged by the DOJ, the OIG and CMS itself. Substantial changes in the risk adjustment mechanism, including changes that result from enforcement or audit actions, could materially affect the amount of our Medicare reimbursement, require us to raise prices or reduce the benefits we offer to Medicare beneficiaries, and potentially limit our (and the industry's) participation in the Medicare program.
- Changes to the ability of PBMs to have pharmacy performance programs in place for clients and report payments via direct and indirect reporting mechanisms could impact the Pharmacy Services business.
- Medicare Part D has resulted in increased utilization of prescription medications and puts pressure on our pharmacy gross margin rates due to regulatory and competitive pressures. Further, as a result of the ACA and changes to the retiree drug subsidy rules, clients of our PBM business could decide to discontinue providing prescription drug benefits to their Medicare-eligible members. To the extent this phenomenon occurs, the adverse effects of increasing customer migration into Medicare Part D may outweigh the benefits we realize from growth of our Medicare Part D products.
- Our Medicare Part D operating results and our ability to expand our Medicare Part D business could be adversely affected if: the cost and complexity of Medicare Part D exceed management's expectations or prevent effective program implementation or administration; changes to the regulations regarding how drug costs are reported for Medicare Part D are implemented in a manner that adversely affects the profitability of our Medicare Part D business; changes to the applicable regulations impact our ability to retain fees from third parties including network pharmacies; the government alters Medicare Part D program requirements or reduces funding because of the higher-than-anticipated cost to taxpayers of Medicare Part D or for other reasons; the government mandated use of point-of-sale manufacturer's rebates effective in 2022 continues; the government makes changes to how pharmacy pay-for-performance is calculated; or reinsurance thresholds are reduced below their current levels.
- We have experienced challenges in obtaining complete and accurate encounter data for our Medicaid products due to difficulties with providers and third-party vendors submitting claims in a timely fashion in the proper format, and with state agencies in coordinating such submissions. As states increase their reliance on encounter data, these difficulties could affect the Medicaid premium rates we receive and how Medicaid membership is assigned to us, which could have a material adverse effect on our Medicaid operating results and cash flows and/or our ability to bid for, and continue to participate in, certain Medicaid programs.

- Federal funding for expanded Medicaid coverage began to decrease in 2017. This reduction is causing states to re-evaluate funding for their Medicaid expansions. That re-evaluation may adversely affect Medicaid payment rates, our Medicaid membership in those states, our revenues, our MLRs and our operating results.
- If we fail to report and correct errors discovered through our own auditing procedures or during a CMS audit or otherwise fail to comply with the applicable laws and regulations, we could be subject to fines, civil monetary penalties or other sanctions, including fines and penalties under the False Claims Act, which could have a material adverse effect on our ability to participate in Medicare Advantage, Part D or other government programs, and on our operating results, cash flows and financial condition.
- In the second quarter of 2014, CMS issued a final rule implementing ACA requirements that Medicare Advantage and PDP plans report and refund to CMS overpayments that those plans receive from CMS. However, CMS's statements in formalized guidance regarding "overpayments" to Medicare Advantage plans appear to be inconsistent with CMS's prior RADV audit guidance. These statements appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without reconciliation to the principles underlying the fee for service adjustment comparison contemplated by CMS's RADV audit methodology. The precise interpretation, impact and legality of the final rule are not clear and are subject to pending litigation. If Medicare Advantage plans were not paid based on payment model principles that align with the requirements of the Social Security Act or such payments were not implemented correctly, it could have a material adverse effect on our operating results, cash flows and/or financial condition.
- Certain of our Medicaid contracts require the submission of complete and correct encounter data. The accurate and timely reporting of encounter data is increasingly important to the success of our Medicaid programs because more states are using encounter data to determine compliance with performance standards and, in part, to set premium rates. We have expended and may continue to expend additional effort and incur significant additional costs to collect accurate, or to correct inaccurate or incomplete, encounter data and have been and could be exposed to premium withholding, operating sanctions and financial fines and penalties for noncompliance. We have experienced challenges in obtaining complete and accurate encounter data due to difficulties with providers and third-party vendors submitting claims in a timely fashion in the proper format, and with state agencies in coordinating such submissions. As states increase their reliance on encounter data, these difficulties could affect the Medicaid premium rates we receive and how Medicaid membership is assigned to us, which could have a material adverse effect on our Medicaid operating results and cash flows and/or our ability to bid for, and continue to participate in, certain Medicaid programs.
- Our businesses that dispense drugs also face challenges in the Medicaid space. The ACA made several significant changes to Medicaid rebates and to reimbursement rates. One of these changes was to revise the definition of the Average Manufacturer Price, a pricing element common to most payment formulas, and the reimbursement formula for generic drugs. This change has adversely affected the reimbursements we receive when we dispense prescription drugs to Medicaid recipients.

Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues, and we expect that percentage to increase.

Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues, and we expect that percentage to increase. As our government funded businesses grow, our exposure to changes in federal and state government policy with respect to and/or regulation of the various government funded programs in which we participate also increases.

Our revenues from government funded programs, including in Health Care Benefits' Medicare, Medicaid, dual eligible and dual eligible special needs plan businesses and from government customers in its Commercial business, are dependent on annual funding by the federal government and/or applicable state or local governments. Federal, state and local governments have the right to cancel or not to renew their contracts with us on short notice without cause or if funds are not available. Funding for these programs is dependent on many factors outside our control, including general economic conditions, continuing government efforts to contain health care costs and budgetary constraints at the federal or applicable state or local level and general political issues and priorities.

The U.S. federal government and our other government customers also may reduce funding for health care or other programs, cancel or decline to renew contracts with us, or make changes that adversely affect the number of persons eligible for certain programs, the services provided to enrollees in such programs, our premiums and our administrative and health care and other benefit costs, any of which could have a material adverse effect on our businesses, operating results and cash flows. When federal funding is delayed, suspended or curtailed, we continue to receive, and we remain liable for and are required to fund, claims from providers for providing services to beneficiaries of federally funded health benefits programs in which we participate. An extended federal government shutdown or a delay by Congress in raising the federal government's debt ceiling

also could lead to a delay, reduction, suspension or cancellation of federal government spending and a significant increase in interest rates that could, in turn, have a material adverse effect on the value of our investment portfolio, our ability to access the capital markets and our businesses, operating results, cash flows and liquidity.

Possible changes in industry pricing benchmarks and drug pricing generally can adversely affect our PBM and Retail/LTC businesses.

It is possible that the pharmaceutical industry or regulators may evaluate and/or develop an alternative pricing reference to replace AWP or Wholesale Acquisition Cost ("WAC"), which are the pricing references used for many of our PBM and LTC client contracts, drug purchase agreements, retail network contracts, specialty payor agreements and other contracts with third party payors in connection with the reimbursement of drug payments. In addition, many state Medicaid fee-for-service programs have established pharmacy network payments on the basis of Actual Acquisition Cost ("AAC"). The use of an AAC basis in FFS Medicaid could have an impact on reimbursement practices in Health Care Benefits' Commercial and other Government products.

Future changes to the use of AWP, WAC or to other published pricing benchmarks used to establish drug pricing, including changes in the basis for calculating reimbursement by federal and state health care programs and/or other payors, could impact the reimbursement we receive from Medicare and Medicaid programs, the reimbursement we receive from our PBM clients and other payors and/or our ability to negotiate rebates and/or discounts with drug manufacturers, wholesalers, PBMs and retail pharmacies. A failure or inability to fully offset any increased prices or costs or to modify our operations to mitigate the impact of such increases could have a material adverse effect on our operating results. Additionally, any future changes in drug prices could be significantly different than our projections. We cannot predict the effect of these possible changes on our businesses.

We may not be able to obtain adequate premium rate increases in our Insured Health Care Benefits products, which would have an adverse effect on our revenues, MBRs and operating results and could magnify the adverse impact of increases in health care and other benefit costs and of ACA assessments, fees and taxes.

Premium rates for our Insured Health Care Benefits products generally must be filed with state insurance regulators and are subject to their approval, which creates risk for us in the current political and regulatory environment. The ACA generally requires a review by HHS in conjunction with state regulators of premium rate increases that exceed a federally specified threshold (or lower state-specific thresholds set by states determined by HHS to have adequate processes). Rate reviews can magnify the adverse impact on our operating margins, MBRs and operating results of increases in health care and other benefit costs, increased utilization of covered services, and ACA assessments, fees and taxes, by restricting our ability to reflect these increases and/or these assessments, fees and taxes in our pricing. Further, our ability to reflect ACA assessments, fees and taxes in our Medicare, Medicaid and CHIP premium rates is limited.

Since 2013, HHS has issued determinations to health plans that their premium rate increases were "unreasonable," and we continue to experience challenges to appropriate premium rate increases in certain states. Regulators or legislatures in several states have implemented or are considering limits on premium rate increases, either by enforcing existing legal requirements more stringently or proposing different regulatory standards. Regulators or legislatures in several states also have conducted hearings on proposed premium rate increases, which can result, and in some instances have resulted, in substantial delays in implementing proposed rate increases even if they ultimately are approved. Our plans can be excluded from participating in small group Public Exchanges if they are deemed to have a history of "unreasonable" rate increases. Any significant rate increases we may request heighten the risks of adverse publicity, adverse regulatory action and adverse selection and the likelihood that our requested premium rate increases will be denied, reduced or delayed, which could adversely affect our MBRs and lead to operating margin compression.

We anticipate continued regulatory and legislative action to increase regulation of premium rates in our Insured Health Care Benefits products. We may not be able to obtain rates that are actuarially justified or that are sufficient to make our policies profitable in one or more product lines or geographies. If we are unable to obtain adequate premium rates and/or premium rate increases, it could materially and adversely affect our operating margins and MBRs and our ability to earn adequate returns on Insured Health Care Benefits products in one or more states or cause us to withdraw from certain geographies and/or products.

Minimum MLR rebate requirements limit the level of margin we can earn in our Insured Health Care Benefits products while leaving us exposed to higher than expected medical costs. Challenges to our minimum MLR rebate methodology and/or reports could adversely affect our operating results.

The ACA's minimum MLR rebate requirements limit the level of margin we can earn in Health Care Benefits' Commercial Insured and Medicare Insured businesses. CMS minimum MLR rebate regulations limit the level of margin we can earn in our Medicaid Insured business. Certain portions of our Health Care Benefits Medicaid and Federal Employees Health Benefits ("FEHB") program business also are subject to minimum MLR rebate requirements in addition to but separate from those imposed by the ACA. Minimum MLR rebate requirements leave us exposed to medical costs that are higher than those reflected in our pricing. The process supporting the management and determination of the amount of MLR rebates payable is complex and requires judgment, and the minimum MLR reporting requirements are detailed. CMS has also proposed, but not yet finalized, a definition of "prescription drug price concessions" for commercial MLR calculation purposes, which would make additional PBM information available to plans and the HHS, potentially further complicating the MLR calculation process. Federal and state auditors are challenging our Commercial Health Care Benefits business' compliance with the ACA's minimum MLR requirements as well as our FEHB plans' compliance with OPM's FEHB program-specific minimum MLR requirements. Our Medicare and Medicaid contracts also are subject to minimum MLR audits. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS. Additional challenges to our methodology and/or reports relating to minimum MLR and related rebates by federal and state regulators and private litigants are reasonably possible. The outcome of these audits and additional challenges could adversely affect our operating results.

Our operating results may be adversely affected by changes in laws and policies governing employers and by union organizing activity.

The federal and certain state legislatures continue to consider and pass legislation that increases our costs of doing business, including increased minimum wages and requiring employers to provide paid sick leave or paid family leave. In addition, our employee-related operating costs may be increased by union organizing activity. If we are unable to reflect these increased expenses in our pricing or otherwise modify our operations to mitigate the effects of such increases, our operating results will be adversely affected.

We face international political, legal and compliance, operational, regulatory, economic and other risks that may be more significant than in our domestic operations.

We significantly expanded our international operations as a result of the Aetna Acquisition. As a result of our expanded international operations, we face political, legal, compliance, operational, regulatory, economic and other risks that we do not face or that are more significant than in our domestic operations. These risks vary widely by country and include varying regional and geopolitical business conditions and demands, government intervention and censorship, discriminatory regulation, nationalization or expropriation of assets and pricing constraints. Our international products need to meet country-specific customer and member preferences as well as country-specific legal requirements, including those related to licensing, data privacy, data storage and data protection.

Our international operations increase our exposure to, and require us to devote significant management resources to implement controls and systems to comply with, the privacy and data protection laws of non-U.S. jurisdictions, such as the EU's GDPR, and the anti-bribery, anti-corruption and anti-money laundering laws of the United States (including the FCPA) and the United Kingdom (including the UK Bribery Act) and similar laws in other jurisdictions. Implementing our compliance policies, internal controls and other systems upon our expansion into new countries and geographies may require the investment of considerable management time and financial and other resources over several years before any significant revenues or profits are generated. Violations of these laws and regulations could result in fines, criminal sanctions against us, our officers or employees, restrictions or outright prohibitions on the conduct of our business, and significant brand and reputational harm. We must regularly reassess the size, capability and location of our global infrastructure and make appropriate changes, and must have effective change management processes and internal controls in place to address changes in our businesses and operations. Our success depends, in part, on our ability to anticipate these risks and manage these difficulties, and the failure to do so could have a material adverse effect on our brand, reputation, businesses, operating results and/or financial condition.

Our international operations require us to overcome logistical and other challenges based on differing languages, cultures, legal and regulatory schemes and time zones. Our international operations encounter labor laws, standards and customs that can be difficult and make employee relationships less flexible than in our domestic operations and expensive to modify or terminate. In

some countries we are required to, or choose to, operate with local business associates, which requires us to manage our relationships with these third parties and may reduce our operational flexibility and ability to quickly respond to business challenges.

In some countries we may be exposed to currency exchange controls or other restrictions that prevent us from transferring funds internationally or converting local currencies into U.S. dollars or other currencies. Fluctuations in foreign currency exchange rates may adversely affect our revenues, operating results and cash flows from our international operations. Some of our operations are, and are increasingly likely to be, in emerging markets where these risks are heightened. Any measures we may implement to reduce the effect of volatile currencies and other risks on our international operations may not be effective.

Risks Associated with Mergers, Acquisitions, and Divestitures

We may be unable to successfully integrate companies we acquire.

Upon the closing of any acquisition we complete, we will need to successfully integrate the products, services and related assets, as well as internal controls into our business operations. If an acquisition is consummated, the integration of the acquired business, its products, services and related assets into our company also may be complex and time-consuming and, if the integration is not fully successful, we may not achieve the anticipated benefits, operating and cost synergies and/or growth opportunities of an acquisition. Potential difficulties that may be encountered in the integration process include the following:

- Integrating personnel, operations and systems (including internal control environments and compliance policies), while maintaining focus on producing and delivering consistent, high quality products and services;
- Coordinating geographically dispersed organizations;
- Disrupting management's attention from our ongoing business operations;
- Retaining existing customers and attracting new customers; and
- Managing inefficiencies associated with integrating our operations.

An inability to realize the full extent of the anticipated benefits, operating and cost synergies, innovations and operations efficiencies or growth opportunities of an acquisition, as well as any delays or additional expenses encountered in the integration process, could have a material adverse effect on our businesses and operating results. Furthermore, acquisitions, even if successfully integrated, may fail to further our business strategy as anticipated, expose us to increased competition or challenges with respect to our products, services or service areas, and expose us to additional liabilities associated with an acquired business including risks and liabilities associated with litigation involving the acquired business. Any one of these challenges or risks could impair our ability to realize any benefit from our acquisitions after we have expended resources on them.

We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities, which may be unsuccessful, cause us to assume unanticipated liabilities, disrupt our existing businesses, be dilutive or lead us to assume significant debt, among other things.

We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities as part of our growth strategy. In addition to the integration risks noted above, some other risks we face with respect to acquisitions and other inorganic growth strategies include:

- we frequently compete with other firms, some of which may have greater financial and other resources and a greater tolerance for risk, to acquire attractive companies;
- the acquired, alliance and/or joint venture businesses may not perform as projected;
- the goodwill or other intangible assets established as a result of our acquisitions may be incorrectly valued or may become impaired; for example, in 2018 we took $6.1 billion of goodwill impairment charges related to our LTC reporting unit within the Retail/LTC segment;
- we may assume unanticipated liabilities, including those that were not disclosed to us or which we underestimated;
- the acquired businesses, or the pursuit of other inorganic growth strategies, could disrupt or compete with our existing businesses, distract management, result in the loss of key employees, divert resources, result in tax costs or inefficiencies and make it difficult to maintain our current business standards, controls, information technology systems, policies, procedures and performance;

- as we did in the Aetna Acquisition, we may finance future acquisitions and other inorganic growth strategies by issuing common stock for some or all of the purchase price, which would dilute the ownership interests of our stockholders;
- as we did in the Aetna Acquisition, we may incur significant debt in connection with acquisitions (whether to finance acquisitions or by assuming debt from the businesses we acquire);
- we may not have the expertise to manage and profitably grow the businesses we acquire, and we may need to rely on the retention of key personnel and other suppliers of businesses we acquire, which may be difficult or impossible to accomplish;
- we may enter into merger or purchase agreements but, due to reasons within or outside our control, fail to complete the related transactions, which could result in termination fees or other penalties that could be material, cause material disruptions to our businesses and operations and adversely affect our brand and reputation;
- in order to complete a proposed acquisition, we may be required to divest certain portions of our business, for which we may not be able to obtain favorable pricing;
- as is the case with the Aetna Acquisition and our acquisition of Omnicare, Inc., we may be involved in litigation related to mergers or acquisitions, including for matters that occurred prior to the applicable closing, which may be costly to defend and may result in adverse rulings against us that could be material; and
- the integration into our businesses of the businesses and entities we acquire may affect the way in which existing laws and regulations apply to us, including subjecting us to laws and regulations that did not previously apply to us.

In addition, joint ventures present risks that are different from acquisitions, including selection of appropriate joint venture parties, initial and ongoing governance of the joint venture, joint venture compliance activities (including compliance with applicable CMS requirements), growing the joint venture's business in a manner acceptable to all the parties, including other providers in the networks that include joint ventures, maintaining positive relationships among the joint venture parties and the joint venture's customers, and member and business disruption that may occur upon joint venture termination.

Risks Related to Our Operations

Failure to meet customer expectations may harm our brand and reputation, our ability to retain and grow our customer base and membership and our operating results and cash flows.

Our ability to attract and retain customers and members is dependent upon providing cost effective, quality customer service operations (such as call center operations, PBM functions, retail pharmacy and LTC services, retail, mail order and specialty pharmacy prescription delivery, claims processing, customer case installation and online access and tools) that meet or exceed our customers' and members' expectations, either directly or through vendors. As we seek to reduce general and administrative expenses, we must balance the potential impact of cost-saving measures on our customers and other services and performances. If we misjudge the effects of such measures, customers and other services may be adversely affected. We depend on third parties for certain of our customer service, PBM and prescription delivery operations. If we or our vendors fail to provide service that meets our customers' and members' expectations, we may have difficulty retaining or profitably growing our customer base and/or membership, which could adversely affect our operating results. For example, noncompliance with any privacy or security laws or regulations or any security breach involving us or one of our third-party vendors could have a material adverse effect on our businesses, operating results, brand and reputation.

We and our vendors have experienced and continue to experience cyber attacks. We can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of such attacks or other information security (including cybersecurity) risks or threats in the future.

We and our vendors have experienced diverse cyber attacks and expect to continue to experience cyber attacks going forward. As examples, the Company and its vendors have experienced attempts to gain access to systems, denial of service attacks, attempted malware infections, account takeovers, scanning activity, and phishing emails. Attacks can originate from external criminals, terrorists, nation states, or internal actors. The Company is dedicating and will continue to dedicate significant resources and incur significant expenses to maintain and update on an ongoing basis the systems and processes that are designed to mitigate the information security risks it faces and protect the security of its computer systems, software, networks and other technology assets against attempts by unauthorized parties to obtain access to confidential information, disrupt or degrade service, or cause other damage. The impact of cyber attacks has not been material to the Company's operations or operating results through December 31, 2020. The Board and its Audit Committee and Nominating and Corporate Governance Committee are regularly informed regarding the Company's information security policies, practices and status.

A compromise of our information security controls or of those businesses with whom we interact, which results in confidential information being accessed, obtained, damaged, or used by unauthorized or improper persons, could harm our reputation and expose us to regulatory actions and claims from customers and clients, financial institutions, payment card associations and other persons, any of which could adversely affect our businesses, operating results and financial condition. Because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and may not immediately produce signs of intrusion, we may be unable to anticipate these techniques or to implement adequate preventative measures. Moreover, a data security breach could require that we expend significant resources related to our information systems and infrastructure, and could distract management and other key personnel from performing their primary operational duties. We also could be adversely affected by any significant disruption in the systems of third parties we interact with, including key payors and vendors.

The costs of attempting to protect against the foregoing risks and the costs of responding to a cyber-incident are significant. Large scale data breaches at other entities increase the challenge we and our vendors face in maintaining the security of our information technology systems and proprietary information and of our customers', members' and other constituents' sensitive information. Following a cyber-incident, our and/or our vendors' remediation efforts may not be successful, and a cyber-incident could result in interruptions, delays or cessation of service, and loss of existing or potential customers and members. In addition, breaches of our and/or our vendors' security measures and the unauthorized dissemination of sensitive personal information or proprietary information or confidential information about us, our customers, our members or other third-parties, could expose our customers', members' and other constituents' private information and our customers, members and other constituents to the risk of financial or medical identity theft, or expose us or other third parties to a risk of loss or misuse of this information, and result in investigations, regulatory enforcement actions, material fines and penalties, loss of customers, litigation or other actions which could have a material adverse effect on our brand, reputation, businesses, operating results and cash flows.

Data governance failures can adversely affect our reputation, businesses and prospects. Our use and disclosure of members', customers' and other constituents' sensitive information is subject to complex regulations at multiple levels. We would be adversely affected if we or our business associates or other vendors fail to adequately protect members', customers' or other constituents' sensitive information.

Our information systems are critical to the operation of our businesses. We collect, process, maintain, retain, evaluate, utilize and distribute large amounts of personal health and financial information and other confidential and sensitive data about our customers, members and other constituents in the ordinary course of our businesses. Some of our information systems rely upon third party systems, including cloud service providers, to accomplish these tasks. The use and disclosure of such information is regulated at the federal, state and international levels, and these laws, rules and regulations are subject to change and increased enforcement activity, such as the California Consumer Privacy Act which went into effect January 1, 2020, the EU's GDPR which began to apply across the EU during 2018 and the audit program implemented by HHS under HIPAA. In some cases, such laws, rules and regulations also apply to our vendors and/or may hold us liable for any violations by our vendors. International laws, rules and regulations governing the use and disclosure of such information are generally more stringent than U.S. laws and regulations, and they vary from jurisdiction to jurisdiction. Noncompliance with any privacy or security laws or regulations, or any security breach, cyber attack or cybersecurity breach, and any incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, sensitive or confidential customer, member or other constituent information, whether by us, by one of our business associates or vendors or by another third party, could require us to expend significant resources to remediate any damage, could interrupt our operations and could adversely affect our brand and reputation, membership and operating results and also could expose and/or has exposed us to mandatory disclosure to the media, litigation (including class action litigation), governmental investigations and enforcement proceedings, material fines, penalties and/or remediation costs, and compensatory, special, punitive and statutory damages, consent orders, adverse actions against our licenses to do business and/or injunctive relief, any of which could adversely affect our businesses, operating results, cash flows or financial condition.

Our businesses depend on our customers', members' and other constituents' willingness to entrust us with their health related and other sensitive personal information. Events that adversely affect that trust, including inadequate disclosure to our members or customers of our uses of their information, failing to keep our information technology systems and our customers', members' and other constituents' sensitive information secure from significant attack, theft, damage, loss or unauthorized disclosure or access, whether as a result of our action or inaction (including human error) or that of our business associates, vendors or other third parties, could adversely affect our brand and reputation, membership and operating results and also could expose and/or has exposed us to mandatory disclosure to the media, litigation (including class action litigation), governmental investigations and enforcement proceedings, material fines, penalties and/or remediation costs, and compensatory, special, punitive and statutory damages, consent orders, adverse actions against our licenses to do business and/or injunctive relief, any of which

could adversely affect our businesses, operating results, cash flows or financial condition. Large scale data breaches at other entities increase the challenge we and our vendors face in maintaining the security of our information technology systems and proprietary information and of our customers', members' and other constituents' sensitive information. There can be no assurance that additional such failures will not occur, or if any do occur, that we will detect them or that they can be sufficiently remediated.

Product liability, product recall or personal injury issues could damage our reputation and have a significant adverse effect on our businesses, operating results, cash flows and/or financial condition.

The products that we sell could become subject to contamination, product tampering, mislabeling, recall or other damage. In addition, errors in the dispensing and packaging of drugs and consuming drugs in a manner that is not prescribed could lead to serious injury or death. Product liability or personal injury claims may be asserted against us with respect to any of the drugs or other products we sell or services we provide. For example, we are a defendant in hundreds of litigation proceedings relating to opioids and the sale of products containing talc. Our businesses involve the provision of professional services, including by pharmacists, physician assistants, nurses and nurse practitioners, which exposes us to professional liability claims. Should a product or other liability issue arise, the coverage available under our insurance programs and the indemnification amounts available to us from third parties may not be adequate to protect us against the financial impact of the related claims. We also may not be able to maintain our existing levels of insurance on acceptable terms in the future. A product liability or personal injury issue or judgment against us or a product recall could damage our reputation and have a significant adverse effect on our businesses, operating results and/or financial condition.

We face significant competition in attracting and retaining talented employees. Further, managing succession for, and retention of, key executives is critical to our success, and our failure to do so could adversely affect our businesses, operating results and/or future performance.

Our ability to attract and retain qualified and experienced employees is essential to meet our current and future goals and objectives. There is no guarantee we will be able to attract and retain such employees or that competition among potential employers will not result in increased compensation and/or benefits costs. If we are unable to retain existing employees or attract additional employees, or we experience an unexpected loss of leadership, we could experience a material adverse effect on our businesses, operating results and/or future performance.

In addition, our failure to adequately plan for succession of senior management and other key management roles or the failure of key employees to successfully transition into new roles could have a material adverse effect on our businesses, operating results and/or future performance. The succession plans we have in place and our employment arrangements with certain key executives do not guarantee the services of these executives will continue to be available to us.

Sales of our products and services are dependent on our ability to attract and motivate internal sales personnel and independent third-party brokers, consultants and agents. New distribution channels create new disintermediation risk. We may be subject to penalties or other regulatory actions as a result of the marketing practices of brokers and agents selling our products.

Our products are sold primarily through our sales personnel, who frequently work with independent brokers, consultants and agents who assist in the production and servicing of business. The independent brokers, consultants and agents generally are not dedicated to us exclusively and may frequently recommend and/or market health care benefits products of our competitors. Accordingly, we must compete intensely for their services and allegiance. Our sales could be adversely affected if we are unable to attract, retain or motivate sales personnel and third-party brokers, consultants and agents, or if we do not adequately provide support, training and education to this sales network regarding our complex product portfolio, or if our sales strategy is not appropriately aligned across distribution channels. This risk is heightened as we develop, operate and expand our consumer-oriented products and services and we expand in the health care space and our business model evolves to include a greater focus on consumers and direct-to-consumer sales, such as competing for sales on Insurance Exchanges.

New distribution channels for our products and services continue to emerge, including Private Exchanges operated by health care consultants and technology companies. These channels may make it more difficult for us to directly engage consumers and other customers in the selection and management of their health care benefits, in health care utilization and in the effective navigation of the health care system. We also may be challenged by new technologies and marketplace entrants that could interfere with our existing relationships with customers and health plan members in these areas.

In addition, there have been several investigations regarding the marketing practices of brokers and agents selling health care and other insurance products and the payments they receive. These investigations have resulted in enforcement actions against companies in our industry and brokers and agents marketing and selling those companies' products. For example, CMS and state departments of insurance have increased their scrutiny of the marketing practices of brokers and agents who market Medicare products. These investigations and enforcement actions could result in penalties and the imposition of corrective action plans and/or changes to industry practices, which could adversely affect our ability to market our products.

Failure of our businesses to effectively collaborate could prevent us from maximizing our operating results.

To maximize our overall enterprise value, our various businesses need to collaborate effectively. Our businesses need to be aligned in order to prioritize goals and coordinate the design of new products intended to utilize the offerings of multiple businesses, including our transformation and enterprise modernization programs. In addition, misaligned incentives, information siloes, ineffective product development and failure of our corporate governance policies or procedures, for example significant financial decisions being made at an inappropriate level in our organization, also could prevent us from maximizing our operating results and/or achieving our financial and other projections.

The failure or disruption of our information technology systems or the failure of our information technology infrastructure to support our businesses could adversely affect our reputation, businesses, operating results and cash flows.

Our information systems are subject to damage or interruption from power outages, facility damage, computer and telecommunications failures, computer viruses, security breaches (including credit card or personally identifiable information breaches), cyber attacks, vandalism, catastrophic events and human error. If our information systems are damaged, fail to work properly or otherwise become unavailable, we may incur substantial costs to repair or replace them, and may experience reputational damage, loss of critical information, customer disruption and interruptions or delays in our ability to perform essential functions and implement new and innovative services. In addition, compliance with changes in U.S. and foreign laws and regulations, including privacy and information security laws and standards, may cause us to incur significant expense due to increased investment in technology and the development of new operational processes.

Our business success and operating results depend in part on effective information technology systems and on continuing to develop and implement improvements in technology. Pursuing multiple initiatives simultaneously could make this continued development and implementation significantly more challenging.

Many aspects of our operations are dependent on our information systems and the information collected, processed, stored, and handled by these systems. We rely heavily on our computer systems to manage our ordering, pricing, point-of-sale, pharmacy fulfillment, inventory replenishment, claims processing, customer loyalty and subscription programs, finance and other processes. Throughout our operations, we collect, process, maintain, retain, evaluate, utilize and distribute large amounts of confidential and sensitive data and information, including personally identifiable information and protected health information, that our customers, members and other constituents provide to purchase products or services, enroll in programs or services, register on our websites, interact with our personnel, or otherwise communicate with us. In addition, for these operations, we depend in part on the secure transmission of confidential information over public networks.

We have many different information and other technology systems supporting our businesses (including as a result of our acquisitions). Our businesses depend in large part on these systems to adequately price our products and services; accurately establish reserves, process claims and report operating results; and interact with providers, employer plan sponsors, customers, members, consumers and vendors in an efficient and uninterrupted fashion. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Certain of our technology systems (including software) are older, legacy systems that are less flexible, less efficient and require a significant ongoing commitment of capital and human resources to maintain, protect and enhance them and to integrate them with our other systems. We must re-engineer and reduce the number of these systems to meet changing consumer and vendor preferences and needs, improve our productivity and reduce our operating expenses. We also need to develop or acquire new technology systems, contract with new vendors or modify certain of our existing systems to support the consumer-oriented and transformation products and services we are developing, operating and expanding and/or to meet current and developing industry and regulatory standards, including to keep pace with continuing changes in information processing technology and emerging cybersecurity risks and threats. If we fail to achieve these objectives, our ability to profitably grow our business and/or our operating results may be adversely affected.

In addition, information technology and other technology and process improvement projects, including our transformation and enterprise modernization programs, frequently are long-term in nature and may take longer to complete and cost more than we

expect and may not deliver the benefits we project once they are complete. If we do not effectively and efficiently secure, manage, integrate and enhance our technology portfolio (including vendor sourced systems), we could, among other things, have problems determining health care and other benefit cost estimates and/or establishing appropriate pricing, meeting the needs of customers, consumers, providers, members and vendors, developing and expanding our consumer-oriented products and services or keeping pace with industry and regulatory standards, and our operating results may be adversely affected.

We are subject to payment-related risks that could increase our operating costs, expose us to fraud or theft, subject us to potential liability and disrupt our business operations.

We accept payments using a variety of methods, including cash, checks, credit cards, debit cards, gift cards, mobile payments and potentially other technologies in the future. Acceptance of these payment methods subjects us to rules, regulations, contractual obligations and compliance requirements, including payment network rules and operating guidelines, data security standards and certification requirements, and rules governing electronic funds transfers. These requirements may change in the future, which could make compliance more difficult or costly. For certain payment options, including credit and debit cards, we pay interchange and other fees, which could increase periodically thereby raising our operating costs. We rely on third parties to provide payment processing services, including the processing of credit cards, debit cards, and various other forms of electronic payment. If these vendors are unable to provide these services to us, or if their systems are compromised, our operations could be disrupted. The payment methods that we offer also expose us to potential fraud and theft by persons seeking to obtain unauthorized access to, or exploit any weaknesses in, the payment systems we use. If we fail to abide by applicable rules or requirements, or if data relating to our payment systems is compromised due to a breach or misuse, we may be responsible for any costs incurred by payment card issuing banks and other third parties or subject to fines and higher transaction fees. In addition, our reputation and ability to accept certain types of payments could each be harmed resulting in reduced sales and adverse effects on our operating results.

Both our and our vendors' operations are subject to a variety of business continuity hazards and risks, any of which could interrupt our operations or otherwise adversely affect our performance and operating results.

We and our vendors are subject to business continuity hazards and other risks, including natural disasters, utility and other mechanical failures, acts of war or terrorism, acts of civil unrest, disruption of communications, data security and preservation, disruption of supply or distribution, safety regulation and labor difficulties. The occurrence of any of these or other events to us or our vendors might disrupt or shut down our operations or otherwise adversely affect our operations. We also may be subject to certain liability claims in the event of an injury or loss of life, or damage to property, resulting from such events. Although we have developed procedures for crisis management and disaster recovery and business continuity plans and maintain insurance policies that we believe are customary and adequate for our size and industry, our insurance policies include limits and exclusions and, as a result, our coverage may be insufficient to protect against all potential hazards and risks incident to our businesses. In addition, our crisis management and disaster recovery procedures and business continuity plans may not be effective. Should any such hazards or risks occur, or should our insurance coverage be inadequate or unavailable, our businesses, operating results, cash flows and financial condition could be adversely affected.

Financial Risks

We would be adversely affected if we do not effectively deploy our capital. Downgrades or potential downgrades in our credit ratings, should they occur, could adversely affect our brand and reputation, businesses, operating results, cash flows and financial condition.

Our operations generate significant capital, and we have the ability to raise additional capital. The manner in which we deploy our capital, including investments in our businesses, our operations (such as information technology and other strategic and capital projects), dividends, acquisitions, share and/or debt repurchases, repayment of debt, reinsurance or other capital uses, impacts our financial strength, claims paying ability and credit ratings issued by nationally-recognized statistical rating organizations. Credit ratings issued by nationally-recognized statistical rating organizations are broadly distributed and generally used throughout our industries. Our ratings reflect each rating organization's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to our insureds. We believe our credit ratings and the financial strength and claims paying ability of our principal insurance and HMO subsidiaries are important factors in marketing our Health Care Benefits products to certain of our customers.

Each of the ratings organizations reviews our ratings periodically, and there can be no assurance that our current ratings will be maintained in the future. In connection with the completion of the Aetna Acquisition, each of Standard & Poor's, Moody's and

Fitch downgraded certain of our debt, financial strength and/or other credit ratings. Downgrades in our ratings could adversely affect our businesses, operating results, cash flows and financial condition.

Goodwill and other intangible assets could, in the future, become impaired.

As of December 31, 2020 and December 31, 2019, we had $110.7 billion and $112.9 billion, respectively, of goodwill and other intangible assets. Goodwill and indefinitely-lived intangible assets are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that the carrying value may not be recoverable. When evaluating goodwill for potential impairment, we compare the fair value of our reporting units to their respective carrying amounts. We estimate the fair value of our reporting units using a combination of a discounted cash flow method and a market multiple method. If the carrying amount of a reporting unit exceeds its estimated fair value, a goodwill impairment loss is recognized in an amount equal to the excess to the extent of the goodwill balance. Estimated fair values could change if, for example, there are changes in the business climate, industry-wide changes, changes in the competitive environment, adverse legal or regulatory actions or developments, changes in capital structure, cost of debt, interest rates, capital expenditure levels, operating cash flows or market capitalization. Because of the significance of our goodwill and intangible assets, any future impairment of these assets could require material noncash charges to our operating results, which also could have a material adverse effect on our financial condition.

Adverse conditions in the U.S. and global capital markets can significantly and adversely affect the value of our investments in debt and equity securities, mortgage loans, alternative investments and other investments, and our operating results and/or our financial condition.

The global capital markets, including credit markets, continue to experience volatility and uncertainty. As an insurer, we have a substantial investment portfolio that supports our policy liabilities and surplus and is comprised largely of debt securities of issuers located in the U.S. As a result, the income we earn from our investment portfolio is largely driven by the level of interest rates in the U.S., and to a lesser extent the international financial markets; and volatility, uncertainty and/or disruptions in the global capital markets, particularly the U.S. credit markets, and governments' monetary policy, particularly U.S. monetary policy, can significantly and adversely affect the value of our investment portfolio, our operating results and/or our financial condition by:

- significantly reducing the value and/or liquidity of the debt securities we hold in our investment portfolio and creating realized capital losses that reduce our operating results and/or unrealized capital losses that reduce our shareholders' equity;
- keeping interest rates low on high-quality short-term or medium-term debt securities (such as we have experienced during recent years) and thereby materially reducing our net investment income and operating results as the proceeds from securities in our investment portfolio that mature or are otherwise disposed of continue to be reinvested in lower yielding securities;
- reducing the fair values of our investments if interest rates rise;
- causing non-performance of or defaults on their obligations to us by third parties, including customers, issuers of securities in our investment portfolio, mortgage borrowers and/or reinsurance and/or derivatives counterparties;
- making it more difficult to value certain of our investment securities, for example if trading becomes less frequent, which could lead to significant period-to-period changes in our estimates of the fair values of those securities and cause period-to-period volatility in our net income and shareholders' equity;
- reducing our ability to issue short-term debt securities at attractive interest rates, thereby increasing our interest expense and decreasing our operating results; and
- reducing our ability to issue other securities.

Although we seek, within guidelines we deem appropriate, to match the duration of our assets and liabilities and to manage our credit and counterparty exposures, a failure adequately to do so could adversely affect our net income and our financial condition and, in extreme circumstances, our cash flows.

We have incurred and assumed significant indebtedness which has increased our consolidated interest expense and could adversely affect our business flexibility and increase our borrowing costs.

In order to complete the Aetna Acquisition, we incurred acquisition-related debt financing of approximately $45.0 billion and assumed Aetna's existing indebtedness with a fair value of approximately $8.1 billion. Our substantial indebtedness and elevated debt-to-equity ratio have the effect, among other things, of reducing our flexibility to respond to changing business and economic conditions and increasing our interest expense compared to pre-Aetna Acquisition periods. In addition, the amount of

cash required to service our increased indebtedness levels and thus the demands on our cash resources are greater than the amount of cash flows required to service our indebtedness prior to the Aetna Acquisition. We have suspended share repurchases until we reach our desired debt-to-equity ratio. The increased levels of indebtedness also could reduce funds available to engage in investments in product development, capital expenditures, dividend payments and other activities and may create competitive disadvantages for us relative to other companies with lower debt levels.

Risks Related to Our Relationships with Manufacturers, Providers, Suppliers and Vendors

We face risks relating to the market availability, pricing, suppliers and safety profiles of prescription drugs and other products that we purchase and sell.

Our Retail/LTC segment and our mail order and specialty pharmacy operations generate revenues in significant part by dispensing prescription drugs. Our PBM business generates revenues primarily by contracting with clients to provide prescription drugs and related health care services to plan members. As a result, we are dependent on our relationships with prescription drug manufacturers and suppliers. We acquire a substantial amount of our mail order and specialty pharmacies' prescription drug supply from a limited number of suppliers. Certain of our agreements with such suppliers are short-term and cancelable by either party without cause. In addition, these agreements may allow the supplier to distribute through channels other than us. Certain of these agreements also allow pricing and other terms to be adjusted periodically for changing market conditions or required service levels. A termination or modification to any of these relationships could adversely affect our prescription drug supply and have a material adverse effect on our businesses, operating results and financial condition. Moreover, many products distributed by our pharmacies are manufactured with ingredients that are susceptible to supply shortages. In some cases, we depend upon a single source of supply. Any such supply shortages or loss of any such single source of supply could adversely affect our operating results and cash flows.

Much of the branded and generic drug product that we sell in our pharmacies, and much of the other merchandise we sell, is manufactured in whole or in substantial part outside of the United States. In most cases, the products or merchandise are imported by others and sold to us. As a result, significant changes in tax or trade policies, tariffs or trade relations between the United States and other countries, such as the imposition of unilateral tariffs on imported products, could result in significant increases in our costs, restrict our access to suppliers, depress economic activity, and have a material adverse effect on our businesses, operating results and cash flows. In addition, other countries may change their business and trade policies and such changes, as well as any negative sentiments towards the United States in response to increased import tariffs and other changes in U.S. trade regulations, could adversely affect our businesses.

Our suppliers are independent entities subject to their own operational and financial risks that are outside our control. If our current suppliers were to stop selling prescription drugs to us or delay delivery, including as a result of supply shortages, supplier production disruptions, supplier quality issues, closing or bankruptcies of our suppliers, or for other reasons, we may be unable to procure alternatives from other suppliers in a timely and efficient manner and on acceptable terms, or at all.

Our operating results may be adversely affected if we are unable to contract with providers on competitive terms and develop and maintain attractive networks with high quality providers.

We are seeking to enhance our health care provider networks by entering into joint ventures and other collaborative risk-sharing arrangements with providers. Providers' willingness to enter these arrangements with us depends upon, among other things, our ability to provide them with up to date quality of care data to support these value-based contracts. These arrangements are designed to give providers incentives to engage in population health management and optimize delivery of health care to our members. These arrangements also may allow us to expand into new geographies, target new customer groups, increase membership and reduce medical costs and, if we provide technology or other services to the relevant health system or provider organization, may contribute to our revenue and earnings from alternative sources. If such arrangements do not result in the lower medical costs that we project or if we fail to attract providers to such arrangements, or are less successful at implementing such arrangements than our competitors, our medical costs may not be competitive and may be higher than we project, our attractiveness to customers may be reduced, we may lose or be unable to grow medical membership, and our ability to profitably grow our business and/or our operating results may be adversely affected.

While we believe joint ventures, accountable care organizations ("ACOs") and other non-traditional health care provider organizational structures present opportunities for us, the implementation of our joint ventures and other non-traditional structure strategies may not achieve the intended results, which could adversely affect our operating results and cash flows. Among other things, joint ventures require us to maintain collaborative relationships with our counterparties, continue to gain access to provider rates that make the joint ventures economically sustainable and devote significant management time to the

operation and management of the joint ventures. We may not be able to achieve these objectives in one or more of our joint ventures, which could adversely affect our operating results and cash flows.

If our service providers fail to meet their contractual obligations to us or to comply with applicable laws or regulations, we may be exposed to brand and reputational harm, litigation and/or regulatory action. This risk is particularly high in our Medicare, Medicaid, dual eligible and dual eligible special needs plan programs.

We contract with various third parties to perform certain functions and services and provide us with certain information technology systems. Our arrangements with these third parties may expose us to public scrutiny, adversely affect our brand and reputation, expose us to litigation or regulatory action, and otherwise make our operations vulnerable if we fail to adequately oversee, monitor and regulate their performance or if they fail to meet their contractual obligations to us or to comply with applicable laws or regulations. For example, certain of our vendors have been responsible for releases of sensitive information of our members and employees, which has caused us to incur additional expenses and given rise to regulatory actions and litigation against us.

These risks are particularly high in our Medicare, Medicaid, dual eligible and dual eligible special needs plan programs, where third parties perform medical management and other member related services for us. Any failure of our or these third parties' prevention, detection or control systems related to regulatory compliance, compliance with our internal policies, data security and/or cybersecurity or any incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, members', customers' or other constituents' sensitive information could require us to expend significant resources to remediate any damage, interrupt our operations and adversely affect our brand and reputation and also expose us to whistleblower, class action and other litigation, other proceedings, prohibitions on marketing or active or passive enrollment of members, corrective actions, fines, sanctions and/or penalties, any of which could adversely affect our businesses, operating results, cash flows and/or financial condition.

We may experience increased medical and other benefit costs, litigation risk and customer and member dissatisfaction when providers that do not have contracts with us render services to our Health Care Benefits members.

Some providers that render services to our Health Care Benefits members do not have contracts with us. In those cases, we do not have a pre-established understanding with these providers as to the amount of compensation that is due to them for services rendered to our members. In some states, the amount of compensation due to these nonparticipating providers is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover the difference between what we have paid them and the amount they charged us from our members, which may result in customer and member dissatisfaction. For example, in October 2018, an arbitrator awarded certain claimant hospitals approximately $150 million in a proceeding relating to Aetna's out-of-network benefit payment and administration practices, and in March 2019 that award was reduced to approximately $86 million. Such disputes may cause us to pay higher medical or other benefit costs than we projected.

Continuing consolidation and integration among providers and other suppliers may increase our medical and other covered benefits costs, make it difficult for us to compete in certain geographies and create new competitors.

Hospitals and other providers and health systems continue to consolidate across the health care industry. While this consolidation could increase efficiency and has the potential to improve the delivery of health care services, it also reduces competition and the number of potential contracting parties in certain geographies. These health systems also are increasingly forming and considering forming health plans to directly offer health insurance in competition with us, a process that has been accelerated by the ACA. In addition, ACOs (including Commercial and Medicaid-only ACOs developed as a result of state Medicaid laws), practice management companies, consolidation among and by integrated health systems and other changes in the organizational structures that physicians, hospitals and other providers adopt continues to change the way these providers interact with us and the competitive landscape in which we operate. These changes may increase our medical and other covered benefits costs, may affect the way we price our products and services and estimate our medical and other covered benefits costs and may require us to change our operations, including by withdrawing from certain geographies where we do not have a significant presence across our businesses or are unable to collaborate or contract with providers on acceptable terms. Each of these changes may adversely affect our businesses and operating results.

Item 1B. Unresolved Staff Comments.

There are no unresolved SEC Staff Comments.

Item 2. Properties.

The Company's principal office is an owned building complex located in Woonsocket, Rhode Island, which totals approximately one million square feet. The Company also leases office space in other locations in the United States.

Pharmacy Services Segment

The Pharmacy Services segment includes owned or leased mail service dispensing pharmacies, call centers, on-site pharmacy stores, retail specialty pharmacy stores, specialty mail service pharmacies and branches for infusion and enteral services throughout the United States.

Retail/LTC Segment

As of December 31, 2020, the Retail/LTC segment operated the following properties:

- Approximately 8,115 retail stores, of which approximately 5% were owned. Net selling space for retail stores was approximately 80.1 million square feet as of December 31, 2020.
- Approximately 1,845 retail pharmacies within retail chains, as well as approximately 80 clinics in Target Corporation ("Target") stores;
- Owned distribution centers and leased distribution facilities throughout the United States totaling approximately 10.5 million square feet; and
- Owned and leased LTC pharmacies throughout the United States and an owned LTC repackaging facility.

In connection with certain business dispositions completed between 1995 and 1997, the Company continues to guarantee lease obligations for 76 former stores. The Company is indemnified for these guarantee obligations by the respective initial purchasers. These guarantees generally remain in effect for the initial lease term and any extension thereof pursuant to a renewal option provided for in the lease prior to the time of the disposition. For additional information on these guarantees, see "Lease Guarantees" in Note 16 ''Commitments and Contingencies'' included in Item 8 of this 10-K.

Health Care Benefits Segment

The Health Care Benefits segment's principal office is an owned building complex located in Hartford, Connecticut, which totals approximately 1.7 million square feet. The Health Care Benefits segment also owns or leases office space in other locations in the United States and several other countries.

Management believes that the Company's owned and leased facilities are suitable and adequate to meet the Company's anticipated needs. At the end of the existing lease terms, management believes the leases can be renewed or replaced by alternative space. For additional information on the right-of-use assets and lease liabilities associated with the Company's leases, see Note 6 ''Leases'' included in Item 8 of this 10-K.

Item 3. Legal Proceedings.

I. Legal Proceedings

The information contained in Note 16 ''Commitments and Contingencies'' included in Item 8 of this 10-K is incorporated herein by reference.

II. Environmental Matters

Item 103 of SEC Regulation S-K requires disclosure of environmental legal proceedings with a governmental authority if management reasonably believes that the proceedings involve potential monetary sanctions of $1 million or more.

The Company is in the process of negotiating with the New York State Department of Environmental Conservation to resolve claims of alleged historical noncompliance with hazardous waste regulations in connection with LTC pharmacies in the State of New York. These proceedings are not material to the Company's business or financial condition.

Item 4. Mine Safety Disclosures.

Not applicable.

Information about our Executive Officers

The following sets forth the name, age and biographical information for each of the Registrant's executive officers as of February 16, 2021. In each case the officer's term of office extends to the date of the meeting of the Board following the next annual meeting of stockholders of CVS Health. Previous positions and responsibilities held by each of the executive officers over the past five years or more are indicated below:

Eva C. Boratto, age 54, Executive Vice President and Chief Financial Officer of CVS Health Corporation since November 2018; Executive Vice President - Controller and Chief Accounting Officer of CVS Health Corporation from March 2017 through November 2018; Senior Vice President - Controller and Chief Accounting Officer of CVS Health Corporation from July 2013 through February 2017. Ms. Boratto is also a member of the board of directors of United Parcel Service, Inc., an international package delivery and supply chain management company.

Troyen A. Brennan, M.D., age 66, Executive Vice President and Chief Medical Officer of CVS Health Corporation since November 2008; Executive Vice President and Chief Medical Officer of Aetna Inc. from February 2006 through November 2008.

James D. Clark, age 56, Senior Vice President - Controller and Chief Accounting Officer of CVS Health Corporation since November 2018; Vice President - Finance and Accounting of CVS Pharmacy, Inc. from September 2009 through October 2018.

Daniel P. Finke, age 50, Executive Vice President of CVS Health Corporation and President of Health Care Benefits since February 2021; Executive Vice President, Commercial Business and Markets of Aetna from February 2020 through January 2021; Executive Vice President, Consumer Health and Service of Aetna from June 2018 through January 2020; Senior Vice President, Network and Clinical Services of Aetna from January 2016 through May 2018.

Laurie P. Havanec, age 60, Executive Vice President and Chief People Officer of CVS Health Corporation since February 2021; Executive Vice President and Chief People Officer, Otis Worldwide Corporation, an elevator, escalator and moving walkway manufacturer, from October 2019 through January 2021; Corporate Vice President, Talent of United Technologies Corporation, a multinational manufacturing conglomerate, from April 2019 through October 2019; Vice President - HR, Institution Businesses of Aetna from 2013 through March 2017.

Alan M. Lotvin, M.D., age 59, Executive Vice President of CVS Health Corporation and President of CVS Caremark since March 2020; Executive Vice President - Transformation of CVS Health Corporation from June 2018 through February 2020; Executive Vice President - Specialty Pharmacy, CVS Caremark from November 2012 through May 2018.

Karen S. Lynch, age 58, President and Chief Executive Officer of CVS Health Corporation since February 2021; Executive Vice President of CVS Health Corporation from November 2018 through January 2021; President of Aetna from January 2015 through January 2021; Executive Vice President, Local and Regional Businesses of Aetna from February 2013 through December 2014; and a director of CVS Health Corporation since February 2021. Ms. Lynch is also a member of the board of directors of U.S. Bancorp, a banking and financial services company.

Neela Montgomery, age 46, Executive Vice President of CVS Health Corporation and President of Retail/Pharmacy since November 2020; Chief Executive Officer of Crate & Barrel Holdings, a retailer of furniture, kitchenware and other home essentials, from August 2017 through August 2020; Executive Board Member of Otto Group GmbH, a German e-commerce company, from November 2014 through July 2017. Ms. Montgomery is also a member of the board of directors of Logitech International SA, a Swiss-American manufacturer of computer peripherals and software.

Thomas M. Moriarty, age 57, Executive Vice President and General Counsel of CVS Health Corporation since October 2012; Chief Policy and External Affairs Officer since March 2017; Chief Strategy Officer from March 2014 through February 2017.

Jonathan C. Roberts, age 65, Executive Vice President and Chief Operating Officer of CVS Health Corporation since March 2017; Executive Vice President of CVS Health Corporation and President of CVS Caremark from September 2012 through February 2017.

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.

Market Information

CVS Health's common stock is listed on the New York Stock Exchange under the symbol "CVS."

Dividends

CVS Health has paid cash dividends every quarter since becoming a public company. Future dividends will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

See Note 12 ''Shareholders' Equity'' included in Item 8 of this 10-K for information regarding CVS Health's dividends.

Holders of Common Stock

As of February 8, 2021, there were 26,078 registered holders of the registrant's common stock according to the records maintained by the registrant's transfer agent.

Issuer Purchases of Equity Securities

The following share repurchase program has been authorized by the Board:

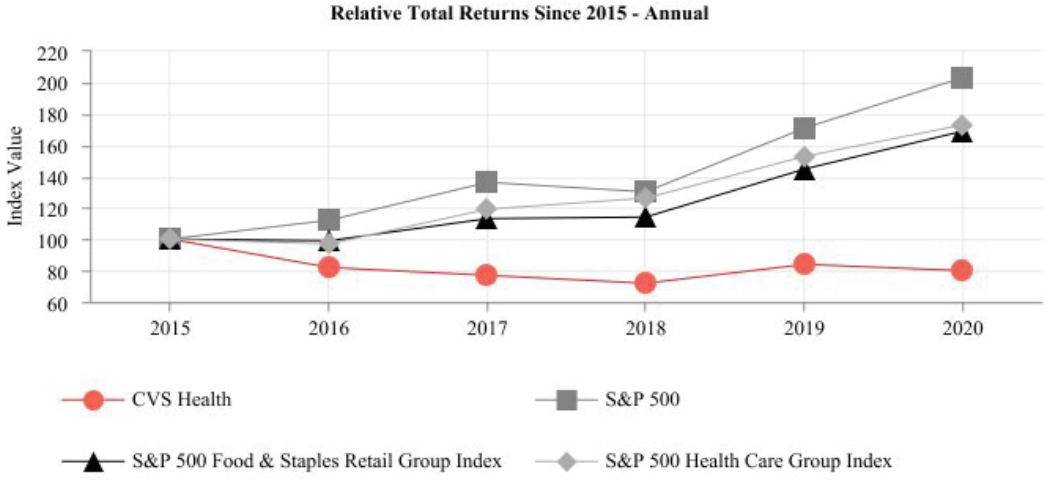
In billions				
Authorization Date		**Authorized**		**Remaining as of December 31, 2020**
November 2, 2016 ("2016 Repurchase Program")	$	15.0	$	13.9

The 2016 Repurchase Program permits the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase transactions, and/or other derivative transactions. The 2016 Repurchase Program can be modified or terminated by the Board at any time. During the three months ended December 31, 2020, the Company did not repurchase any shares of common stock.

See Note 12 ''Shareholders' Equity'' included in Item 8 of this 10-K for additional information regarding the Company's share repurchases.

Stock Performance Graph

The following graph compares the cumulative total shareholder return on CVS Health's common stock (assuming reinvestment of dividends) with the cumulative total return on the S&P 500 Index, the S&P 500 Food and Staples Retailing Industry Group Index and the S&P 500 Healthcare Sector Group Index from December 31, 2015 through December 31, 2020. The graph assumes a $100 investment in shares of CVS Health's common stock on December 31, 2015.



	December 31,					
	2015	2016	2017	2018	2019	2020
CVS Health Corporation	$ 100	$ 82	$ 77	$ 72	$ 84	$ 80
S&P 500 (1)	100	112	136	130	171	203
S&P 500 Food & Staples Retail Group Index (2)	100	99	113	114	145	169
S&P 500 Health Care Group Index (1) (3)	100	97	119	126	153	173

(1) Includes CVS Health.
(2) Includes five companies (COST, KR, SYY, WBA, WMT).
(3) Includes 63 companies.

The year-ended values of each investment shown in the preceding graph are based on share price appreciation plus dividends, with the dividends reinvested as of the last business day of the month during which such dividends were ex-dividend. The calculations exclude trading commissions and taxes. Total shareholder returns from each investment can be calculated from the year-end investment values shown beneath the graph.

Item 6. Reserved

Not applicable.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations. ("MD&A")

The following discussion and analysis should be read in conjunction with the audited consolidated financial statements and related notes included in Item 8 of this 10-K, "Risk Factors" included in Item 1A of this 10-K and the "Cautionary Statement Concerning Forward-Looking Statements" in this 10-K.

Overview of Business

CVS Health Corporation ("CVS Health"), together with its subsidiaries (collectively, the "Company," "we," "our" or "us"), is a diversified health services company united around a common purpose of helping people on their path to better health. In an increasingly connected and digital world, we are meeting people wherever they are and changing health care to meet their needs. The Company has more than 9,900 retail locations, approximately 1,100 walk-in medical clinics, a leading pharmacy benefits manager with approximately 105 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year and expanding specialty pharmacy services. We also serve an estimated 34 million people through traditional, voluntary and consumer-directed health insurance products and related services, including expanding Medicare Advantage offerings and a leading standalone Medicare Part D prescription drug plan ("PDP"). The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

On November 28, 2018 (the "Aetna Acquisition Date"), the Company acquired Aetna Inc. ("Aetna"). As a result of the acquisition of Aetna (the "Aetna Acquisition"), the Company added the Health Care Benefits segment. Certain aspects of Aetna's operations, including products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, are included in the Company's Corporate/Other segment. The consolidated financial statements reflect Aetna's results subsequent to the Aetna Acquisition Date.

The Company has four reportable segments: Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other, which are described below.

Overview of the Pharmacy Services Segment

The Pharmacy Services segment provides a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services, mail order pharmacy, specialty pharmacy and infusion services, clinical services, disease management services and medical spend management. The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, PDPs, Medicaid managed care plans, plans offered on public health insurance exchanges and private health insurance exchanges and other sponsors of health benefit plans throughout the United States. The Pharmacy Services segment operates retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services.

Overview of the Retail/LTC Segment

The Retail/LTC segment sells prescription drugs and a wide assortment of health and wellness products and general merchandise, provides health care services through its MinuteClinic® walk-in medical clinics, provides medical diagnostic testing, administers vaccinations for illnesses such as influenza, COVID-19 and shingles and conducts long-term care pharmacy ("LTC") operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to long-term care facilities and other care settings. As of December 31, 2020, the Retail/LTC segment operated more than 9,900 retail locations, approximately 1,100 MinuteClinic locations as well as online retail pharmacy websites, LTC pharmacies and on-site pharmacies. For the year ended December 31, 2020, the Company dispensed approximately 27.1% of the total retail pharmacy prescriptions in the United States.

Overview of the Health Care Benefits Segment

The Health Care Benefits segment is one of the nation's leading diversified health care benefits providers. The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make more informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental and behavioral health plans, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services and health information technology products and services. The Health Care Benefits

segment also provided workers' compensation administrative services through its Coventry Health Care Workers' Compensation business ("Workers' Compensation business") prior to the sale of this business on July 31, 2020. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates. The Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk for medical and dental care costs) as "ASC." For periods prior to the Aetna Acquisition Date, the Health Care Benefits segment was comprised only of the Company's SilverScript® PDP business.

Overview of the Corporate/Other Segment

The Company presents the remainder of its financial results in the Corporate/Other segment, which primarily consists of:

- Management and administrative expenses to support the Company's overall operations, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments, expenses associated with the Company's investments in its transformation and enterprise modernization programs and acquisition-related transaction and integration costs; and
- Products for which the Company no longer solicits or accepts new customers such as large case pensions and long-term care insurance products.

COVID-19

The COVID-19 pandemic has severely impacted the economies of the U.S. and other countries around the world. Beginning in March 2020, the effects of the COVID-19 pandemic began to emerge in the U.S. The Company executed preparedness plans to maintain continuity of its operations, including transitioning many office-based colleagues to a remote work environment and installing protective equipment in our retail pharmacies. The Company also provided enhanced benefits to its colleagues, including bonuses to frontline colleagues, dependent care financial assistance, paid sick leave for part-time colleagues and paid time off to colleagues who test positive or are quarantined due to exposure to COVID-19. Our strong local presence and scale in communities across the country enabled us to play an indispensable role in the national response to COVID-19, as well as provide seamless support for our customers wherever they needed us: in our CVS locations, in their homes, and virtually. The COVID-19 pandemic had a significant impact on the Company's operating results for the year ended December 31, 2020, primarily in the Company's Health Care Benefits and Retail/LTC segments.

Health Care Benefits Segment

Beginning in mid-March, the health system experienced a significant reduction in utilization of medical services ("utilization") that is discretionary and the cancellation of elective medical procedures. Utilization remained below historical levels through April, began to recover in May and June and reached more normal levels in the third and fourth quarters, with select geographies impacted by COVID-19 waves.

In response to COVID-19, the Company expanded benefit coverage to its members. These expanded benefits included cost-sharing waivers for COVID-19 related treatments, as well as assistance to members through premium credits, telehealth cost-sharing waivers and other investments.

COVID-19 also resulted in a shift in the Company's medical membership during the year. The Company experienced declines in Commercial membership due to reductions in workforce at our existing customers, substantially offset by increases in Medicaid membership primarily as a result of the suspension of eligibility redeterminations and increased unemployment.

Retail/LTC Segment

During March 2020, the Company experienced increased prescription volume due to the greater use of 90-day prescriptions and early refills of maintenance medications, as well as increased front store volume as consumers prepared for the COVID-19 pandemic. Beginning in the second quarter and continuing throughout the remainder of the year, the Company experienced reduced customer traffic in its retail pharmacies and MinuteClinic locations due to shelter-in-place orders as well as reduced new therapy prescriptions and decreased long-term care prescription volume as a result of the COVID-19 pandemic. In addition, the Company incurred incremental operating expenses associated with the Company's COVID-19 pandemic response efforts and waived fees associated with prescription home delivery and associated front store products.

During 2020, the Company also played a key role in supporting the local communities in which it operates. The Company offered COVID-19 diagnostic testing at more than 4,000 CVS Pharmacy locations as of December 31, 2020. In addition, the Company launched critical diagnostic testing for the vulnerable senior population in long-term care facilities in partnership with three states. The Company was also selected to administer COVID-19 vaccines in both long-term care facilities and its retail pharmacies. The Company began administering COVID-19 vaccinations in long-term care facilities and in certain of its retail pharmacies during December 2020 and February 2021, respectively, and expects to play a significant role in COVID-19 vaccine administration in the future.

The COVID-19 pandemic continues to evolve. We believe COVID-19's impact on our businesses, operating results, cash flows and/or financial condition primarily will be driven by the geographies impacted and the severity and duration of the pandemic; the pandemic's impact on the U.S. and global economies and consumer behavior and health care utilization patterns; and the timing, scope and impact of stimulus legislation as well as other federal, state and local governmental responses to the pandemic. Those primary drivers are beyond our knowledge and control. As a result, the impact COVID-19 will have on our businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be adverse and material.

Results of Operations

The following information summarizes the Company's results of operations for 2020 compared to 2019. For discussion of the Company's results of operations for 2019 compared to 2018, see "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2019 filed with the U.S. Securities and Exchange Commission (the "SEC") on February 18, 2020.

Summary of Consolidated Financial Results

				Change			
	Year Ended December 31,			2020 vs. 2019		2019 vs. 2018	
In millions	**2020**	**2019**	**2018**	**$**	**%**	**$**	**%**
Revenues:							
Products	$ 190,688	$ 185,236	$ 183,910	$ 5,452	2.9 %	$ 1,326	0.7 %
Premiums	69,364	63,122	8,184	6,242	9.9 %	54,938	671.3 %
Services	7,856	7,407	1,825	449	6.1 %	5,582	305.9 %
Net investment income	798	1,011	660	(213)	(21.1)%	351	53.2 %
Total revenues	268,706	256,776	194,579	11,930	4.6 %	62,197	32.0 %
Operating costs:							
Cost of products sold	163,981	158,719	156,447	5,262	3.3 %	2,272	1.5 %
Benefit costs	55,679	52,529	6,594	3,150	6.0 %	45,935	696.6 %
Goodwill impairments	—	—	6,149	—	— %	(6,149)	(100.0)%
Operating expenses	35,135	33,541	21,368	1,594	4.8 %	12,173	57.0 %
Total operating costs	254,795	244,789	190,558	10,006	4.1 %	54,231	28.5 %
Operating income	13,911	11,987	4,021	1,924	16.1 %	7,966	198.1 %
Interest expense	2,907	3,035	2,619	(128)	(4.2)%	416	15.9 %
Loss on early extinguishment of debt	1,440	79	—	1,361	1,722.8 %	79	— %
Other income	(206)	(124)	(4)	(82)	(66.1)%	(120)	(3,000.0)%
Income before income tax provision	9,770	8,997	1,406	773	8.6 %	7,591	539.9 %
Income tax provision	2,569	2,366	2,002	203	8.6 %	364	18.2 %
Income (loss) from continuing operations	7,201	6,631	(596)	570	8.6 %	7,227	1,212.6 %
Loss from discontinued operations, net of tax	(9)	—	—	(9)	— %	—	— %
Net income (loss)	7,192	6,631	(596)	561	8.5 %	7,227	1,212.6 %
Net (income) loss attributable to noncontrolling interests	(13)	3	2	(16)	(533.3)%	1	50.0 %
Net income (loss) attributable to CVS Health	$ 7,179	$ 6,634	$ (594)	$ 545	8.2 %	$ 7,228	1,216.8 %

Commentary - 2020 compared to 2019

Revenues

- Total revenues increased $11.9 billion or 4.6% in 2020 compared to 2019. The increase in total revenues was primarily driven by growth in the Health Care Benefits and Retail/LTC segments.
- Please see "Segment Analysis" later in this MD&A for additional information about the revenues of the Company's segments.

Operating expenses

- Operating expenses increased $1.6 billion or 4.8% in 2020 compared to 2019. Operating expenses as a percentage of total revenues remained consistent at 13.1% in both 2020 and 2019. The increase in operating expenses was primarily due to the reinstatement of the non-deductible health insurer fee ("HIF") which was $1.0 billion for 2020, incremental operating expenses associated with the Company's COVID-19 pandemic response efforts and increased operating expenses associated with growth in the business. The increase in operating expenses was partially offset by (i) a $269 million pre-tax gain on the sale of the Workers' Compensation business, which occurred on July 31, 2020, (ii) the absence of $231 million of store rationalization charges and a $205 million pre-tax loss on the sale of the Company's Brazilian subsidiary, Drogaria

Onofre Ltda. (“Onofre”), both recorded in the year ended December 31, 2019, and (iii) the favorable impact of enterprise-wide cost savings initiatives in 2020.

- Please see “Segment Analysis” later in this MD&A for additional information about the operating expenses of the Company’s segments.

Operating income

- Operating income increased $1.9 billion or 16.1% in 2020 compared to 2019. The increase in operating income was primarily due to:
    - Increased operating income in the Health Care Benefits segment, primarily as a result of the COVID-19 pandemic, pre-tax income of $307 million associated with the receipt of amounts owed to the Company under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the “ACA”) risk corridor program that was previously fully reserved for as payment was uncertain, and the $269 million pre-tax gain on the sale of the Workers’ Compensation business;
    - Increased operating income in the Pharmacy Services segment, primarily related to improved purchasing economics; and
    - The favorable impact of enterprise-wide cost savings initiatives in 2020, partially offset by:
    - Decreased operating income in the Retail/LTC segment, primarily as a result of continued reimbursement pressure and the net adverse impact of the COVID-19 pandemic, partially offset by the absence of $231 million of store rationalization charges and the $205 million pre-tax loss on the sale of Onofre, both recorded in 2019.
- Please see “Segment Analysis” later in this MD&A for additional information about the operating income of the Company’s segments.

Interest expense

- Interest expense decreased $128 million in 2020 compared to 2019, primarily due to lower average debt in 2020. See “Liquidity and Capital Resources” later in this report for additional information.

Loss on early extinguishment of debt

- During 2020, the loss on early extinguishment of debt relates to the Company’s repayment of $6.0 billion of its outstanding senior notes pursuant to its tender offers for such senior notes in August 2020, which resulted in a loss on early extinguishment of debt of $766 million, and the repayment of $4.5 billion of its outstanding senior notes pursuant to its tender offers for such senior notes in December 2020, which resulted in a loss on early extinguishment of debt of $674 million. During 2019, the loss on early extinguishment of debt relates to the Company’s repayment of $4.0 billion of its outstanding senior notes pursuant to its tender offers for such senior notes in August 2019, which resulted in a loss on early extinguishment of debt of $79 million. See Note 8 ‘‘Borrowings and Credit Agreements’’ included in Item 8 of this 10-K for additional information.

Other income

- Other income increased $82 million in 2020 compared to 2019. Other income represents pension plan asset returns in excess of interest cost on pension plan obligations. The increase in other income in 2020 was primarily due to lower discount rates in 2020 compared to 2019 when determining the interest cost on the Company’s pension plan obligations as well as strong plan asset returns.

Income tax provision

- The Company’s effective income tax rate remained consistent at 26.3% in both 2020 and 2019, with the impact of the non-deductible HIF offset by the favorable resolution of certain tax matters in the year ended December 31, 2020.

Loss from discontinued operations

- In connection with certain business dispositions completed between 1995 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Linens ‘n Things and Bob’s Stores, each of which subsequently filed for bankruptcy. The Company’s loss from discontinued operations in 2020 primarily includes lease-related costs required to satisfy these lease guarantees.
- See “Discontinued Operations” in Note 1 ‘‘Significant Accounting Policies’’ and “Lease Guarantees” in Note 16 ‘‘Commitments and Contingencies’’ included in Item 8 of this 10-K for additional information about the Company’s discontinued operations and the Company’s lease guarantees, respectively.

Outlook for 2021

With respect to 2021, the Company believes you should consider the following important information:

- The Pharmacy Services segment is expected to benefit from continued growth in specialty pharmacy and our ability to drive further improvements in purchasing economics, partially offset by continued price compression.
- The Retail/LTC segment is expected to benefit from increased prescription volume, diagnostic testing and improved generic drug purchasing, partially offset by continued reimbursement pressure and operating expenses associated with the Company's COVID-19 pandemic response efforts. The projected adjusted prescription growth is expected to be driven by the continued successful execution of our patient care programs, the anticipated return of provider visits as we move through the year and vaccination administration. While lower front store traffic has persisted into the first quarter of 2021, we expect front store traffic to increase as we move through the year.
- The Health Care Benefits segment is expected to benefit from Medicare membership growth, partially offset by membership declines in our Medicaid products, the adverse impact of the COVID-19 pandemic and the removal of the HIF. The projected MBR is expected to increase compared to 2020, reflecting the return to more normal levels of utilization, the removal of the HIF, lower Medicare risk adjustment revenue and the continued shift in business mix. The COVID-19 pandemic is expected to adversely impact earnings in 2021 due to the regulatory changes included in the Consolidated Appropriations Act of 2021; testing, treatment and vaccination costs; and lower Medicare risk adjustment revenue.
- The Company is expected to benefit from the continuation of its enterprise-wide cost savings initiatives that are expected to ramp as we move through the year. Key drivers include:
    - The ongoing digitalization of our business along with technology improvements in our operations,
    - Office real estate reductions associated with workforce management changes and
    - Productivity/operational efficiency initiatives within each of the Company's segments.
- Based upon current tax legislation, the Company expects its effective income tax rate to decrease primarily due to the removal of the HIF in 2021.
- The Company expects changes to its business environment to continue as elected and other government officials at the national and state levels continue to propose and enact significant modifications to public policy and existing laws and regulations that govern or impact the Company's businesses.

The Company's current expectations described above are forward-looking statements. Please see "Risk Factors" included in Item 1A of this 10-K and the "Cautionary Statement Concerning Forward-Looking Statements" in this 10-K for information regarding important factors that may cause the Company's actual results to differ from those currently projected and/or otherwise materially affect the Company.

Segment Analysis

The following discussion of segment operating results is presented based on the Company's reportable segments in accordance with the accounting guidance for segment reporting and is consistent with the segment disclosure in Note 17 ''Segment Reporting'' included in Item 8 of this 10-K.

The Company has three operating segments, Pharmacy Services, Retail/LTC and Health Care Benefits, as well as a Corporate/Other segment. The Company's segments maintain separate financial information, and the Company's chief operating decision maker ("CODM") evaluates the segments' operating results on a regular basis in deciding how to allocate resources among the segments and in assessing segment performance. The CODM evaluates the performance of the Company's segments based on adjusted operating income, which is defined as operating income (GAAP measure) excluding the impact of amortization of intangible assets and other items, if any, that neither relate to the ordinary course of the Company's business nor reflect the Company's underlying business performance. See the reconciliations of operating income (GAAP measure) to adjusted operating income below for further context regarding the items excluded from operating income in determining adjusted operating income. The Company uses adjusted operating income as its principal measure of segment performance as it enhances the Company's ability to compare past financial performance with current performance and analyze underlying business performance and trends. Non-GAAP financial measures the Company discloses, such as consolidated adjusted operating income, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

The following is a reconciliation of financial measures of the Company's segments to the consolidated totals:

In millions	**Pharmacy Services [1]**	**Retail/ LTC**	**Health Care Benefits**	**Corporate/ Other**	**Intersegment Eliminations [2]**	**Consolidated Totals**
2020						
Total revenues	$ 141,938	$ 91,198	$ 75,467	$ 426	$ (40,323)	$ 268,706
Adjusted operating income (loss)	5,688	6,146	6,188	(1,306)	(708)	16,008
2019						
Total revenues	141,491	86,608	69,604	512	(41,439)	256,776
Adjusted operating income (loss)	5,129	6,705	5,202	(1,000)	(697)	15,339
2018						
Total revenues	134,736	83,989	8,962	606	(33,714)	194,579
Adjusted operating income (loss)	4,955	7,403	528	(856)	(769)	11,261

(1) Total revenues of the Pharmacy Services segment include approximately $10.9 billion, $11.5 billion and $11.4 billion of retail co-payments for 2020, 2019 and 2018, respectively. See Note 1 ''Significant Accounting Policies'' included in Item 8 of this 10-K for additional information about retail co-payments.

(2) Intersegment eliminations relate to intersegment revenue generating activities that occur between the Pharmacy Services segment, the Retail/LTC segment and/or the Health Care Benefits segment.

The following are reconciliations of operating income to adjusted operating income for the years ended December 31, 2020, 2019 and 2018:

	Year Ended December 31, 2020					
In millions	**Pharmacy Services**	**Retail/ LTC**	**Health Care Benefits**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
Operating income (loss) (GAAP measure)	$ 5,454	$ 5,640	$ 5,166	$ (1,641)	$ (708)	$ 13,911
Non-GAAP adjustments:						
Amortization of intangible assets [1]	234	506	1,598	3	—	2,341
Acquisition-related integration costs [2]	—	—	—	332	—	332
Gain on divestiture of subsidiary [3]	—	—	(269)	—	—	(269)
Receipt of fully reserved ACA risk corridor receivable [4]	—	—	(307)	—	—	(307)
Adjusted operating income (loss)	$ 5,688	$ 6,146	$ 6,188	$ (1,306)	$ (708)	$ 16,008

	Year Ended December 31, 2019					
In millions	**Pharmacy Services**	**Retail/ LTC**	**Health Care Benefits**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
Operating income (loss) (GAAP measure)	$ 4,735	$ 5,793	$ 3,639	$ (1,483)	$ (697)	$ 11,987
Non-GAAP adjustments:						
Amortization of intangible assets [1]	394	476	1,563	3	—	2,436
Acquisition-related integration costs [2]	—	—	—	480	—	480
Loss on divestiture of subsidiary [3]	—	205	—	—	—	205
Store rationalization charges [5]	—	231	—	—	—	231
Adjusted operating income (loss)	$ 5,129	$ 6,705	$ 5,202	$ (1,000)	$ (697)	$ 15,339

	Year Ended December 31, 2018					
In millions	**Pharmacy Services**	**Retail/ LTC**	**Health Care Benefits**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
Operating income (loss) (GAAP measure)	$ 4,607	$ 620	$ 368	$ (805)	$ (769)	$ 4,021
Non-GAAP adjustments:						
Amortization of intangible assets [1]	348	498	160	—	—	1,006
Acquisition-related transaction and integration costs [2]	—	7	—	485	—	492
Loss on divestiture of subsidiary [3]	—	86	—	—	—	86
Goodwill impairments [6]	—	6,149	—	—	—	6,149
Impairment of long-lived assets [7]	—	43	—	—	—	43
Interest income on financing for the Aetna Acquisition [8]	—	—	—	(536)	—	(536)
Adjusted operating income (loss)	$ 4,955	$ 7,403	$ 528	$ (856)	$ (769)	$ 11,261

(1) The Company's acquisition activities have resulted in the recognition of intangible assets as required under the acquisition method of accounting which consist primarily of trademarks, customer contracts/relationships, covenants not to compete, technology, provider networks and value of business acquired. Definite-lived intangible assets are amortized over their estimated useful lives and are tested for impairment when events indicate that the carrying value may not be recoverable. The amortization of intangible assets is reflected in the Company's statements of operations in operating expenses within each segment. Although intangible assets contribute to the Company's revenue generation, the amortization of intangible assets does not directly relate to the underwriting of the Company's insurance products, the services performed for the Company's customers or the sale of the Company's products or services. Additionally, intangible asset amortization expense typically fluctuates based on the size and timing of the Company's acquisition activity. Accordingly, the Company believes excluding the amortization of intangible assets enhances the Company's and investors' ability to compare the Company's past financial performance with its current performance and to analyze underlying business performance and trends. Intangible asset amortization excluded from the related non-GAAP financial measure represents the entire amount recorded within the Company's GAAP financial statements, and the revenue generated by the associated intangible assets has not been excluded from the related non-GAAP financial measure. Intangible asset amortization is excluded from the related non-GAAP financial measure because the amortization, unlike the related revenue, is not affected by operations of any particular period unless an intangible asset becomes impaired or the estimated useful life of an intangible asset is revised.

(2) In 2020, 2019 and 2018, acquisition-related transaction and integration costs relate to the Aetna Acquisition. In 2018, acquisition-related integration costs also relate to the acquisition of Omnicare, Inc. ("Omnicare"). The acquisition-related transaction and integration costs are reflected in the Company's consolidated statements of operations in operating expenses within the Corporate/Other segment and the Retail/LTC segment.

(3) In 2020, the gain on divestiture of subsidiary represents the pre-tax gain on the sale of the Workers' Compensation business, which the Company sold on July 31, 2020 for approximately $850 million. The gain on divestiture is reflected as a reduction in operating expenses in the Company's consolidated statement of operations within the Health Care Benefits segment. In 2019, the loss on divestiture of subsidiary represents the pre-tax loss on the sale of Onofre, which occurred on July 1, 2019. The loss on divestiture primarily relates to the elimination of the cumulative translation adjustment from accumulated other comprehensive income. In 2018, the loss on divestiture of subsidiary represents the pre-tax loss on the sale of the Company's RxCrossroads subsidiary for $725 million on January 2, 2018. The losses on divestiture in 2019 and 2018 are reflected in the Company's consolidated statements of operations in operating expenses within the Retail/LTC segment.

(4) In 2020, the Company received $313 million owed to it under the ACA's risk corridor program that was previously fully reserved for as payment was uncertain. After considering offsetting items such as the ACA's minimum medical loss ratio ("MLR") rebate requirements and premium taxes, the Company recognized pre-tax income of $307 million in the Company's consolidated statement of operations within the Health Care Benefits segment.

(5) In 2019, the store rationalization charges relate to the planned closure of 46 underperforming retail pharmacy stores in the second quarter of 2019 and the planned closure of 22 underperforming retail pharmacy stores in the first quarter of 2020. The store rationalization charges primarily relate to operating lease right-of-use asset impairment charges and are reflected in the Company's consolidated statement of operations in operating expenses within the Retail/LTC segment.

(6) In 2018, the goodwill impairments relate to the LTC reporting unit within the Retail/LTC segment.

(7) In 2018, impairment of long-lived assets primarily relates to the impairment of property and equipment within the Retail/LTC segment and is reflected in operating expenses in the Company's consolidated statement of operations.

(8) In 2018, the Company recorded interest income of $536 million on the proceeds of the $40 billion of unsecured senior notes it issued in March 2018 to partially fund the Aetna Acquisition. All amounts are for the periods prior to the close of the Aetna Acquisition, which occurred on November 28, 2018, and were recorded within the Corporate/Other segment.

Pharmacy Services Segment

The following table summarizes the Pharmacy Services segment's performance for the respective periods:

	Year Ended December 31,			Change			
				2020 vs. 2019		2019 vs. 2018	
In millions, except percentages	**2020**	**2019**	**2018**	**$**	**%**	**$**	**%**
Revenues:							
Products	$ 140,950	$ 140,946	$ 134,285	$ 4	— %	$ 6,661	5.0 %
Services	988	545	451	443	81.3 %	94	20.8 %
Total revenues	141,938	141,491	134,736	447	0.3 %	6,755	5.0 %
Cost of products sold	135,045	135,245	128,777	(200)	(0.1)%	6,468	5.0 %
Operating expenses	1,439	1,511	1,352	(72)	(4.8)%	159	11.8 %
Operating expenses as a % of total revenues	1.0 %	1.1 %	1.0 %				
Operating income	$ 5,454	$ 4,735	$ 4,607	$ 719	15.2 %	$ 128	2.8 %
Operating income as a % of total revenues	3.8 %	3.3 %	3.4 %				
Adjusted operating income [1]	$ 5,688	$ 5,129	$ 4,955	$ 559	10.9 %	$ 174	3.5 %
Adjusted operating income as a % of total revenues	4.0 %	3.6 %	3.7 %				
Revenues (by distribution channel):							
Pharmacy network [2]	$ 85,045	$ 88,755	$ 87,167	$ (3,710)	(4.2)%	$ 1,588	1.8 %
Mail choice [3]	56,071	52,141	47,049	3,930	7.5 %	5,092	10.8 %
Other	822	595	520	227	38.2 %	75	14.4 %
Pharmacy claims processed: [4]							
Total	2,112.9	2,014.2	1,889.8	98.7	4.9 %	124.4	6.6 %
Pharmacy network [2]	1,790.1	1,704.0	1,601.4	86.1	5.1 %	102.6	6.4 %
Mail choice [3]	322.8	310.2	288.4	12.6	4.1 %	21.8	7.6 %
Generic dispensing rate: [4]							
Total	88.2 %	88.2 %	87.3 %				
Pharmacy network [2]	88.7 %	88.7 %	87.9 %				
Mail choice [3]	85.3 %	85.1 %	83.9 %				

(1) See "Segment Analysis" above in this MD&A for a reconciliation of operating income (GAAP measure) to adjusted operating income for the Pharmacy Services segment.

(2) Pharmacy network is defined as claims filled at retail and specialty retail pharmacies, including the Company's retail pharmacies and LTC pharmacies, but excluding Maintenance Choice® activity, which is included within the mail choice category. Maintenance Choice permits eligible client plan members to fill their maintenance prescriptions through mail order delivery or at a CVS pharmacy retail store for the same price as mail order.

(3) Mail choice is defined as claims filled at a Pharmacy Services mail order facility, which includes specialty mail claims inclusive of Specialty Connect® claims picked up at a retail pharmacy, as well as prescriptions filled at the Company's retail pharmacies under the Maintenance Choice program.

(4) Includes an adjustment to convert 90-day prescriptions to the equivalent of three 30-day prescriptions. This adjustment reflects the fact that these prescriptions include approximately three times the amount of product days supplied compared to a normal prescription.

Commentary - 2020 compared to 2019

Revenues

- Total revenues increased $447 million, or 0.3%, to $141.9 billion in 2020 compared to 2019. The increase was primarily driven by growth in specialty pharmacy and brand inflation, partially offset by continued price compression and changes in net new business mix.

Operating expenses

- Operating expenses in the Pharmacy Services segment include selling, general and administrative expenses; depreciation and amortization expense; and expenses related to specialty retail pharmacies, which include store and administrative payroll, employee benefits and occupancy costs.
- Operating expenses decreased $72 million, or 4.8%, in 2020 compared to 2019 primarily driven by lower amortization expense in 2020, partially offset by incremental operating expenses associated with growth in the business, including investments in the Company's growth initiatives.
- Operating expenses as a percentage of total revenues remained relatively consistent at 1.0% and 1.1% in 2020 and 2019, respectively.

Operating income and adjusted operating income

- Operating income increased $719 million, or 15.2%, and adjusted operating income increased $559 million, or 10.9%, in 2020 compared to 2019. The increase in both operating income and adjusted operating income was primarily driven by improved purchasing economics and growth in specialty pharmacy, partially offset by continued price compression. The increase in operating income also was driven by lower amortization expense in 2020.
- As you review the Pharmacy Services segment's performance in this area, you should consider the following important information about the business:
    - The Company's efforts to (i) retain existing clients, (ii) obtain new business and (iii) maintain or improve the rebates and/or discounts the Company receives from manufacturers, wholesalers and retail pharmacies continue to have an impact on operating income and adjusted operating income. In particular, competitive pressures in the PBM industry have caused the Company and other PBMs to continue to share with clients a larger portion of rebates and/or discounts received from pharmaceutical manufacturers. In addition, marketplace dynamics and regulatory changes have limited the Company's ability to offer plan sponsors pricing that includes retail network "differential" or "spread," and the Company expects these trends to continue. The "differential" or "spread" is any difference between the drug price charged to plan sponsors, including Medicare Part D plan sponsors, by a PBM and the price paid for the drug by the PBM to the dispensing provider.

Pharmacy claims processed

- Total pharmacy claims processed represents the number of prescription claims processed through our pharmacy benefits manager and dispensed by either our retail network pharmacies or our own mail and specialty pharmacies. Management uses this metric to understand variances between actual claims processed and expected amounts as well as trends in period-over-period results. This metric provides management and investors with information useful in understanding the impact of pharmacy claim volume on segment total revenues and operating results.
- The Company's pharmacy network claims processed on a 30-day equivalent basis increased 5.1% to 1.8 billion claims in 2020 compared to 1.7 billion claims in 2019. The increase in pharmacy network claims processed was primarily driven by net new business.
- The Company's mail choice claims processed on a 30-day equivalent basis increased 4.1% to 322.8 million claims in 2020 compared to 310.2 million claims in 2019. The increase in mail choice claims was primarily driven by net new business and the continued adoption of Maintenance Choice offerings.

Generic dispensing rate

- Generic dispensing rate is calculated by dividing the Pharmacy Services segment's generic drug prescriptions processed or filled by its total prescriptions processed or filled. Management uses this metric to evaluate the effectiveness of the business at encouraging the use of generic drugs when they are available and clinically appropriate, which aids in decreasing costs for client members and retail customers. This metric provides management and investors with information useful in understanding trends in segment total revenues and operating results.
- The Pharmacy Services segment's total generic dispensing rate remained consistent at 88.2% in both 2020 and 2019.

Retail/LTC Segment

The following table summarizes the Retail/LTC segment's performance for the respective periods:

	Year Ended December 31,			Change			
				2020 vs. 2019		2019 vs. 2018	
In millions, except percentages	**2020**	**2019**	**2018**	**$**	**%**	**$**	**%**
Revenues:							
Products	$ 89,944	$ 85,729	$ 83,175	$ 4,215	4.9 %	$ 2,554	3.1 %
Services	1,254	879	814	375	42.7 %	65	8.0 %
Total revenues	91,198	86,608	83,989	4,590	5.3 %	2,619	3.1 %
Cost of products sold	67,284	62,688	59,906	4,596	7.3 %	2,782	4.6 %
Goodwill impairments	—	—	6,149	—	— %	(6,149)	(100.0)%
Operating expenses	18,274	18,127	17,314	147	0.8 %	813	4.7 %
Operating expenses as a % of total revenues	20.0 %	20.9 %	20.6 %				
Operating income	$ 5,640	$ 5,793	$ 620	$ (153)	(2.6)%	$ 5,173	834.4 %
Operating income as a % of total revenues	6.2 %	6.7 %	0.7 %				
Adjusted operating income [1]	$ 6,146	$ 6,705	$ 7,403	$ (559)	(8.3)%	$ (698)	(9.4)%
Adjusted operating income as a % of total revenues	6.7 %	7.7 %	8.8 %				
Revenues (by major goods/service lines):							
Pharmacy	$ 70,176	$ 66,442	$ 64,179	$ 3,734	5.6 %	$ 2,263	3.5 %
Front Store	19,655	19,422	19,055	233	1.2 %	367	1.9 %
Other	1,367	744	755	623	83.7 %	(11)	(1.5)%
Prescriptions filled [2]	1,465.2	1,417.2	1,339.1	48.0	3.4 %	78.1	5.8 %
Same store sales increase: [3]							
Total	5.6 %	3.7 %	6.0 %				
Pharmacy	7.0 %	4.5 %	7.9 %				
Front Store	0.9 %	1.1 %	0.5 %				
Prescription volume [2]	4.7 %	7.2 %	9.1 %				
Generic dispensing rate [2]	88.3 %	88.3 %	87.5 %				

(1) See "Segment Analysis" above in this MD&A for a reconciliation of operating income (GAAP measure) to adjusted operating income for the Retail/LTC segment.

(2) Includes an adjustment to convert 90-day prescriptions to the equivalent of three 30-day prescriptions. This adjustment reflects the fact that these prescriptions include approximately three times the amount of product days supplied compared to a normal prescription.

(3) Same store sales and prescription volume represent the change in revenues and prescriptions filled in the Company's retail pharmacy stores that have been operating for greater than one year, expressed as a percentage that indicates the increase or decrease relative to the comparable prior period. Same store metrics exclude revenues from MinuteClinic, revenues and prescriptions from LTC operations and, in 2019 and 2018, revenues and prescriptions from stores in Brazil. Management uses these metrics to evaluate the performance of existing stores on a comparable basis and to inform future decisions regarding existing stores and new locations. Same-store metrics provide management and investors with information useful in understanding the portion of current revenues and prescriptions resulting from organic growth in existing locations versus the portion resulting from opening new stores.

Commentary - 2020 compared to 2019

Revenues

- Total revenues increased $4.6 billion, or 5.3%, to $91.2 billion in 2020 compared to 2019. The increase was primarily driven by increased prescription volume, COVID-19 diagnostic testing and brand inflation, partially offset by continued reimbursement pressure and the impact of recent generic introductions.
- Pharmacy same store sales increased 7.0% in 2020 compared to 2019. The increase was driven by the 4.7% increase in pharmacy same store prescription volume on a 30-day equivalent basis, pharmacy drug mix and brand inflation. These increases were partially offset by continued reimbursement pressure and the impact of recent generic introductions.

- Front store same store sales increased 0.9% in 2020 compared to 2019. The increase was primarily due to increases in consumer health and general merchandise sales.
- Other revenues increased 83.7% in 2020 compared to 2019. The increase was primarily due to increased diagnostic testing in response to the COVID-19 pandemic in 2020.

Operating expenses
- Operating expenses in the Retail/LTC segment include store payroll, store employee benefits, store occupancy costs, selling expenses, advertising expenses, depreciation and amortization expense and certain administrative expenses.
- Operating expenses increased $147 million, or 0.8%, in 2020 compared to 2019. The increase was primarily due to incremental operating expenses associated with the Company's COVID-19 pandemic response efforts, the increased volume described above and investments in the business in 2020. The increase was partially offset by the absence of $231 million of store rationalization charges in connection with the planned closure of underperforming retail pharmacy stores and the $205 million pre-tax loss on the sale of Onofre, both recorded in 2019, as well as the impact of cost savings initiatives in 2020.
- Operating expenses as a percentage of total revenues decreased to 20.0% in 2020 compared to 20.9% in 2019. The decrease in operating expenses as a percentage of total revenues was primarily driven by the increases in total revenues described above.

Operating income and adjusted operating income
- Operating income decreased $153 million, or 2.6%, and adjusted operating income decreased $559 million, or 8.3%, in 2020 compared to 2019. The decrease in both operating income and adjusted operating income was primarily due to continued reimbursement pressure and the net impact of the COVID-19 pandemic, partially offset by the increased pharmacy volume described above and improved generic drug purchasing. The COVID-19 pandemic resulted in reduced operating income and adjusted operating income in 2020 as a result of decreased customer traffic in the segment's retail pharmacies and MinuteClinic locations and incremental operating expenses associated with the Company's COVID-19 pandemic response efforts, partially offset by COVID-19 diagnostic testing. The decrease in operating income also was partially offset by the absence of the $231 million of store rationalization charges and the $205 million pre-tax loss on the sale of Onofre, both recorded in 2019.
- As you review the Retail/LTC segment's performance in this area, you should consider the following important information about the business:
    - The segment's pharmacy operating income and adjusted operating income have been adversely affected by the efforts of managed care organizations, PBMs and governmental and other third-party payors to reduce their prescription drug costs, including the use of restrictive networks, as well as changes in the mix of business within the pharmacy portion of the Retail/LTC segment. If the reimbursement pressure accelerates, the segment may not be able to grow revenues, and its operating income and adjusted operating income could be adversely affected.
    - The increased use of generic drugs has positively impacted the segment's operating income and adjusted operating income but has resulted in third-party payors augmenting their efforts to reduce reimbursement payments to retail pharmacies for prescriptions. This trend, which the Company expects to continue, reduces the benefit the segment realizes from brand-to-generic drug conversions.

Prescriptions filled
- Prescriptions filled represents the number of prescriptions dispensed through the Retail/LTC segment's pharmacies. Management uses this metric to understand variances between actual prescriptions dispensed and expected amounts as well as trends in period-over-period results. This metric provides management and investors with information useful in understanding the impact of prescription volume on segment total revenues and operating results.
- Prescriptions filled increased 3.4% on a 30-day equivalent basis in 2020 compared to 2019 primarily driven by the continued adoption of patient care programs, partially offset by reduced new therapy prescriptions as a result of the COVID-19 pandemic and decreased long-term care prescription volume.

Generic dispensing rate
- Generic dispensing rate is calculated by dividing the Retail/LTC segment's generic drug prescriptions filled by its total prescriptions filled. Management uses this metric to evaluate the effectiveness of the business at encouraging the use of generic drugs when they are available and clinically appropriate, which aids in decreasing costs for client members and retail customers. This metric provides management and investors with information useful in understanding trends in segment total revenues and operating results.
- The Retail/LTC segment's generic dispensing rate remained consistent at 88.3% in both 2020 and 2019.

Health Care Benefits Segment

For periods prior to November 28, 2018 (the Aetna Acquisition Date), the Health Care Benefits segment was comprised only of the Company's SilverScript PDP business. The following table summarizes the Health Care Benefits segment's performance for the respective periods:

	Year Ended December 31,			Change			
				2020 vs. 2019		2019 vs. 2018	
In millions, except percentages and basis points ("bps")	**2020**	**2019**	**2018**	**$**	**%**	**$**	**%**
Revenues:							
Products	$ —	$ —	$ 164	$ —	— %	$ (164)	(100.0)%
Premiums	69,301	63,031	8,180	6,270	9.9 %	54,851	670.6 %
Services	5,683	5,974	560	(291)	(4.9)%	5,414	966.8 %
Net investment income	483	599	58	(116)	(19.4)%	541	932.8 %
Total revenues	75,467	69,604	8,962	5,863	8.4 %	60,642	676.7 %
Cost of products sold	—	—	147	—	— %	(147)	(100.0)%
Benefit costs	56,083	53,092	6,678	2,991	5.6 %	46,414	695.0 %
MBR (Benefit costs as a % of premium revenues) [1]	80.9 %	84.2 %	NM	(330) bps		NM	
Operating expenses	$ 14,218	$ 12,873	$ 1,769	$ 1,345	10.4 %	$ 11,104	627.7 %
Operating expenses as a % of total revenues	18.8 %	18.5 %	19.7 %				
Operating income	$ 5,166	$ 3,639	$ 368	$ 1,527	42.0 %	$ 3,271	888.9 %
Operating income as a % of total revenues	6.8 %	5.2 %	4.1 %				
Adjusted operating income [2]	$ 6,188	$ 5,202	$ 528	$ 986	19.0 %	$ 4,674	885.2 %
Adjusted operating income as a % of total revenues	8.2 %	7.5 %	5.9 %				
Premium revenues (by business):							
Government	$ 48,928	$ 41,818	$ 6,091	$ 7,110	17.0 %	$ 35,727	586.6 %
Commercial	20,373	21,213	2,089	(840)	(4.0)%	19,124	915.5 %

(1) For periods prior to the Aetna Acquisition Date, the Health Care Benefits segment was comprised only of the Company's SilverScript PDP business. Accordingly, the MBR for the year ended December 31, 2018 is not meaningful ("NM") and is not directly comparable to the MBRs for the years ended December 31, 2020 and 2019.

(2) See "Segment Analysis" above in this MD&A for a reconciliation of operating income (GAAP measure) to adjusted operating income for the Health Care Benefits segment.

Commentary - 2020 compared to 2019

Revenues

- Total revenues increased $5.9 billion, or 8.4%, to $75.5 billion in 2020 compared to 2019 primarily driven by membership growth in the Health Care Benefits segment's Government products, the favorable impact of the reinstatement of the HIF for 2020 and the receipt of $313 million owed to the Company under the ACA's risk corridor program. These increases were partially offset by the divestitures of Aetna's standalone PDPs (which the Company retained the financial results of through 2019) and Workers' Compensation business, membership declines in the segment's Commercial products and COVID-19 related investments benefiting customers in 2020.

Medical Benefit Ratio ("MBR")

- Medical benefit ratio is calculated as benefit costs divided by premium revenues and represents the percentage of premium revenues spent on medical benefits for the Company's Insured members. Management uses MBR to assess the underlying business performance and underwriting of its insurance products, understand variances between actual results and expected results and identify trends in period-over-period results. MBR provides management and investors with information useful in assessing the operating results of the Company's Insured Health Care Benefits products.
- The Health Care Benefits segment's MBR decreased 330 basis points from 84.2% to 80.9% in 2020 compared to 2019. The decrease was primarily due to (i) the impact of the COVID-19 pandemic, which resulted in reduced benefit costs due

to the deferral of elective procedures and other discretionary utilization, partially offset by COVID-19 related investments, testing and treatment costs, (ii) the reinstatement of the HIF for 2020 and (iii) the receipt of amounts owed to the Company under the ACA's risk corridor program in 2020.

Operating expenses

- Operating expenses in the Health Care Benefits segment include selling, general and administrative expenses and depreciation and amortization expenses.
- Operating expenses increased $1.3 billion in 2020 compared to 2019. The increase in operating expenses was primarily due to the reinstatement of the HIF which was $1.0 billion for 2020 and incremental operating expenses to support the increased membership described above, including operating expenses to support additional Medicaid members onboarded during the first quarter of 2020. The increase was partially offset by the divestitures of Aetna's standalone PDPs and Workers' Compensation business, the $269 million pre-tax gain on the sale of the Workers' Compensation business and the impact of cost savings initiatives in 2020.

Operating income and adjusted operating income

- Operating income and adjusted operating income increased $1.5 billion and $1.0 billion, respectively, in 2020 compared to 2019. The increase in both operating income and adjusted operating income was primarily driven by the impact of the COVID-19 pandemic, partially offset by the divestitures of Aetna's standalone PDPs and Workers' Compensation business. The COVID-19 pandemic resulted in reduced benefit costs due to the deferral of elective procedures and other discretionary utilization, partially offset by COVID-19 related investments, testing and treatment costs. Operating income also includes pre-tax income of $307 million associated with the receipt of amounts owed to the Company under the ACA's risk corridor program and the $269 million pre-tax gain on the sale of the Workers' Compensation business in 2020.

The following table summarizes the Health Care Benefits segment's medical membership as of December 31, 2020 and 2019:

	2020			2019		
In thousands	**Insured**	**ASC**	**Total**	**Insured**	**ASC**	**Total**
Medical membership:						
Commercial	3,258	13,644	16,902	3,591	14,159	17,750
Medicare Advantage	2,705	—	2,705	2,321	—	2,321
Medicare Supplement	1,082	—	1,082	881	—	881
Medicaid	2,100	623	2,723	1,398	558	1,956
Total medical membership	9,145	14,267	23,412	8,191	14,717	22,908
Supplemental membership information:						
Medicare Prescription Drug Plan (standalone) [1]			5,490			5,994

(1) Represents the Company's SilverScript PDP membership only. Excludes 2.5 million members as of December 31, 2019 related to Aetna's standalone PDPs that were sold effective December 31, 2018. The Company retained the financial results of the divested plans through 2019 through a reinsurance agreement. Subsequent to 2019, the Company no longer retains the financial results of the divested plans.

Medical Membership

- Medical membership represents the number of members covered by the Company's Insured and ASC medical products and related services at a specified point in time. Management uses this metric to understand variances between actual medical membership and expected amounts as well as trends in period-over-period results. This metric provides management and investors with information useful in understanding the impact of medical membership on segment total revenues and operating results.
- Medical membership as of December 31, 2020 of 23.4 million increased 504 thousand compared with December 31, 2019, primarily reflecting increases in Medicaid and Medicare products, partially offset by declines in Commercial products.

Medicare Update

On April 6, 2020, the U.S. Centers for Medicare & Medicaid Services ("CMS") issued its final notice detailing final 2021 Medicare Advantage benchmark payment rates (the "Final Notice"). Overall the Company projects the benchmark rates in the Final Notice will increase funding for its Medicare Advantage business, excluding the impact of the HIF in 2020, by approximately 1.8% in 2021 compared to 2020.

On January 15, 2021, CMS issued its Final Notice detailing final 2022 Medicare Advantage benchmark payment rates. Final 2022 Medicare Advantage rates resulted in an increase in industry benchmark rates of approximately 4.1%.

The ACA ties a portion of each Medicare Advantage plan's reimbursement to the plan's "star ratings." Plans must have a star rating of four or higher (out of five) to qualify for bonus payments. CMS released the Company's 2021 star ratings in October 2020. The Company's 2021 star ratings will be used to determine which of the Company's Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2022. Based on the Company's membership at December 31, 2020, 83% of the Company's Medicare Advantage members were in plans with 2021 star ratings of at least four stars, consistent with 83% of the Company's Medicare Advantage members being in plans with 2020 star ratings of at least four stars based on the Company's membership at December 31, 2019.

Corporate/Other Segment

The following table summarizes the Corporate/Other segment's performance for the respective periods:

	Year Ended December 31,			Change			
				2020 vs. 2019		2019 vs. 2018	
In millions, except percentages	**2020**	**2019**	**2018**	**$**	**%**	**$**	**%**
Revenues:							
Premiums	$ 63	$ 91	$ 4	$ (28)	(30.8)%	$ 87	2,175.0 %
Services	48	9	—	39	433.3 %	9	100.0 %
Net investment income	315	412	602	(97)	(23.5)%	(190)	(31.6)%
Total revenues	426	512	606	(86)	(16.8)%	(94)	(15.5)%
Benefit costs	221	285	22	(64)	(22.5)%	263	1,195.5 %
Operating expenses	1,846	1,710	1,389	136	8.0 %	321	23.1 %
Operating loss	(1,641)	(1,483)	(805)	(158)	(10.7)%	(678)	(84.2)%
Adjusted operating loss [1]	(1,306)	(1,000)	(856)	(306)	(30.6)%	(144)	(16.8)%

(1) See "Segment Analysis" above in this MD&A for a reconciliation of operating loss (GAAP measure) to adjusted operating loss for the Corporate/Other segment.

Commentary - 2020 compared to 2019

Revenues

- Revenues primarily relate to products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, that were acquired in the Aetna Acquisition. In 2018, revenues relate primarily to interest income on the proceeds from the financing of the Aetna Acquisition.
- Total revenues decreased $86 million in 2020 compared to 2019. The decrease was primarily driven by lower net investment income including an $80 million decrease in net realized capital gains in 2020 compared to 2019.

Operating expenses

- Operating expenses within the Corporate/Other segment consist of management and administrative expenses to support the Company's overall operations, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments, expenses associated with the Company's investments in its transformation and enterprise modernization programs and acquisition-related transaction and integration costs. Subsequent to the Aetna Acquisition Date, segment operating expenses also include operating costs to support the Company's large case pensions and long-term care insurance products.
- Operating expenses increased $136 million in 2020 compared to 2019. The increase was primarily driven by incremental operating expenses associated with the Company's investments in transformation and its COVID-19 pandemic response efforts, as well as increased charitable contributions in 2020. The increase was partially offset by a $148 million decrease in acquisition-related integration costs compared to the prior year.

Liquidity and Capital Resources

Cash Flows

The Company maintains a level of liquidity sufficient to allow it to meet its cash needs in the short-term. Over the long term, the Company manages its cash and capital structure to maximize shareholder return, maintain its financial condition and maintain flexibility for future strategic initiatives. The Company continuously assesses its regulatory capital requirements, working capital needs, debt and leverage levels, debt maturity schedule, capital expenditure requirements, dividend payouts, potential share repurchases and future investments or acquisitions. The Company believes its operating cash flows, commercial paper program, credit facilities, sale-leaseback program, as well as any potential future borrowings, will be sufficient to fund these future payments and long-term initiatives. As of December 31, 2020, the Company had approximately $7.9 billion in cash and cash equivalents, approximately $2.2 billion of which was held by the parent company or nonrestricted subsidiaries.

The COVID-19 pandemic has severely impacted global economic activity and during the first half of the year caused significant volatility and negative pressure in the capital markets. As a result of the uncertainty generated by COVID-19, on March 31, 2020, the Company issued $4.0 billion aggregate principal amount of unsecured senior notes to enhance its liquidity and strengthen its capital. As markets stabilized, in August 2020, the Company purchased $6.0 billion of its outstanding senior notes through cash tender offers, while issuing $4.0 billion aggregate principal amount of unsecured senior notes. In December 2020, the Company purchased $4.5 billion of its outstanding senior notes through cash tender offers, while issuing $2.0 billion aggregate principal amount of unsecured senior notes. The Company will continue to monitor the severity and duration of the pandemic and its impact on the U.S. and global economies, consumer behavior and health care utilization patterns and our businesses, results of operations, financial condition, and cash flows.

The net change in cash, cash equivalents and restricted cash for the years ended December 31, 2020, 2019 and 2018 was as follows:

				Change			
	Year Ended December 31,			2020 vs. 2019		2019 vs. 2018	
In millions	2020	2019	2018	$	%	$	%
Net cash provided by operating activities	$ 15,865	$ 12,848	$ 8,865	$ 3,017	23.5 %	$ 3,983	44.9 %
Net cash used in investing activities	(5,534)	(3,339)	(43,285)	(2,195)	65.7 %	39,946	92.3 %
Net cash provided by (used in) financing activities	(8,155)	(7,850)	36,819	(305)	3.9 %	(44,669)	(121.3)%
Effect of exchange rate changes on cash, cash equivalents and restricted cash	—	—	(4)	—	— %	4	100.0 %
Net increase in cash, cash equivalents and restricted cash	$ 2,176	$ 1,659	$ 2,395	$ 517	31.2 %	$ (736)	(30.7)%

Commentary - 2020 compared to 2019

- *Net cash provided by operating activities* increased by $3.0 billion in 2020 compared to 2019 due primarily to higher operating income in the Health Care Benefits segment and the deferral of approximately $670 million of certain payroll tax payments to future years, as permitted in response to the COVID-19 pandemic.
- *Net cash used in investing activities* increased by $2.2 billion in 2020 compared to 2019 primarily due to increased net purchases of investments and an increase in cash used for acquisitions, partially offset by $840 million in proceeds from the sale of the Workers' Compensation business. In addition, cash used in investing activities reflected the following activity:
    - Gross capital expenditures remained relatively consistent at approximately $2.4 billion and $2.5 billion in 2020 and 2019, respectively. During 2020, approximately 62% of the Company's total capital expenditures were for technology and other corporate initiatives, 30% were for store, fulfillment and support facilities expansion and improvements and 8% were for new store construction.
- *Net cash used in financing activities* increased slightly to $8.2 billion in 2020 compared to $7.9 billion in 2019. The increase in cash used in finance activities primarily related to an increase in net debt repaid during 2020 compared to 2019.

Included in net cash used in investing activities for the years ended December 31, 2020, 2019 and 2018 was the following store development activity: [1]

	2020	2019	2018
Total stores (beginning of year)	9,896	9,921	9,803
New and acquired stores [2]	156	102	145
Closed stores [2]	(90)	(127)	(27)
Total stores (end of year)	9,962	9,896	9,921
Relocated stores [2]	18	23	34

(1) Includes retail drugstores and pharmacies within retail chains, primarily in Target Corporation ("Target") stores.
(2) Relocated stores are not included in new and acquired stores or closed stores totals.

Short-term Borrowings

Commercial Paper and Back-up Credit Facilities
The Company did not have any commercial paper outstanding as of December 31, 2020 or 2019. In connection with its commercial paper program, the Company maintains a $1.0 billion 364-day unsecured back-up revolving credit facility, which expires on May 12, 2021, a $1.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 18, 2022, a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 17, 2023 and a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 16, 2024. The credit facilities allow for borrowings at various rates that are dependent, in part, on the Company's public debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately 0.03%, regardless of usage. As of December 31, 2020 and 2019, there were no borrowings outstanding under any of the Company's back-up credit facilities.

Federal Home Loan Bank of Boston
Since the Aetna Acquisition Date, a subsidiary of the Company is a member of the Federal Home Loan Bank of Boston (the "FHLBB"). As a member, the subsidiary has the ability to obtain cash advances, subject to certain minimum collateral requirements. The maximum borrowing capacity available from the FHLBB as of December 31, 2020 was approximately $925 million. At both December 31, 2020 and 2019, there were no outstanding advances from the FHLBB.

Long-term Borrowings

2020 Notes
On December 16, 2020, the Company issued $750 million aggregate principal amount of 1.3% unsecured senior notes due August 21, 2027 and $1.25 billion aggregate principal amount of 1.875% unsecured senior notes due February 28, 2031 for total proceeds of approximately $1.99 billion, net of discounts and underwriting fees. The $750 million aggregate principal amount of 1.3% unsecured senior notes represent a further issuance of the Company's 1.3% unsecured senior notes due August 21, 2027 initially issued in an aggregate principal amount of $1.5 billion on August 21, 2020.

On August 21, 2020, the Company issued $1.5 billion aggregate principal amount of 1.3% unsecured senior notes due August 21, 2027, $1.25 billion aggregate principal amount of 1.75% unsecured senior notes due August 21, 2030 and $1.25 billion aggregate principal amount of 2.7% unsecured senior notes due August 21, 2040 (collectively, the "August 2020 Notes") for total proceeds of approximately $3.97 billion, net of discounts and underwriting fees.

On March 31, 2020, the Company issued $750 million aggregate principal amount of 3.625% unsecured senior notes due April 1, 2027, $1.5 billion aggregate principal amount of 3.75% unsecured senior notes due April 1, 2030, $1.0 billion aggregate principal amount of 4.125% unsecured senior notes due April 1, 2040 and $750 million aggregate principal amount of 4.25% unsecured senior notes due April 1, 2050 (collectively, the "March 2020 Notes") for total proceeds of approximately $3.95 billion, net of discounts and underwriting fees.

The net proceeds of these offerings were used for general corporate purposes, which may include working capital, capital expenditures, as well as the repurchase and/or repayment of indebtedness.

During March 2020, the Company entered into several interest rate swap transactions to manage interest rate risk. These agreements were designated as cash flow hedges and were used to hedge the exposure to variability in future cash flows resulting from changes in interest rates related to the anticipated issuance of the March 2020 Notes. In connection with the

issuance of the March 2020 Notes, the Company terminated all outstanding cash flow hedges. The Company paid a net amount of $7 million to the hedge counterparties upon termination, which was recorded as a loss, net of tax, of $5 million in accumulated other comprehensive income and will be reclassified as interest expense over the life of the March 2020 Notes. See Note 13 ‘‘Other Comprehensive Income’’ included in Item 8 of this 10-K for additional information.

2019 Notes
On August 15, 2019, the Company issued $1.0 billion aggregate principal amount of 2.625% unsecured senior notes due August 15, 2024, $750 million aggregate principal amount of 3% unsecured senior notes due August 15, 2026 and $1.75 billion aggregate principal amount of 3.25% unsecured senior notes due August 15, 2029 (collectively, the “2019 Notes”) for total proceeds of approximately $3.46 billion, net of discounts and underwriting fees. The net proceeds of the 2019 Notes were used to repay certain of the Company’s outstanding debt.

Beginning in July 2019, the Company entered into several interest rate swap and treasury lock transactions to manage interest rate risk. These agreements were designated as cash flow hedges and were used to hedge the exposure to variability in future cash flows resulting from changes in interest rates related to the anticipated issuance of the 2019 Notes. In connection with the issuance of the 2019 Notes, the Company terminated all outstanding cash flow hedges. The Company paid a net amount of $25 million to the hedge counterparties upon termination, which was recorded as a loss, net of tax, of $18 million in accumulated other comprehensive income and will be reclassified as interest expense over the life of the 2019 Notes. See Note 13 ‘‘Other Comprehensive Income’’ included in Item 8 of this 10-K for additional information.

Early Extinguishments of Debt
In December 2020, the Company purchased $4.5 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $113 million of its 4.0% senior notes due 2023, $1.4 billion of its 3.7% senior notes due 2023, $1.0 billion of its 4.1% senior notes due 2025 and $2.0 billion of its 4.3% senior notes due 2028. In connection with the purchase of such senior notes, the Company paid a premium of $619 million in excess of the aggregate principal amount of the senior notes that were purchased, wrote-off $45 million of unamortized deferred financing costs and incurred $10 million in fees, for a total loss on early extinguishment of debt of $674 million.

In August 2020, the Company purchased $6.0 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $723 million of its 4.0% senior notes due 2023, $2.3 billion of its 3.7% senior notes due 2023 and $3.0 billion of its 4.1% senior notes due 2025. In connection with the purchase of such senior notes, the Company paid a premium of $706 million in excess of the aggregate principal amount of the senior notes that were purchased, wrote-off $47 million of unamortized deferred financing costs and incurred $13 million in fees, for a total loss on early extinguishment of debt of $766 million.

In August 2019, the Company purchased $4.0 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $1.3 billion of its 3.125% senior notes due 2020, $723 million of its floating rate notes due 2020, $328 million of its 4.125% senior notes due 2021, $297 million of 4.125% senior notes due 2021 issued by Aetna, $413 million of 5.45% senior notes due 2021 issued by Coventry Health Care, Inc., a wholly-owned subsidiary of Aetna, and $962 million of its 3.35% senior notes due 2021. In connection with the purchase of such senior notes, the Company paid a premium of $76 million in excess of the aggregate principal amount of the senior notes that were purchased, incurred $8 million in fees and recognized a net gain of $5 million on the write-off of net unamortized deferred financing premiums, for a net loss on early extinguishment of debt of $79 million.

See Note 8 ‘‘Borrowings and Credit Agreements’’ and Note 12 ‘‘Shareholders’ Equity’’ included in Item 8 of this 10-K for additional information about debt issuances, debt repayments, share repurchases and dividend payments.

Derivative Financial Instruments

The Company uses derivative financial instruments in order to manage interest rate and foreign exchange risk and credit exposure. The Company’s use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps.

Debt Covenants

The Company’s back-up revolving credit facilities, unsecured senior notes and unsecured floating rate notes (see Note 8 ‘‘Borrowings and Credit Agreements’’ included in Item 8 of this 10-K) contain customary restrictive financial and operating covenants. These covenants do not include an acceleration of the Company’s debt maturities in the event of a downgrade in the

Company's credit ratings. The Company does not believe the restrictions contained in these covenants materially affect its financial or operating flexibility. As of December 31, 2020, the Company was in compliance with all of its debt covenants.

Debt Ratings

As of December 31, 2020, the Company's long-term debt was rated "Baa2" by Moody's Investors Service, Inc. ("Moody's") and "BBB" by Standard & Poor's Financial Services LLC ("S&P"), and its commercial paper program was rated "P-2" by Moody's and "A-2" by S&P. The outlook on the Company's long-term debt is "Stable" by S&P. In December 2020, Moody's changed the outlook on the Company's long-term debt from "Negative" to "Stable." In assessing the Company's credit strength, the Company believes that both Moody's and S&P considered, among other things, the Company's capital structure and financial policies as well as its consolidated balance sheet, its historical acquisition activity and other financial information. Although the Company currently believes its long-term debt ratings will remain investment grade, it cannot guarantee the future actions of Moody's and/or S&P. The Company's debt ratings have a direct impact on its future borrowing costs, access to capital markets and new store operating lease costs.

Share Repurchase Programs

During the years ended December 31, 2020, 2019 and 2018, the Company did not repurchase any shares of common stock. See Note 12 ''Shareholders' Equity'' included in Item 8 of this 10-K for additional information on the Company's share repurchase program.

Quarterly Cash Dividend

During 2020, 2019 and 2018, the quarterly cash dividend was $0.50 per share. CVS Health has paid cash dividends every quarter since becoming a public company and expects to maintain its quarterly dividend of $0.50 per share throughout 2021. Future dividends will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

Future Cash Requirements

The following table summarizes certain estimated future cash requirements under the Company's various contractual obligations at December 31, 2020, in total and disaggregated into current and long-term obligations. The table below does not include future payments of claims to health care providers or pharmacies because certain terms of these payments are not determinable at December 31, 2020 (for example, the timing and volume of future services provided under fee-for-service arrangements and future membership levels for capitated arrangements).

In millions	Total	Current	Long-Term
Operating lease liabilities [1]	$ 27,142	$ 2,688	$ 24,454
Finance lease liabilities [1]	1,812	100	1,712
Contractual lease obligations with Target [2]	2,332	—	2,332
Long-term debt [3]	64,235	5,405	58,830
Interest payments on long-term debt [3]	34,565	2,409	32,156
Other long-term liabilities on the consolidated balance sheets [4]			
Future policy benefits [5]	5,983	462	5,521
Unpaid claims [5]	2,018	532	1,486
Policyholders' funds [5] [6]	1,870	1,374	496
Total	$ 139,957	$ 12,970	$ 126,987

(1) Refer to Note 6 ''Leases'' included in Item 8 of this 10-K for additional information regarding the maturity of lease liabilities under operating and finance leases.

(2) The Company leases pharmacy and clinic space from Target. See Note 6 ''Leases'' included in Item 8 of this 10-K for additional information regarding the lease arrangements with Target. Amounts related to such operating and finance leases are reflected within the operating lease liabilities and finance lease liabilities in the table above. Pharmacy lease amounts due in excess of the remaining estimated economic life of the buildings are reflected in the table above assuming equivalent stores continue to operate through the term of the arrangements.

(3) Refer to Note 8 ''Borrowings and Credit Agreements'' included in Item 8 of this 10-K for additional information regarding the maturities of debt principal. Interest payments on long-term debt are calculated using outstanding balances and interest rates in effect on December 31, 2020.

(4) Payments of other long-term liabilities exclude Separate Accounts liabilities of approximately $4.9 billion because these liabilities are supported by assets that are legally segregated and are not subject to claims that arise out of the Company's business.

(5) Total payments of future policy benefits, unpaid claims and policyholders' funds include $763 million, $2.0 billion and $210 million, respectively, of reserves for contracts subject to reinsurance. The Company expects the assuming reinsurance carrier to fund these obligations and has reflected these amounts as reinsurance recoverable assets on the consolidated balance sheets.

(6) Customer funds associated with group life and health contracts of approximately $2.9 billion have been excluded from the table above because such funds may be used primarily at the customer's discretion to offset future premiums and/or for refunds, and the timing of the related cash flows cannot be determined. Additionally, net unrealized capital gains on debt securities supporting experience-rated products of $135 million, before tax, have been excluded from the table above.

Restrictions on Certain Payments

In addition to general state law restrictions on payments of dividends and other distributions to stockholders applicable to all corporations, health maintenance organizations ("HMOs") and insurance companies are subject to further regulations that, among other things, may require those companies to maintain certain levels of equity (referred to as surplus) and restrict the amount of dividends and other distributions that may be paid to their equity holders. These regulations are not directly applicable to CVS Health as a holding company, since CVS Health is not an HMO or an insurance company. In addition, in connection with the Aetna Acquisition, the Company made certain undertakings that require prior regulatory approval of dividends by certain of its HMOs and insurance companies. The additional regulations and undertakings applicable to the Company's HMO and insurance company subsidiaries are not expected to affect the Company's ability to service the Company's debt, meet other financing obligations or pay dividends, or the ability of any of the Company's subsidiaries to service their debt or other financing obligations. Under applicable regulatory requirements and undertakings, at December 31, 2020, the maximum amount of dividends that may be paid by the Company's insurance and HMO subsidiaries without prior approval by regulatory authorities was $2.9 billion in the aggregate.

The Company maintains capital levels in its operating subsidiaries at or above targeted and/or required capital levels and dividends amounts in excess of these levels to meet liquidity requirements, including the payment of interest on debt and stockholder dividends. In addition, at the Company's discretion, it uses these funds for other purposes such as funding share and debt repurchase programs, investments in new businesses and other purposes considered advisable.

At December 31, 2020 and 2019, the Company held investments of $524 million and $537 million, respectively, that are not accounted for as Separate Accounts assets but are legally segregated and are not subject to claims that arise out of the Company's business. See Note 3 ''Investments'' included in Item 8 of this 10-K for additional information on investments related to the 2012 conversion of an existing group annuity contract from a participating to a non-participating contract.

Solvency Regulation

The National Association of Insurance Commissioners (the "NAIC") utilizes risk-based capital ("RBC") standards for insurance companies that are designed to identify weakly-capitalized companies by comparing each company's adjusted surplus to its required surplus (the "RBC Ratio"). The RBC Ratio is designed to reflect the risk profile of insurance companies. Within certain ratio ranges, regulators have increasing authority to take action as the RBC Ratio decreases. There are four levels of regulatory action, ranging from requiring an insurer to submit a comprehensive financial plan for increasing its RBC to the state insurance commissioner to requiring the state insurance commissioner to place the insurer under regulatory control. At December 31, 2020, the RBC Ratio of each of the Company's primary insurance subsidiaries was above the level that would require regulatory action. The RBC framework described above for insurers has been extended by the NAIC to health organizations, including HMOs. Although not all states had adopted these rules at December 31, 2020, at that date, each of the Company's active HMOs had a surplus that exceeded either the applicable state net worth requirements or, where adopted, the levels that would require regulatory action under the NAIC's RBC rules. External rating agencies use their own capital models and/or RBC standards when they determine a company's rating.

Critical Accounting Policies

The Company prepares the consolidated financial statements in conformity with generally accepted accounting principles, which require management to make certain estimates and apply judgment. Estimates and judgments are based on historical experience, current trends and other factors that management believes to be important at the time the consolidated financial statements are prepared. On a regular basis, the Company reviews its accounting policies and how they are applied and disclosed in the consolidated financial statements. While the Company believes the historical experience, current trends and other factors considered by management support the preparation of the consolidated financial statements in conformity with generally accepted accounting principles, actual results could differ from estimates, and such differences could be material.

Significant accounting policies are discussed in Note 1 ‘‘Significant Accounting Policies’’ included in Item 8 of this 10-K. Management believes the following accounting policies include a higher degree of judgment and/or complexity and, thus, are considered to be critical accounting policies. The Company has discussed the development and selection of these critical accounting policies with the Audit Committee of the Board (the “Audit Committee”), and the Audit Committee has reviewed the disclosures relating to them.

Revenue Recognition

Pharmacy Services Segment
The Pharmacy Services segment sells prescription drugs directly through its mail service dispensing pharmacies and indirectly through the Company’s retail pharmacy network. The Company’s pharmacy benefit arrangements are accounted for in a manner consistent with a master supply arrangement as there are no contractual minimum volumes and each prescription is considered a separate purchasing decision and distinct performance obligation transferred at a point in time. PBM services performed in connection with each prescription claim are considered part of a single performance obligation which culminates in the dispensing of prescription drugs.

The Company recognizes revenue using the gross method at the contract price negotiated with its clients when the Company has concluded it controls the prescription drug before it is transferred to the client plan members. The Company controls prescriptions dispensed indirectly through its retail pharmacy network because it has separate contractual arrangements with those pharmacies, has discretion in setting the price for the transaction and assumes primary responsibility for fulfilling the promise to provide prescription drugs to its client plan members while also performing the related PBM services.

Revenues include (i) the portion of the price the client pays directly to the Company, net of any discounts earned on brand name drugs or other discounts and refunds paid back to the client (see “Drug Discounts” and “Guarantees” below), (ii) the price paid to the Company by client plan members for mail order prescriptions and the price paid to retail network pharmacies by client plan members for retail prescriptions (“retail co-payments”), and (iii) claims based administrative fees for retail pharmacy network contracts. Sales taxes are not included in revenues.

The Company recognizes revenue when control of the prescription drugs is transferred to customers, in an amount that reflects the consideration the Company expects to be entitled to receive in exchange for those prescription drugs. The Company has established the following revenue recognition policies for the Pharmacy Services segment:

- Revenues generated from prescription drugs sold by mail service dispensing pharmacies are recognized when the prescription drug is delivered to the client plan member. At the time of delivery, the Company has performed substantially all of its performance obligations under its client contracts and does not experience a significant level of returns or reshipments.
- Revenues generated from prescription drugs sold by third party pharmacies in the Company’s retail pharmacy network and associated administrative fees are recognized at the Company’s point-of-sale, which is when the claim is adjudicated by the Company’s online claims processing system and the Company has transferred control of the prescription drug and performed all of its performance obligations.

For contracts under which the Company acts as an agent or does not control the prescription drugs prior to transfer to the client plan member, revenue is recognized using the net method.

Drug Discounts
The Company records revenue net of manufacturers’ rebates earned by its clients based on their plan members’ utilization of brand-name formulary drugs. The Company estimates these rebates at period-end based on actual and estimated claims data and its estimates of the manufacturers’ rebates earned by its clients. The estimates are based on the best available data at period-end

and recent history for the various factors that can affect the amount of rebates due to the client. The Company adjusts its rebates payable to clients to the actual amounts paid when these rebates are paid or as significant events occur. Any cumulative effect of these adjustments is recorded against revenues at the time it is identified. Adjustments generally result from contract changes with clients or manufacturers that have retroactive rebate adjustments, differences between the estimated and actual product mix subject to rebates, or whether the brand name drug was included in the applicable formulary. The effect of adjustments between estimated and actual manufacturers' rebate amounts has not been material to the Company's operating results or financial condition.

Guarantees

The Company also adjusts revenues for refunds owed to clients resulting from pricing guarantees and performance against defined service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's operating results or financial condition.

Retail/LTC Segment

Retail Pharmacy

The Company's retail drugstores recognize revenue at the time the customer takes possession of the merchandise. For pharmacy sales, each prescription claim is its own arrangement with the customer and is a performance obligation, separate and distinct from other prescription claims under other retail network arrangements. Revenues are adjusted for refunds owed to third party payers resulting from pricing guarantees and performance against defined value-based service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's operating results or financial condition.

Revenue from Company gift cards purchased by customers is deferred as a contract liability until goods or services are transferred. Any amounts not expected to be redeemed by customers (i.e., breakage) are recognized based on historical redemption patterns.

Customer returns are not material to the Company's operating results or financial condition. Sales taxes are not included in revenues.

Loyalty and Other Programs

The Company's customer loyalty program, ExtraCare®, consists of two components, ExtraSavings™ and ExtraBucks® Rewards. ExtraSavings are coupons that are recorded as a reduction of revenue when redeemed as the Company concluded that they do not represent a promise to the customer to deliver additional goods or services at the time of issuance because they are not tied to a specific transaction or spending level.

ExtraBucks Rewards are accumulated by customers based on their historical spending levels. Thus, the Company has determined that there is an additional performance obligation to those customers at the time of the initial transaction. The Company allocates the transaction price to the initial transaction and the ExtraBucks Rewards transaction based upon the relative standalone selling price, which considers historical redemption patterns for the rewards. Revenue allocated to ExtraBucks Rewards is recognized as those rewards are redeemed. At the end of each period, unredeemed ExtraBucks Rewards are reflected as a contract liability.

The Company also offers a subscription-based membership program, CarePass®, under which members are entitled to a suite of benefits delivered over the course of the subscription period, as well as a promotional reward that can be redeemed for future goods and services. Subscriptions are paid for on a monthly or annual basis at the time of or in advance of the Company delivering the goods and services. Revenue from these arrangements is recognized as the performance obligations are satisfied.

Long-term Care

Revenue is recognized when control of the promised goods or services is transferred to customers in an amount that reflects the consideration the Company expects to be entitled to receive in exchange for those goods or services. Each prescription claim represents a separate performance obligation of the Company, separate and distinct from other prescription claims under customer arrangements. A significant portion of Long-term Care revenue from sales of pharmaceutical and medical products is reimbursed by the federal Medicare Part D program and, to a lesser extent, state Medicaid programs. The Company monitors its revenues and receivables from these reimbursement sources, as well as long-term care facilities and other third party insurance payors, and reduces revenue at the revenue recognition date to properly account for the variable consideration due to anticipated

differences between billed and reimbursed amounts. Accordingly, the total revenues and receivables reported in the Company's consolidated financial statements are recorded at the amount expected to be ultimately received from these payors.

Patient co-payments associated with Medicare Part D, certain state Medicaid programs, Medicare Part B and certain third party payors typically are not collected at the time products are delivered or services are rendered, but are billed to the individuals as part of normal billing procedures and subject to normal accounts receivable collections procedures.

Walk-In Medical Clinics
For services provided by the Company's walk-in medical clinics, revenue recognition occurs for completed services provided to patients, with adjustments taken for third party payor contractual obligations and patient direct bill historical collection rates.

Health Care Benefits Segment
Health Care Benefits revenue is principally derived from insurance premiums and fees billed to customers. Revenue is recognized based on customer billings, which reflect contracted rates per employee and the number of covered employees recorded in the Company's records at the time the billings are prepared. Billings are generally sent monthly for coverage during the following month.

The Company's billings may be subsequently adjusted to reflect enrollment changes due to member terminations or other factors. These adjustments are known as retroactivity adjustments. In each period, the Company estimates the amount of future retroactivity and adjusts the recorded revenue accordingly. As information regarding actual retroactivity amounts becomes known, the Company refines its estimates and records any required adjustments to revenues in the period in which they arise. A significant difference in the actual level of retroactivity compared to estimated levels would have a significant effect on the Company's operating results.

Premium Revenue
Premiums are recognized as revenue in the month in which the enrollee is entitled to receive health care services. Premiums are reported net of an allowance for estimated terminations and uncollectible amounts. Additionally, premium revenue subject to the MLR rebate requirements of the ACA is recorded net of the estimated minimum MLR rebates for the current calendar year. Premiums related to unexpired contractual coverage periods (unearned premiums) are reported as other insurance liabilities on the consolidated balance sheets and recognized as revenue when earned.

Some of the Company's contracts allow for premiums to be adjusted to reflect actual experience or the relative health status of Insured members. Such adjustments are reasonably estimable at the outset of the contract, and adjustments to those estimates are made based on actual experience of the customer emerging under the contract and the terms of the underlying contract.

Services Revenue
Services revenue relates to contracts that can include various combinations of services or series of services which generally are capable of being distinct and accounted for as separate performance obligations. The Health Care Benefits segment's services revenue primarily consists of ASC fees received in exchange for performing certain claim processing and member services for ASC members. ASC fee revenue is recognized over the period the service is provided. Some of the Company's administrative services contracts include guarantees with respect to certain functions, such as customer service response time, claim processing accuracy and claim processing turnaround time, as well as certain guarantees that a plan sponsor's benefit claim experience will fall within a certain range. With any of these guarantees, the Company is financially at risk if the conditions of the arrangements are not met, although the maximum amount at risk typically is limited to a percentage of the fees otherwise payable to the Company by the customer involved. Each period the Company estimates its obligations under the terms of these guarantees and records its estimate as an offset to services revenues.

Accounting for Medicare Part D
Revenues include insurance premiums earned by the Company's PDPs, which are determined based on the PDP's annual bid and related contractual arrangements with CMS. The insurance premiums include a beneficiary premium, which is the responsibility of the PDP member, and can be subsidized by CMS in the case of low-income members, and a direct premium paid by CMS. Premiums collected in advance are initially recorded within other insurance liabilities and are then recognized ratably as revenue over the period in which members are entitled to receive benefits.

Revenues also include a risk-sharing feature of the Medicare Part D program design referred to as the risk corridor. The Company estimates variable consideration in the form of amounts payable to, or receivable from, CMS under the risk corridor, and adjusts revenue based on calculations of additional subsidies to be received from or owed to CMS at the end of the reporting year.

In addition to Medicare Part D premiums, the Company receives additional payments each month from CMS related to catastrophic reinsurance, low-income cost-sharing subsidies and coverage gap benefits. If the subsidies received differ from the amounts earned from actual prescriptions transferred, the difference is recorded in either accounts receivable, net or accrued expenses.

Impairments of Debt Securities

The Company regularly reviews its debt securities to determine whether a decline in fair value below the cost basis or carrying value has occurred. If a debt security is in an unrealized loss position and the Company has the intent to sell the security, or it is more likely than not that the Company will have to sell the security before recovery of its amortized cost basis, the amortized cost basis of the security is written down to its fair value and the difference is recognized in net income. If a debt security is in an unrealized loss position and the Company does not have the intent to sell and it is more likely than not that the Company will not have to sell such security before recovery of its amortized cost basis, the Company bifurcates the impairment into credit-related and non-credit related components. The amount of the credit-related component is recorded as an allowance for credit losses and recognized in net income, and the amount of the non-credit related component is included in other comprehensive income. The Company analyzes all facts and circumstances believed to be relevant for each investment when performing this analysis, in accordance with applicable accounting guidance.

In evaluating whether a credit related loss exists, the Company considers a variety of factors including: the extent to which the fair value is less than the amortized cost basis; adverse conditions specifically related to the issuer of a security, an industry or geographic area; the payment structure of the security; the failure of the issuer of the security to make scheduled interest or principle payments; and any changes to the rating of the security by a rating agency.

During the year ended December 31, 2020, the Company recorded yield-related impairment losses on debt securities of $49 million. During the year ended December 31, 2020, the Company did not record credit-related impairment losses on debt securities. During the year ended December 31, 2019, the Company recorded other-than-temporary impairment (“OTTI”) losses on debt securities of $24 million. There were no material OTTI losses on debt securities for the year ended December 31, 2018.

The risks inherent in assessing the impairment of a debt security include the risk that market factors may differ from projections and the risk that facts and circumstances factored into the Company’s assessment may change with the passage of time. Unexpected changes to market factors and circumstances that were not present in past reporting periods are among the factors that may result in a current period decision to sell debt securities that were not impaired in prior reporting periods.

Vendor Allowances and Purchase Discounts

Vendor and manufacturer receivables were $9.8 billion and $7.9 billion as of December 31, 2020 and 2019, respectively, the majority of which relate to purchase discounts and vendor allowances as described below.

Pharmacy Services Segment
The Pharmacy Services segment receives purchase discounts on products purchased. Contractual arrangements with vendors, including manufacturers, wholesalers and retail pharmacies, normally provide for the Pharmacy Services segment to receive purchase discounts from established list prices in one, or a combination, of the following forms: (i) a direct discount at the time of purchase, (ii) a discount for the prompt payment of invoices or (iii) when products are purchased indirectly from a manufacturer (e.g., through a wholesaler or retail pharmacy), a discount (or rebate) paid subsequent to dispensing. These rebates are recognized when prescriptions are dispensed and are generally calculated and billed to manufacturers within 30 days of the end of each completed quarter. Historically, the effect of adjustments resulting from the reconciliation of rebates recognized to the amounts billed and collected has not been material to the Company’s operating results or financial condition. The Company accounts for the effect of any such differences as a change in accounting estimate in the period the reconciliation is completed. The Pharmacy Services segment also receives additional discounts under its wholesaler contracts if it exceeds contractually defined purchase volumes. In addition, the Pharmacy Services segment receives fees from pharmaceutical manufacturers for administrative services. Purchase discounts and administrative service fees are recorded as a reduction of cost of products sold.

Retail/LTC Segment
Vendor allowances received by the Retail/LTC segment reduce the carrying cost of inventory and are recognized in cost of products sold when the related inventory is sold, unless they are specifically identified as a reimbursement of incremental costs for promotional programs and/or other services provided. Amounts that are directly linked to advertising commitments are

recognized as a reduction of advertising expense (included in operating expenses) when the related advertising commitment is satisfied. Any such allowances received in excess of the actual cost incurred also reduce the carrying cost of inventory. The total value of any upfront payments received from vendors that are linked to purchase commitments is initially deferred. The deferred amounts are then amortized to reduce cost of products sold over the life of the contract based upon purchase volume. The total value of any upfront payments received from vendors that are not linked to purchase commitments is also initially deferred. The deferred amounts are then amortized to reduce cost of products sold on a straight-line basis over the life of the related contract.

The Company establishes a receivable for vendor income that is earned but not yet received based on historical trends and data. The majority of vendor receivables are collected within the following fiscal quarter. Historically, adjustments to the Company's vendor receivables resulting from the reconciliation of receivables recognized to the amounts collected have not been material to the Company's operating results or financial condition.

There have not been any material changes in the way the Company accounts for vendor allowances or purchase discounts during the past three years.

Inventory

Inventories are valued at the lower of cost or net realizable value using the weighted average cost method.

The value of ending inventory is reduced for estimated inventory losses that have occurred during the interim period between physical inventory counts. Physical inventory counts are taken on a regular basis in each retail store and LTC pharmacy, and a continuous cycle count process is the primary procedure used to validate the inventory balances on hand in each distribution center and mail facility to ensure that the amounts reflected in the consolidated financial statements are properly stated. The Company's accounting for inventory contains uncertainty since management must use judgment to estimate the inventory losses that have occurred during the interim period between physical inventory counts. When estimating these losses, a number of factors are considered which include historical physical inventory results on a location-by-location basis and current physical inventory loss trends.

The total reserve for estimated inventory losses covered by this critical accounting policy was $369 million and $401 million as of December 31, 2020 and 2019, respectively. Although management believes there is sufficient current and historical information available to record reasonable estimates for estimated inventory losses, it is possible that actual results could differ. In order to help investors assess the aggregate risk, if any, associated with the inventory-related uncertainties discussed above, a ten percent (10%) pre-tax change in estimated inventory losses, which is a reasonably likely change, would increase or decrease the total reserve for estimated inventory losses by approximately $37 million as of December 31, 2020.

Although management believes that the estimates discussed above are reasonable and the related calculations conform to generally accepted accounting principles, actual results could differ from such estimates, and such differences could be material.

Right-of-Use Assets and Lease Liabilities

The Company determines if an arrangement contains a lease at the inception of a contract. Right-of-use assets represent the Company's right to use an underlying asset for the lease term and lease liabilities represent the Company's obligation to make lease payments arising from the lease. Right-of-use assets and lease liabilities are recognized at the commencement date of the lease, renewal date of the lease or significant remodeling of the lease space based on the present value of the remaining future minimum lease payments. As the interest rate implicit in the Company's leases is not readily determinable, the Company utilizes its incremental borrowing rate, determined by class of underlying asset, to discount the lease payments. The operating lease right-of-use assets also include lease payments made before commencement and are reduced by lease incentives.

The Company's real estate leases typically contain options that permit renewals for additional periods of up to five years each. For real estate leases, the options to extend are not considered reasonably certain at lease commencement because the Company reevaluates each lease on a regular basis to consider the economic and strategic incentives of exercising the renewal options and regularly opens or closes stores to align with its operating strategy. Generally, the renewal option periods are not included within the lease term and the associated payments are not included in the measurement of the right-of-use asset and lease liability. Similarly, renewal options are not included in the lease term for non-real estate leases because they are not considered reasonably certain of being exercised at lease commencement. Leases with an initial term of 12 months or less are not recorded on the balance sheets, and lease expense is recognized on a straight-line basis over the term of the short-term lease.

For real estate leases, the Company accounts for lease components and nonlease components as a single lease component. Certain real estate leases require additional payments based on sales volume, as well as reimbursement for real estate taxes, common area maintenance and insurance, which are expensed as incurred as variable lease costs. Other real estate leases contain one fixed lease payment that includes real estate taxes, common area maintenance and insurance. These fixed payments are considered part of the lease payment and included in the right-of-use assets and lease liabilities.

Long-Lived Asset Impairment

Recoverability of Definite-Lived Assets
The Company evaluates the recoverability of long-lived assets, excluding goodwill and indefinite-lived intangible assets, which are tested for impairment using separate tests described below, whenever events or changes in circumstances indicate that the carrying value of such an asset may not be recoverable. The Company groups and evaluates these long-lived assets for impairment at the lowest level at which individual cash flows can be identified. If indicators of impairment are present, the Company first compares the carrying amount of the asset group to the estimated future cash flows associated with the asset group (undiscounted and without interest charges). If the estimated future cash flows used in this analysis are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to the asset group's estimated future cash flows (discounted and with interest charges). If required, an impairment loss is recorded for the portion of the asset group's carrying value that exceeds the asset group's estimated future cash flows (discounted and with interest charges).

The long-lived asset impairment loss calculation contains uncertainty since management must use judgment to estimate each asset group's future sales, profitability and cash flows. When preparing these estimates, the Company considers historical results and current operating trends and consolidated sales, profitability and cash flow results and forecasts. These estimates can be affected by a number of factors including general economic and regulatory conditions, efforts of third party organizations to reduce their prescription drug costs and/or increased member co-payments, the continued efforts of competitors to gain market share and consumer spending patterns.

There were no material impairment charges recognized on long-lived assets in the year ended December 31, 2020. During the year ended December 31, 2019, the Company recorded store rationalization charges of $231 million, primarily related to operating lease right-of-use asset impairment charges. During the year ended December 31, 2018, the Company recognized a $43 million long-lived asset impairment charge, primarily related to the impairment of property and equipment.

Recoverability of Goodwill
Goodwill represents the excess of amounts paid for acquisitions over the fair value of the net identifiable assets acquired. Goodwill is subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that the carrying value may not be recoverable. Goodwill is tested for impairment on a reporting unit basis. The impairment test is performed by comparing the reporting unit's fair value with its net book value (or carrying amount), including goodwill. The fair value of the reporting units is estimated using a combination of a discounted cash flow method and a market multiple method. If the net book value (carrying amount) of the reporting unit exceeds its fair value, the reporting unit's goodwill is considered to be impaired, and an impairment is recognized in an amount equal to the excess.

The determination of the fair value of the reporting units requires the Company to make significant assumptions and estimates. These assumptions and estimates primarily include the selection of appropriate peer group companies; control premiums and valuation multiples appropriate for acquisitions in the industries in which the Company competes; discount rates; terminal growth rates; and forecasts of revenue, operating income, depreciation and amortization, income taxes, capital expenditures and future working capital requirements. When determining these assumptions and preparing these estimates, the Company considers each reporting unit's historical results and current operating trends; consolidated revenues, profitability and cash flow results and forecasts; and industry trends. The Company's estimates can be affected by a number of factors, including general economic and regulatory conditions; the risk-free interest rate environment; the Company's market capitalization; efforts of customers and payers to reduce costs, including their prescription drug costs, and/or increase member co-payments; the continued efforts of competitors to gain market share, consumer spending patterns and the Company's ability to achieve its revenue growth projections and execute on its cost reduction initiatives.

2020 Goodwill Impairment Test
During the third quarter of 2020, the Company performed its required annual impairment test of goodwill. The results of this impairment test indicated that there was no impairment of goodwill as of the testing date. The goodwill impairment test resulted in the fair values of all of the Company's reporting units exceeding their carrying values by significant margins, with the

exception of the Commercial Business and LTC reporting units, which exceeded their carrying values by approximately 6% and 12%, respectively.

In connection with the Aetna Acquisition in November 2018, the Company added the Health Care Benefits segment which included the Commercial Business reporting unit. The transaction was accounted for using the acquisition method of accounting which requires, among other things, the assets acquired and liabilities assumed to be recognized at their fair values at the date of acquisition. As a result, at the time of the acquisition the fair value of the Commercial Business reporting unit was equal to its carrying value.

The Company has experienced declines in its Commercial Insured medical membership subsequent to the closing date of the Aetna Acquisition and may continue to do so for a number of reasons, including as a result of the competitive Commercial business environment. In addition, COVID-19 has had and may continue to have an adverse impact on medical membership in the Commercial business due to reductions in workforce at existing customers (including due to business failures) as well as reduced willingness to change benefit providers by prospective customers. The Company's fair value estimate is sensitive to significant assumptions including changes in medical membership, revenue growth rate, operating income and the discount rate. Although the Company believes the financial projections used to determine the fair value of the Commercial Business reporting unit in the third quarter of 2020 were reasonable and achievable, the challenges described above may affect the Company's ability to increase medical membership or operating income in the Commercial Business reporting unit at the rate estimated when such goodwill impairment test was performed and may continue to do so. As of December 31, 2020, the goodwill balance in the Commercial Business reporting unit was $26.5 billion.

The LTC reporting unit continues to experience industry-wide challenges that have impacted management's ability to grow the business at the rate that was originally estimated when the Company acquired Omnicare in 2015. Those challenges included lower client retention rates, lower occupancy rates in skilled nursing facilities, the deteriorating financial health of numerous skilled nursing facility customers which resulted in a number of customer bankruptcies in 2018, and continued facility reimbursement pressures. COVID-19 has also had an adverse impact on the financial health of the Company's long-term care facility customers due to declines in occupancy rates and increased operating expenses. A number of these customers have relied on supplemental liquidity sources such as grants and advance Medicare payments under programs expanded or created under the CARES Act to maintain adequate liquidity during the COVID-19 pandemic and may require additional sources of liquidity throughout the duration of the COVID-19 pandemic.

Although the Company believes the financial projections used to determine the fair value of the LTC reporting unit in the third quarter of 2020 were reasonable and achievable, the LTC reporting unit has faced challenges that affect the Company's ability to grow the LTC reporting unit's business at the rate estimated when such goodwill impairment test was performed and may continue to do so. These challenges and some of the key assumptions included in the Company's financial projections to determine the estimated fair value of the LTC reporting unit include client retention rates; occupancy rates in skilled nursing facilities; the financial health of skilled nursing facility customers; facility reimbursement pressures; the Company's ability to extract cost savings from labor productivity and other initiatives; the geographies impacted and the severity and duration of COVID-19; COVID-19's impact on health care utilization patterns; and the timing, scope and impact of stimulus legislation as well as other federal, state and local governmental responses to COVID-19. The fair value of the LTC reporting unit also is dependent on market multiples of peer group companies and the risk-free interest rate environment, which impacts the discount rate used in the discounted cash flow valuation method. If the LTC reporting unit does not achieve its forecasts, it is reasonably possible in the near term that the goodwill of the LTC reporting unit could be deemed to be impaired by a material amount. As of December 31, 2020, the goodwill balance in the LTC reporting unit was $431 million.

The COVID-19 pandemic severely impacted global economic activity in 2020, including the businesses of some of the Company's customers, and during the first half of the year caused significant volatility and negative pressure in the capital markets. In addition to adversely affecting the Company's businesses, which may have a material adverse impact on the Company's profitability and cash flows, these developments may adversely affect the timing and collectability of payments to the Company from customers, clients, government payers and members as a result of the impact of COVID-19 on them. For further information regarding the potential adverse impact of COVID-19 on the Company, please see "Risk Factors" included in Item 1A of this report. The COVID-19 pandemic continues to evolve. We believe COVID-19's impact on our businesses, operating results, cash flows and/or financial condition primarily will be driven by the geographies impacted and the severity and duration of the pandemic; the pandemic's impact on the U.S. and global economies and consumer behavior and health care utilization patterns; and the timing, scope and impact of stimulus legislation as well as other federal, state and local governmental responses to the pandemic. Those primary drivers are beyond our knowledge and control. As a result, the impact COVID-19 will have on our businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be adverse and material. COVID-19 also may result in legal and regulatory proceedings, investigations and claims against

us. If the Company's businesses, results of operations, financial condition and/or cash flows are materially adversely affected, the goodwill of the LTC and Commercial Business reporting units could be deemed to be impaired by a material amount.

2019 Goodwill Impairment Test

During the third quarter of 2019, the Company performed its required annual impairment test of goodwill. The results of this impairment test indicated that there was no impairment of goodwill as of the testing date. The goodwill impairment test resulted in the fair values of all of the Company's reporting units exceeding their carrying values by significant margins, with the exception of the Commercial Business and LTC reporting units, which exceeded their carrying values by approximately 4% and 9%, respectively.

2018 Goodwill Impairment Tests

As discussed in Note 5 ''Goodwill and Other Intangibles'' included in Item 8 of this 10-K, during 2018, the LTC reporting unit experienced industry-wide challenges that impacted management's ability to grow the business at the rate that was originally estimated when the Company acquired Omnicare and when the 2017 annual goodwill impairment test was performed. Those challenges include lower client retention rates, lower occupancy rates in skilled nursing facilities, the deteriorating financial health of numerous skilled nursing facility customers which resulted in a number of customer bankruptcies in 2018, and continued facility reimbursement pressures. Following the update of its current and long-term forecast, in June 2018, management determined that there were indicators that the LTC reporting unit's goodwill may be impaired and, accordingly, management performed an interim goodwill impairment test as of June 30, 2018. The results of that interim impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in a $3.9 billion pre-tax goodwill impairment charge in the second quarter of 2018.

During the third quarter of 2018, the Company performed its required annual impairment tests of goodwill and concluded there was no impairment of goodwill. The goodwill impairment tests showed that the fair values of the Pharmacy Services and Retail Pharmacy reporting units exceeded their carrying values by significant margins and the fair value of the LTC reporting unit exceeded its carrying value by approximately 2%.

During the fourth quarter of 2018, the LTC reporting unit missed its forecast primarily due to operational issues and customer liquidity issues, including one significant customer bankruptcy. Additionally, LTC management submitted updated projected financial results which showed significant additional deterioration primarily due to continued industry and operational challenges, which also caused management to make further updates to its long-term forecast beyond 2019. Based on these updated projections, management determined that there were indicators that the LTC reporting unit's goodwill may be further impaired and, accordingly, management performed an interim goodwill impairment test during the fourth quarter of 2018. The results of that interim impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in an additional $2.2 billion pre-tax goodwill impairment charge in the fourth quarter of 2018.

In 2018, the fair value of the LTC reporting unit was determined using a combination of a discounted cash flow method and a market multiple method. In addition to the lower financial projections, changes in risk-free interest rates and lower market multiples of peer group companies also contributed to the amount of the 2018 goodwill impairment charges.

Recoverability of Indefinite-Lived Intangible Assets

Indefinite-lived intangible assets are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that their carrying value may not be recoverable. Indefinite-lived intangible assets are tested by comparing the estimated fair value of the asset to its carrying value. If the carrying value of the asset exceeds its estimated fair value, an impairment loss is recognized, and the asset is written down to its estimated fair value.

The indefinite-lived intangible asset impairment loss calculation contains uncertainty since management must use judgment to estimate fair value based on the assumption that, in lieu of ownership of an intangible asset, the Company would be willing to pay a royalty in order to utilize the benefits of the asset. Fair value is estimated by discounting the hypothetical royalty payments to their present value over the estimated economic life of the asset. These estimates can be affected by a number of factors including general economic conditions, availability of market information and the profitability of the Company. There were no impairment losses recognized on indefinite-lived intangible assets in any of the years ended December 31, 2020, 2019 or 2018.

Health Care Costs Payable

At December 31, 2020 and 2019, 77% and 73% respectively, of health care costs payable are estimates of the ultimate cost of (i) services rendered to the Company's Insured members but not yet reported to the Company and (ii) claims which have been

reported to the Company but not yet paid (collectively, "IBNR"). Health care costs payable also include an estimate of the cost of services that will continue to be rendered after the financial statement date if the Company is obligated to pay for such services in accordance with contractual or regulatory requirements. The remainder of health care costs payable is primarily comprised of pharmacy and capitation payables, other amounts due to providers pursuant to risk sharing agreements and accruals for state assessments. The Company develops its estimate of IBNR using actuarial principles and assumptions that consider numerous factors. See Note 1 ''Significant Accounting Policies'' included in Item 8 of this 10-K for additional information on the Company's reserving methodology.

During 2020 and 2019, the Company observed an increase in completion factors relative to those assumed at the prior year end. After considering the claims paid in 2020 and 2019 with dates of service prior to the fourth quarter of the previous year, the Company observed assumed incurred claim weighted average completion factors that were 4 and 27 basis points higher, respectively, than previously estimated, resulting in a decrease of $35 million and $240 million in 2020 and 2019, respectively, in health care costs payable that related to the prior year. The Company has considered the pattern of changes in its completion factors when determining the completion factors used in its estimates of IBNR as of December 31, 2020. However, based on historical claim experience, it is reasonably possible that the Company's estimated weighted average completion factors may vary by plus or minus 11 basis points from the Company's assumed rates, which could impact health care costs payable by approximately plus or minus $140 million pretax.

Also during 2020 and 2019, the Company observed that health care costs for claims with claim incurred dates of three months or less before the financial statement date were lower than previously estimated. Specifically, after considering the claims paid in 2020 and 2019 with claim incurred dates for the fourth quarter of the previous year, the Company observed health care costs that were 4.0% and 3.2% lower, respectively, for each fourth quarter than previously estimated, resulting in a reduction of $394 million and $284 million in 2020 and 2019, respectively, in health care costs payable that related to prior year.

Management considers historical health care cost trend rates together with its knowledge of recent events that may impact current trends when developing estimates of current health care cost trend rates. When establishing reserves as of December 31, 2020, the Company increased its assumed health care cost trend rates for the most recent three months by 9.6% from health care cost trend rates recently observed. Assumed health care cost trend rates during the fourth quarter of 2020 are elevated compared to historical levels due to the impact of COVID-19 pandemic on utilization during 2020. Specifically, beginning in mid-March, the health system experienced a significant reduction in utilization that is discretionary and the cancellation of elective medical procedures. Utilization remained below historical levels through April, began to recover in May and June and reached more normal levels in the third and fourth quarters, with select geographies impacted by COVID-19 waves. Based on historical claim experience, it is reasonably possible that the Company's estimated health care cost trend rates may vary by plus or minus 3.5% from the assumed rates, which could impact health care costs payable by plus or minus $404 million pretax.

Income Taxes

The Company accounts for income taxes using the asset and liability method. Deferred tax assets and liabilities are established for any temporary differences between financial and tax reporting bases and are adjusted as needed to reflect changes in the enacted tax rates expected to be in effect when the temporary differences reverse. Such adjustments are recorded in the period in which changes in tax laws are enacted, regardless of when they are effective. Deferred tax assets are reduced, if necessary, by a valuation allowance to the extent future realization of those losses, deductions or other tax benefits is sufficiently uncertain. Significant judgment is required in determining the provision for income taxes and the related taxes payable and deferred tax assets and liabilities since, in the ordinary course of business, there are transactions and calculations where the ultimate tax outcome is uncertain. Additionally, the Company's tax returns are subject to audit by various domestic and foreign tax authorities that could result in material adjustments based on differing interpretations of the tax laws. Although management believes that its estimates are reasonable and are based on the best available information at the time the provision is prepared, actual results could differ from these estimates resulting in a final tax outcome that may be materially different from that which is reflected in the consolidated financial statements.

The tax benefit from an uncertain tax position is recognized only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position. The tax benefits recognized in the consolidated financial statements from such positions are then measured based on the largest benefit that has a greater than 50% likelihood of being realized upon settlement with the related tax authority. Interest and/or penalties related to uncertain tax positions are recognized in the income tax provision. Significant judgment is required in determining uncertain tax positions. The Company has established accruals for uncertain tax positions using its judgment and adjusts these accruals, as warranted, due to changing facts and circumstances.

New Accounting Pronouncements

See Note 1 ‘‘Significant Accounting Policies’’ included in Item 8 of this 10-K for a description of new accounting pronouncements applicable to the Company.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk.

The Company's earnings and financial condition are exposed to interest rate risk, credit quality risk, market valuation risk, foreign currency risk, commodity risk and operational risk.

Evaluation of Interest Rate and Credit Quality Risk

The Company manages interest rate risk by seeking to maintain a tight match between the durations of assets and liabilities when appropriate. The Company manages credit quality risk by seeking to maintain high average credit quality ratings and diversified sector exposure within its debt securities portfolio. In connection with its investment and risk management objectives, the Company also uses derivative financial instruments whose market value is at least partially determined by, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets or credit ratings/spreads. The Company's use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps. These instruments, viewed separately, subject the Company to varying degrees of interest rate, equity price and credit risk. However, when used for hedging, the Company expects these instruments to reduce overall risk.

Investments
The Company's investment portfolio supported the following products at December 31, 2020 and 2019:

In millions	**2020**	**2019**
Experience-rated products	$ 1,037	$ 1,100
Remaining products	22,775	18,587
Total investments	$ 23,812	$ 19,687

Investment risks associated with experience-rated products generally do not impact the Company's operating results. The risks associated with investments supporting experience-rated pension and annuity products in the large case pensions business in the Company's Corporate/Other segment are assumed by the contract holders and not by the Company (subject to, among other things, certain minimum guarantees). Assets supporting experience-rated products may be subject to contract holder or participant withdrawals.

The debt securities in the Company's investment portfolio had an average credit quality rating of A at both December 31, 2020 and 2019 with approximately $6.3 billion and $4.4 billion rated AAA at December 31, 2020 and 2019, respectively. The debt securities that were rated below investment grade (that is, having a credit quality rating below BBB-/Baa3) were $1.9 billion and $1.2 billion at December 31, 2020 and 2019, respectively (of which 2% and 4% at December 31, 2020 and 2019, respectively, supported experience-rated products).

At December 31, 2020 and 2019, the Company held $321 million and $333 million, respectively, of municipal debt securities that were guaranteed by third parties, representing 2% of total investments at both December 31, 2020 and 2019. These securities had an average credit quality rating of AA at both December 31, 2020 and 2019 with the guarantee. These securities had an average credit quality rating of A and A+ at December 31, 2020 and 2019, respectively, without the guarantee. The Company does not have any significant concentration of investments with third party guarantors (either direct or indirect).

The Company generally classifies debt securities as available for sale, and carries them at fair value on the consolidated balance sheets. At both December 31, 2020 and 2019, less than 1% of debt securities were valued using inputs that reflect the Company's assumptions (categorized as Level 3 inputs in accordance with accounting principles generally accepted in the United States of America). See Note 4 ''Fair Value'' included in Item 8 of this 10-K for additional information on the methodologies and key assumptions used to determine the fair value of investments. For additional information related to investments, see Note 3 ''Investments'' included in Item 8 of this 10-K.

The Company regularly reviews debt securities in its portfolio to determine whether a decline in fair value below the cost basis or carrying value has occurred. If a debt security is in an unrealized loss position and the Company has the intent to sell the security, or it is more likely than not that the Company will have to sell the security before recovery of its amortized cost basis, the amortized cost basis of the security is written down to its fair value and the difference is recognized in net income. If a debt security is in an unrealized loss position and the Company does not have the intent to sell and it is more likely than not that the Company will not have to sell such security before recovery of its amortized cost basis, the Company bifurcates the impairment into credit-related and non-credit related components. The amount of the credit-related component is recorded as an allowance

for credit losses and recognized in net income, and the amount of the non-credit related component is included in other comprehensive income. The impairment of debt securities is considered a critical accounting policy. See ‘‘Critical Accounting Policies - Impairments of Debt Securities” in the MD&A included in Item 7 of this 10-K for additional information.

Evaluation of Market Valuation Risks

The Company regularly evaluates its risk from market-sensitive instruments by examining, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets and/or credit ratings/spreads. The Company also regularly evaluates the appropriateness of investments relative to management-approved investment guidelines (and operates within those guidelines) and the business objectives of its portfolios.

On a quarterly basis, the Company reviews the impact of hypothetical net losses in its investment portfolio on the Company’s consolidated near-term financial condition, operating results and cash flows assuming the occurrence of certain reasonably possible changes in near-term market rates and prices. Interest rate changes (whether resulting from changes in treasury yields or credit spreads or other factors) represent the most material risk exposure category for the Company. The Company has estimated the impact on the fair value of market sensitive instruments based on the net present value of cash flows using a representative set of likely future interest rate scenarios. The assumptions used were as follows: an immediate increase of 100 basis points in interest rates (which the Company believes represents a moderately adverse scenario) for long-term debt issued by the Company, as well as its interest rate sensitive investments and an immediate decrease of 15% in prices for publicly traded domestic equity securities.

Assuming an immediate increase of 100 basis points in interest rates, the theoretical decline in the fair values of market sensitive instruments at December 31, 2020 is as follows:

- The fair value of long-term debt issued by the Company would decline by approximately $5.3 billion ($6.7 billion pretax). Changes in the fair value of long-term debt do not impact the Company’s operating results or financial condition.
- The theoretical reduction in the fair value of interest rate sensitive investments partially offset by the theoretical reduction in the fair value of interest rate sensitive liabilities would result in a net decline in fair value of approximately $490 million ($615 million pretax) related to continuing non-experience-rated products. Reductions in the fair value of investment securities would be reflected as an unrealized loss in equity, as the Company classifies these debt securities as available for sale. The Company does not record liabilities at fair value.

If the value of the Company’s publicly traded domestic equity securities were to decline by 15%, this would result in a net decline in fair value of $5 million ($7 million pretax).

Based on overall exposure to interest rate risk and equity price risk, the Company believes that these changes in market rates and prices would not materially affect consolidated near-term financial condition, operating results or cash flows as of December 31, 2020.

Evaluation of Foreign Currency and Commodity Risk

At December 31, 2020 and 2019, the Company did not have any material foreign currency exchange rate or commodity derivative instruments in place and believes its exposure to foreign currency exchange rate risk is not material.

At December 31, 2020 and 2019, 5.5% and 6.1%, respectively, of the Company’s investment portfolio was comprised of investments that have exposure to the oil and gas industry, with more than half that amount comprised of investment grade rated debt securities. These exposures are experiencing varied degrees of financial strains in the current depressed oil and gas price environment, and the likelihood of the Company’s portfolio incurring additional realized capital losses on these exposures may increase if such depressed prices persist and/or decline further.

Evaluation of Operational Risks

The Company also faces certain operational risks. Those risks include risks related to the COVID-19 pandemic and risks related to information security, including cybersecurity.

The spread of COVID-19, or actions taken to mitigate its spread, could have material and adverse effects on our ability to operate our businesses effectively, including as a result of the complete or partial closure of facilities or labor shortages. Disruptions in our supply chains, our distribution chains and/or public and private infrastructure, including communications, financial services and supply chains, could materially and adversely impact our business operations. We have transitioned a significant subset of our colleagues to a remote work environment in an effort to mitigate the spread of COVID-19, as have a significant number of our third-party service providers, which may amplify certain risks to our businesses, including an increased demand for information technology resources, increased risk of phishing and other cyber attacks, increased risk of unauthorized dissemination of sensitive personal information or proprietary or confidential information about us or our medical members or other third-parties and increased risk of business interruptions.

The Company and its vendors have experienced diverse cyber attacks and expect to continue to experience cyber attacks going forward. As examples, the Company and its vendors have experienced attempts to gain access to systems, denial of service attacks, attempted malware infections, account takeovers, scanning activity and phishing emails. Attacks can originate from external criminals, terrorists, nation states or internal actors. The Company is dedicating and will continue to dedicate significant resources and incur significant expenses to maintain and update on an ongoing basis the systems and processes that are designed to mitigate the information security risks it faces and protect the security of its computer systems, software, networks and other technology assets against attempts by unauthorized parties to obtain access to confidential information, disrupt or degrade service or cause other damage. The impact of cyber attacks has not been material to the Company’s operations or operating results through December 31, 2020. The Board and its Audit Committee and Nominating and Corporate Governance Committee are regularly informed regarding the Company’s information security policies, practices and status.

Item 8. Financial Statements and Supplementary Data.

Index to Consolidated Financial Statements

Consolidated Statements of Operations

In millions, except per share amounts	For the Years Ended December 31, 2020	2019	2018
Revenues:			
Products	$ 190,688	$ 185,236	$ 183,910
Premiums	69,364	63,122	8,184
Services	7,856	7,407	1,825
Net investment income	798	1,011	660
Total revenues	268,706	256,776	194,579
Operating costs:			
Cost of products sold	163,981	158,719	156,447
Benefit costs	55,679	52,529	6,594
Goodwill impairments	—	—	6,149
Operating expenses	35,135	33,541	21,368
Total operating costs	254,795	244,789	190,558
Operating income	13,911	11,987	4,021
Interest expense	2,907	3,035	2,619
Loss on early extinguishment of debt	1,440	79	—
Other income	(206)	(124)	(4)
Income before income tax provision	9,770	8,997	1,406
Income tax provision	2,569	2,366	2,002
Income (loss) from continuing operations	7,201	6,631	(596)
Loss from discontinued operations, net of tax	(9)	—	—
Net income (loss)	7,192	6,631	(596)
Net (income) loss attributable to noncontrolling interests	(13)	3	2
Net income (loss) attributable to CVS Health	$ 7,179	$ 6,634	$ (594)
Basic earnings (loss) per share:			
Income (loss) from continuing operations attributable to CVS Health	$ 5.49	$ 5.10	$ (0.57)
Loss from discontinued operations attributable to CVS Health	$ (0.01)	$ —	$ —
Net income (loss) attributable to CVS Health	$ 5.48	$ 5.10	$ (0.57)
Weighted average basic shares outstanding	1,309	1,301	1,044
Diluted earnings (loss) per share:			
Income (loss) from continuing operations attributable to CVS Health	$ 5.47	$ 5.08	$ (0.57)
Loss from discontinued operations attributable to CVS Health	$ (0.01)	$ —	$ —
Net income (loss) attributable to CVS Health	$ 5.46	$ 5.08	$ (0.57)
Weighted average diluted shares outstanding	1,314	1,305	1,044
Dividends declared per share	$ 2.00	$ 2.00	$ 2.00

See accompanying notes to consolidated financial statements.

Consolidated Statements of Comprehensive Income (Loss)

In millions	For the Years Ended December 31, 2020	2019	2018
Net income (loss)	$ 7,192	$ 6,631	$ (596)
Other comprehensive income (loss), net of tax:			
Net unrealized investment gains	440	677	97
Foreign currency translation adjustments	3	162	(29)
Net cash flow hedges	(31)	(33)	330
Pension and other postretirement benefits	(17)	111	(124)
Other comprehensive income	395	917	274
Comprehensive income (loss)	7,587	7,548	(322)
Comprehensive (income) loss attributable to noncontrolling interests	(13)	3	2
Comprehensive income (loss) attributable to CVS Health	$ 7,574	$ 7,551	$ (320)

See accompanying notes to consolidated financial statements.

Consolidated Balance Sheets

In millions, except per share amounts	At December 31, 2020	2019
Assets:		
Cash and cash equivalents	$ 7,854	$ 5,683
Investments	3,000	2,373
Accounts receivable, net	21,742	19,617
Inventories	18,496	17,516
Other current assets	5,277	5,113
Total current assets	56,369	50,302
Long-term investments	20,812	17,314
Property and equipment, net	12,606	12,044
Operating lease right-of-use assets	20,729	20,860
Goodwill	79,552	79,749
Intangible assets, net	31,142	33,121
Separate accounts assets	4,881	4,459
Other assets	4,624	4,600
Total assets	$ 230,715	$ 222,449
Liabilities:		
Accounts payable	$ 11,138	$ 10,492
Pharmacy claims and discounts payable	15,795	13,601
Health care costs payable	7,936	6,879
Policyholders' funds	4,270	2,991
Accrued expenses	14,243	12,133
Other insurance liabilities	1,557	1,830
Current portion of operating lease liabilities	1,638	1,596
Current portion of long-term debt	5,440	3,781
Total current liabilities	62,017	53,303
Long-term operating lease liabilities	18,757	18,926
Long-term debt	59,207	64,699
Deferred income taxes	6,794	7,294
Separate accounts liabilities	4,881	4,459
Other long-term insurance liabilities	7,007	7,436
Other long-term liabilities	2,351	2,162
Total liabilities	161,014	158,279
Commitments and contingencies (Note 16)		
Shareholders' equity:		
Preferred stock, par value $0.01: 0.1 shares authorized; none issued or outstanding	—	—
Common stock, par value $0.01: 3,200 shares authorized; 1,733 shares issued and 1,310 shares outstanding at December 31, 2020 and 1,727 shares issued and 1,302 shares outstanding at December 31, 2019 and capital surplus	46,513	45,972
Treasury stock, at cost: 423 and 425 shares at December 31, 2020 and 2019	(28,178)	(28,235)
Retained earnings	49,640	45,108
Accumulated other comprehensive income	1,414	1,019
Total CVS Health shareholders' equity	69,389	63,864
Noncontrolling interests	312	306
Total shareholders' equity	69,701	64,170
Total liabilities and shareholders' equity	$ 230,715	$ 222,449

See accompanying notes to consolidated financial statements.

Consolidated Statements of Cash Flows

In millions	For the Years Ended December 31, 2020	2019	2018
Cash flows from operating activities:			
Cash receipts from customers	$ 264,327	$ 248,393	$ 186,519
Cash paid for inventory and prescriptions dispensed by retail network pharmacies	(158,636)	(149,655)	(148,981)
Insurance benefits paid	(55,124)	(52,242)	(6,897)
Cash paid to other suppliers and employees	(29,763)	(28,932)	(17,234)
Interest and investment income received	894	955	644
Interest paid	(2,904)	(2,954)	(2,803)
Income taxes paid	(2,929)	(2,717)	(2,383)
Net cash provided by operating activities	15,865	12,848	8,865
Cash flows from investing activities:			
Proceeds from sales and maturities of investments	6,467	7,049	817
Purchases of investments	(9,639)	(7,534)	(692)
Purchases of property and equipment	(2,437)	(2,457)	(2,037)
Proceeds from sale-leaseback transactions	101	5	—
Acquisitions (net of cash acquired)	(866)	(444)	(42,226)
Proceeds from sale of subsidiaries and other assets	840	—	832
Other	—	42	21
Net cash used in investing activities	(5,534)	(3,339)	(43,285)
Cash flows from financing activities:			
Net repayments of short-term debt	—	(720)	(556)
Proceeds from issuance of long-term debt	9,958	3,736	44,343
Repayments of long-term debt	(15,631)	(8,336)	(5,522)
Derivative settlements	(7)	(25)	446
Dividends paid	(2,624)	(2,603)	(2,038)
Proceeds from exercise of stock options	264	210	242
Payments for taxes related to net share settlement of equity awards	(88)	(112)	(97)
Other	(27)	—	1
Net cash provided by (used in) financing activities	(8,155)	(7,850)	36,819
Effect of exchange rate changes on cash, cash equivalents and restricted cash	—	—	(4)
Net increase in cash, cash equivalents and restricted cash	2,176	1,659	2,395
Cash, cash equivalents and restricted cash at the beginning of the period	5,954	4,295	1,900
Cash, cash equivalents and restricted cash at the end of the period	$ 8,130	$ 5,954	$ 4,295

In millions	For the Years Ended December 31, 2020	2019	2018
Reconciliation of net income (loss) to net cash provided by operating activities:			
Net income (loss)	$ 7,192	$ 6,631	$ (596)
Adjustments required to reconcile net income (loss) to net cash provided by operating activities:			
Depreciation and amortization	4,441	4,371	2,718
Goodwill impairments	—	—	6,149
Stock-based compensation	400	453	280
(Gain) loss on sale of subsidiaries	(269)	205	86
Loss on early extinguishment of debt	1,440	79	—
Deferred income taxes	(570)	(654)	87
Other noncash items	72	264	253
Change in operating assets and liabilities, net of effects from acquisitions:			
Accounts receivable, net	(1,510)	(2,158)	(1,139)
Inventories	(973)	(1,075)	(1,153)
Other assets	364	(614)	(3)
Accounts payable and pharmacy claims and discounts payable	2,769	3,550	2,329
Health care costs payable and other insurance liabilities	(231)	320	(311)
Other liabilities	2,740	1,476	165
Net cash provided by operating activities	$ 15,865	$ 12,848	$ 8,865

See accompanying notes to consolidated financial statements.

Consolidated Statements of Shareholders' Equity

	Number of shares outstanding		Attributable to CVS Health						
In millions	Common Shares	Treasury Shares [1]	Common Stock and Capital Surplus [2]	Treasury Stock [1]	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Total CVS Health Shareholders' Equity	Noncontrolling Interests	Total Shareholders' Equity
Balance at December 31, 2017	**1,712**	**(698)**	**$ 32,096**	**$ (37,796)**	**$ 43,556**	**$ (165)**	**$ 37,691**	**$ 4**	**$ 37,695**
Adoption of new accounting standards [3]	—	—	—	—	(6)	(7)	(13)	—	(13)
Net loss	—	—	—	—	(594)	—	(594)	(2)	(596)
Other comprehensive income (Note 13)	—	—	—	—	—	274	274	—	274
Common shares issued to acquire Aetna	—	274	12,923	9,561	—	—	22,484	—	22,484
Stock option activity, stock awards and other	8	—	421	—	—	—	421	—	421
Purchase of treasury shares, net of ESPP issuances	—	(1)	—	7	—	—	7	—	7
Common stock dividends	—	—	—	—	(2,045)	—	(2,045)	—	(2,045)
Acquisition of noncontrolling interests	—	—	—	—	—	—	—	329	329
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(13)	(13)
Balance at December 31, 2018	1,720	(425)	45,440	(28,228)	40,911	102	58,225	318	58,543
Adoption of new accounting standard [4]	—	—	—	—	178	—	178	—	178
Net income (loss)	—	—	—	—	6,634	—	6,634	(3)	6,631
Other comprehensive income (Note 13)	—	—	—	—	—	917	917	—	917
Stock option activity, stock awards and other	7	2	532	—	—	—	532	—	532
Purchase of treasury shares, net of ESPP issuances	—	(2)	—	(7)	—	—	(7)	—	(7)
Common stock dividends	—	—	—	—	(2,615)	—	(2,615)	—	(2,615)
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(9)	(9)
Balance at December 31, 2019	1,727	(425)	45,972	(28,235)	45,108	1,019	63,864	306	64,170
Adoption of new accounting standard (Note 1)	—	—	—	—	(3)	—	(3)	—	(3)
Net income	—	—	—	—	7,179	—	7,179	13	7,192
Other comprehensive income (Note 13)	—	—	—	—	—	395	395	—	395
Stock option activity, stock awards and other	6	—	541	—	—	—	541	—	541
ESPP issuances, net of purchase of treasury shares	—	2	—	57	—	—	57	—	57
Common stock dividends	—	—	—	—	(2,644)	—	(2,644)	—	(2,644)
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(7)	(7)
Balance at December 31, 2020	**1,733**	**(423)**	**$ 46,513**	**$ (28,178)**	**$ 49,640**	**$ 1,414**	**$ 69,389**	**$ 312**	**$ 69,701**

(1) Treasury shares include 1 million shares held in trust for each of the years ended December 31, 2020, 2019 and 2018. Treasury stock includes $29 million related to shares held in trust for each of the years ended December 31, 2020, 2019 and 2018. See Note 1 ''Significant Accounting Policies'' for additional information.

(2) Common stock and capital surplus includes the par value of common stock of $17 million as of December 31, 2020, 2019 and 2018.

(3) Reflects the adoption of Accounting Standards Update ("ASU") 2014-09, *Revenue from Contracts with Customers*, which resulted in a reduction to retained earnings of $13 million and the adoption of ASU 2018-02, *Income Statement - Reporting Comprehensive Income (Topic 220): Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income*, which resulted in a reduction to accumulated other comprehensive income of $7 million and an increase to retained earnings of $7 million, each during the year ended December 31, 2018.

(4) Reflects the adoption of ASU 2016-02, *Leases* (Topic 842), which resulted in an increase to retained earnings of $178 million during the year ended December 31, 2019.

See accompanying notes to consolidated financial statements.

Notes to Consolidated Financial Statements

1. Significant Accounting Policies

Description of Business

CVS Health Corporation ("CVS Health"), together with its subsidiaries (collectively, the "Company"), has more than 9,900 retail locations, approximately 1,100 walk-in medical clinics, a leading pharmacy benefits manager with approximately 105 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year and expanding specialty pharmacy services. The Company also serves an estimated 34 million people through traditional, voluntary and consumer-directed health insurance products and related services, including expanding Medicare Advantage offerings and a leading standalone Medicare Part D prescription drug plan ("PDP"). The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

The coronavirus disease 2019 ("COVID-19") pandemic has severely impacted the economies of the U.S. and other countries around the world. The impact of COVID-19 on the Company's businesses, operating results, cash flows and financial condition in the year ended December 31, 2020, as well as information regarding certain expected impacts of COVID-19 on the Company, is discussed throughout this Annual Report on Form 10-K.

On November 28, 2018 (the "Aetna Acquisition Date"), the Company acquired Aetna Inc. ("Aetna"). As a result of the acquisition of Aetna (the "Aetna Acquisition"), the Company added the Health Care Benefits segment. Certain aspects of Aetna's operations, including products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, are included in the Company's Corporate/Other segment. The consolidated financial statements reflect Aetna's results subsequent to the Aetna Acquisition Date.

The Company has four reportable segments: Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other, which are described below.

Pharmacy Services Segment
The Pharmacy Services segment provides a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services, mail order pharmacy, specialty pharmacy and infusion services, clinical services, disease management services and medical spend management. The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, PDPs, Medicaid managed care plans, plans offered on public health insurance exchanges ("Public Exchanges") and private health insurance exchanges and other sponsors of health benefit plans throughout the United States. The Pharmacy Services segment operates retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services.

Retail/LTC Segment
The Retail/LTC segment sells prescription drugs and a wide assortment of health and wellness products and general merchandise, provides health care services through its MinuteClinic® walk-in medical clinics, provides medical diagnostic testing, administers vaccinations for illnesses such as influenza, COVID-19 and shingles and conducts long-term care pharmacy ("LTC") operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to long-term care facilities and other care settings. As of December 31, 2020, the Retail/LTC segment operated more than 9,900 retail locations, approximately 1,100 MinuteClinic locations as well as online retail pharmacy websites, LTC pharmacies and on-site pharmacies.

Health Care Benefits Segment
The Health Care Benefits segment is one of the nation's leading diversified health care benefits providers. The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make more informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental and behavioral health plans, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services and health information technology products and services. The Health Care Benefits segment also provided workers' compensation administrative services through its Coventry Health Care Workers' Compensation business ("Workers' Compensation business") prior to the sale of this business on July 31, 2020. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates. The

Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk for medical and dental care costs) as "ASC." For periods prior to the Aetna Acquisition Date, the Health Care Benefits segment was comprised only of the Company's SilverScript® PDP business.

Corporate/Other Segment
The Company presents the remainder of its financial results in the Corporate/Other segment, which primarily consists of:

- Management and administrative expenses to support the Company's overall operations, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments, expenses associated with the Company's investments in its transformation and enterprise modernization programs and acquisition-related transaction and integration costs; and
- Products for which the Company no longer solicits or accepts new customers such as its large case pensions and long-term care insurance products.

Basis of Presentation

The accompanying consolidated financial statements of CVS Health and its subsidiaries have been prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP"). The consolidated financial statements include the accounts of the Company and its majority-owned subsidiaries and variable interest entities ("VIEs") for which the Company is the primary beneficiary. All material intercompany balances and transactions have been eliminated.

Reclassifications

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

Use of Estimates

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and temporary investments with maturities of three months or less when purchased. The Company invests in short-term money market funds, commercial paper and time deposits, as well as other debt securities that are classified as cash equivalents within the accompanying consolidated balance sheets, as these funds are highly liquid and readily convertible to known amounts of cash.

Restricted Cash

Restricted cash included in other current assets on the consolidated balance sheets represents amounts held in escrow accounts in connection with certain recent acquisitions. Restricted cash included in other assets on the consolidated balance sheets represents amounts held in a trust in one of the Company's captive insurance companies to satisfy collateral requirements associated with the assignment of certain insurance policies. All restricted cash is invested in time deposits, money market funds or commercial paper.

The following is a reconciliation of cash and cash equivalents on the consolidated balance sheets to total cash, cash equivalents and restricted cash on the consolidated statements of cash flows as of December 31, 2020, 2019 and 2018:

In millions	**2020**	**2019**	**2018**
Cash and cash equivalents	$ 7,854	$ 5,683	$ 4,059
Restricted cash (included in other current assets)	—	—	6
Restricted cash (included in other assets)	276	271	230
Total cash, cash equivalents and restricted cash in the consolidated statements of cash flows	$ 8,130	$ 5,954	$ 4,295

Investments

Debt Securities
Debt securities consist primarily of U.S. Treasury and agency securities, mortgage-backed securities, corporate and foreign bonds and other debt securities. Debt securities are classified as either current or long-term investments based on their contractual maturities unless the Company intends to sell an investment within the next twelve months, in which case it is classified as current on the consolidated balance sheets. Debt securities are classified as available for sale and are carried at fair value. See Note 4 ‘‘Fair Value’’ for additional information on how the Company estimates the fair value of these investments.

If a debt security is in an unrealized loss position and the Company has the intent to sell the security, or it is more likely than not that the Company will have to sell the security before recovery of its amortized cost basis, the amortized cost basis of the security is written down to its fair value and the difference is recognized in net income. If a debt security is in an unrealized loss position and the Company does not have the intent to sell and it is more likely than not that the Company will not have to sell such security before recovery of its amortized cost basis, the Company bifurcates the impairment into credit-related and non-credit related components. In evaluating whether a credit related loss exists, the Company considers a variety of factors including: the extent to which the fair value is less than the amortized cost basis; adverse conditions specifically related to the issuer of a security, an industry or geographic area; the payment structure of the security; the failure of the issuer of the security to make scheduled interest or principle payments; and any changes to the rating of the security by a rating agency. The amount of the credit-related component is recorded as an allowance for credit losses and recognized in net income, and the amount of the non-credit related component is included in other comprehensive income. Interest is not accrued on debt securities when management believes the collection of interest is unlikely.

The credit-related component is determined by comparing the present value of cash flows expected to be collected from the security, considering all reasonably available information relevant to the collectability of the security, with the amortized cost basis of the security. If the present value of cash flows expected to be collected is less than the amortized cost basis of the security, the Company records an allowance for credit losses, which is limited by the amount that the fair value is less than amortized cost basis.

For mortgage-backed and other asset-backed securities, the Company recognizes 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 Company’s investment in the security is adjusted to the amount that would have existed had the new effective yield been applied since the acquisition of the security, with adjustments recognized in net income.

Equity Securities
Equity securities with readily available fair values are measured at fair value with changes in fair value recognized in net income (loss).

Mortgage Loans
Mortgage loan investments on the consolidated balance sheets are valued at the unpaid principal balance, net of an allowance for credit losses. Mortgage loans with a maturity date or a committed prepayment date within twelve months are classified as current on the consolidated balance sheets. The Company assesses whether its loans share similar risk characteristics and, if so, groups such loans in a risk pool when measuring expected credit losses. The Company considers the following characteristics when evaluating whether its loans share similar risk characteristics: loan-to-value ratios, property type (e.g., office, retail, apartment, industrial), geographic location, vacancy rates and property condition.

Credit loss reserves are determined using a loss rate method that multiplies the unpaid principal balance of each loan within a risk pool group by an estimated loss rate percentage. The loss rate percentage considers both the expected loan loss severity and the probability of loan default. For periods where the Company is able to make or obtain reasonable and supportable forecasts of expected economic conditions (e.g., gross domestic product, employment), the Company adjusts its expected loss rates to reflect these forecasted economic conditions. For periods beyond which the Company is able to make or obtain reasonable and supportable forecasts of expected economic conditions, the Company reverts to historical loss rates in determining expected credit losses.

Interest income on a potential problem loan (i.e., high probability of default) or restructured loan is accrued to the extent it is deemed to be collectible and the loan continues to perform under its original or restructured terms. Interest income on problem loans (i.e., more than 60 days delinquent, in bankruptcy or in process of foreclosure) is recognized on a cash basis. Cash payments on loans in the process of foreclosure are treated as a return of principal.

Other Investments
Other investments consist primarily of the following:

- Private equity and hedge fund limited partnerships, which are accounted for using the equity method of accounting. Under this method, the carrying value of the investment is based on the value of the Company's equity ownership of the underlying investment funds provided by the general partner or manager of the investments, the financial statements of which generally are audited. As a result of the timing of the receipt of the valuation information provided by the fund managers, these investments are generally reported on up to a three month lag. The Company reviews investments for impairment at least quarterly and monitors their performance throughout the year through discussions with the administrators, managers and/or general partners. If the Company becomes aware of an impairment of a limited partnership's investments through its review or prior to receiving the limited partnership's financial statements at the financial statement date, an impairment will be recognized by recording a reduction in the carrying value of the limited partnership with a corresponding charge to net investment income.
- Investment real estate, which is carried on the consolidated balance sheets at depreciated cost, including capital additions, net of write-downs for other-than-temporary declines in fair value. Depreciation is calculated using the straight-line method based on the estimated useful life of each asset. If any real estate investment is considered held-for-sale, it is carried at the lower of its carrying value or fair value less estimated selling costs. The Company generally estimates fair value using a discounted future cash flow analysis in conjunction with comparable sales information. At the time of the sale, the difference between the sales price and the carrying value is recorded as a realized capital gain or loss.
- Privately-placed equity securities, which are carried on the consolidated balance sheets at cost less impairments, plus or minus subsequent adjustments for observable price changes. Additionally, as a member of the Federal Home Loan Bank of Boston ("FHLBB"), a subsidiary of the Company is required to purchase and hold shares of the FHLBB. These shares are restricted and carried at cost.

Net Investment Income
Net investment income on the Company's investments is recorded when earned and is reflected in the Company's net income (other than net investment income on assets supporting experience-rated products). Experience-rated products are products in the large case pensions business where the contract holder, not the Company, assumes investment and other risks, subject to, among other things, minimum guarantees provided by the Company. The effect of investment performance on experience-rated products is allocated to contract holders' accounts daily, based on the underlying investment experience and, therefore, does not impact the Company's net income (as long as the contract's minimum guarantees are not triggered). Net investment income on assets supporting large case pensions' experience-rated products is included in net investment income in the consolidated statements of operations and is credited to contract holders' accounts through a charge to benefit costs.

Realized capital gains and losses on investments (other than realized capital gains and losses on investments supporting experience-rated products) are included as a component of net investment income in the consolidated statements of operations. Realized capital gains and losses are determined on a specific identification basis. Purchases and sales of debt and equity securities and alternative investments are reflected on the trade date. Purchases and sales of mortgage loans and investment real estate are reflected on the closing date.

Realized capital gains and losses on investments supporting large case pensions' experience-rated products are not included in realized capital gains and losses in the consolidated statements of operations and instead are credited directly to contract holders' accounts. The contract holders' accounts are reflected in policyholders' funds on the consolidated balance sheets.

Unrealized capital gains and losses on investments (other than unrealized capital gains and losses on investments supporting experience-rated products) are reflected in shareholders' equity, net of tax, as a component of accumulated other comprehensive income. Unrealized capital gains and losses on investments supporting large case pensions' experience-rated products are credited directly to contract holders' accounts. The contract holders' accounts are reflected in policyholders' funds on the consolidated balance sheets.

Derivative Financial Instruments

The Company uses derivative financial instruments in order to manage interest rate and foreign exchange risk and credit exposure. The Company's use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps.

Accounts Receivable

Accounts receivable are stated net of allowances for credit losses, customer credit allowances, contractual allowances and estimated terminations. Accounts receivable, net is composed of the following at December 31, 2020 and 2019:

In millions	2020	2019
Trade receivables	$ 7,101	$ 6,717
Vendor and manufacturer receivables	9,815	7,856
Premium receivables	2,628	2,663
Other receivables	2,198	2,381
Total accounts receivable, net	$ 21,742	$ 19,617

The Company's allowance for credit losses was $358 million as of December 31, 2020. When developing an estimate of the Company's expected credit losses, the Company considers all available relevant information regarding the collectability of cash flows, including historical information, current conditions and reasonable and supportable forecasts of future economic conditions over the contractual life of the receivable. The Company's accounts receivable are short duration in nature and typically settle in less than 30 days. The Company's allowance for doubtful accounts was $319 million as of December 31, 2019.

Inventories

Inventories are valued at the lower of cost or net realizable value using the weighted average cost method. Physical inventory counts are taken on a regular basis in each retail store and LTC pharmacy, and a continuous cycle count process is the primary procedure used to validate the inventory balances on hand in each distribution center and mail facility to ensure that the amounts reflected in the consolidated financial statements are properly stated. During the interim period between physical inventory counts, the Company accrues for anticipated physical inventory losses on a location-by-location basis based on historical results and current physical inventory trends.

Reinsurance Recoverables

The Company utilizes reinsurance agreements primarily to: (a) reduce required capital and (b) facilitate the acquisition or disposition of certain insurance contracts. Ceded reinsurance agreements permit the Company to recover a portion of its losses from reinsurers, although they do not discharge the Company's primary liability as the direct insurer of the risks reinsured. Failure of reinsurers to indemnify the Company could result in losses; however, the Company does not expect charges for unrecoverable reinsurance to have a material effect on its consolidated operating results or financial condition. The Company evaluates the financial condition of its reinsurers and monitors concentrations of credit risk arising from similar geographic regions, activities or economic characteristics of its reinsurers. At December 31, 2020, the Company's reinsurance recoverables consisted primarily of amounts due from third parties that are rated consistent with companies that are considered to have the ability to meet their obligations. Reinsurance recoverables are recorded as other current assets or other assets on the consolidated balance sheets.

Health Care Contract Acquisition Costs

Insurance products included in the Health Care Benefits segment are cancelable by either the customer or the member monthly upon written notice. Acquisition costs related to prepaid health care and health indemnity contracts are generally expensed as incurred. Acquisition costs for certain long-duration insurance contracts are deferred and are recorded as other current assets or other assets on the consolidated balance sheets and are amortized over the estimated life of the contracts. The amortization of deferred acquisition costs is recorded in operating expenses in the consolidated statements of operations. At December 31, 2020 and 2019, the balance of deferred acquisition costs was $546 million and $271 million, respectively, comprised primarily of commissions paid on Medicare Supplement products within the Health Care Benefits segment.

Property and Equipment

Property and equipment is reported at historical cost, net of accumulated depreciation. Property, equipment and improvements to leased premises are depreciated using the straight-line method over the estimated useful lives of the assets, or when applicable, the term of the lease, whichever is shorter. Estimated useful lives generally range from 1 to 40 years for buildings, building improvements and leasehold improvements and 3 to 10 years for fixtures, equipment and internally developed

software. Repair and maintenance costs are charged directly to expense as incurred. Major renewals or replacements that substantially extend the useful life of an asset are capitalized and depreciated. Application development stage costs for significant internally developed software projects are capitalized and depreciated.

Property and equipment consists of the following at December 31, 2020 and 2019:

In millions	**2020**	**2019**
Land	$ 2,134	$ 1,981
Building and improvements	3,950	3,541
Fixtures and equipment	13,125	12,401
Leasehold improvements	6,077	5,611
Software	6,020	5,400
Total property and equipment	31,306	28,934
Accumulated depreciation and amortization	(18,700)	(16,890)
Property and equipment, net	$ 12,606	$ 12,044

Depreciation expense (which includes the amortization of property and equipment under finance or capital leases) totaled $2.1 billion, $1.9 billion and $1.7 billion for the years ended December 31, 2020, 2019 and 2018, respectively. See Note 6 ‘‘Leases’’ for additional information about finance leases.

Right-of-Use Assets and Lease Liabilities

The Company determines if an arrangement contains a lease at the inception of a contract. Right-of-use assets represent the Company’s right to use an underlying asset for the lease term and lease liabilities represent the Company’s obligation to make lease payments arising from the lease. Right-of-use assets and lease liabilities are recognized at the commencement date of the lease, renewal date of the lease or significant remodeling of the lease space based on the present value of the remaining future minimum lease payments. As the interest rate implicit in the Company’s leases is not readily determinable, the Company utilizes its incremental borrowing rate, determined by class of underlying asset, to discount the lease payments. The operating lease right-of-use assets also include lease payments made before commencement and are reduced by lease incentives.

The Company’s real estate leases typically contain options that permit renewals for additional periods of up to five years each. For real estate leases, the options to extend are not considered reasonably certain at lease commencement because the Company reevaluates each lease on a regular basis to consider the economic and strategic incentives of exercising the renewal options and regularly opens or closes stores to align with its operating strategy. Generally, the renewal option periods are not included within the lease term and the associated payments are not included in the measurement of the right-of-use asset and lease liability. Similarly, renewal options are not included in the lease term for non-real estate leases because they are not considered reasonably certain of being exercised at lease commencement. Leases with an initial term of 12 months or less are not recorded on the balance sheets, and lease expense is recognized on a straight-line basis over the term of the short-term lease.

For real estate leases, the Company accounts for lease components and nonlease components as a single lease component. Certain real estate leases require additional payments based on sales volume, as well as reimbursement for real estate taxes, common area maintenance and insurance, which are expensed as incurred as variable lease costs. Other real estate leases contain one fixed lease payment that includes real estate taxes, common area maintenance and insurance. These fixed payments are considered part of the lease payment and included in the right-of-use assets and lease liabilities.

See Note 6 ‘‘Leases’’ for additional information about right-of-use assets and lease liabilities.

Goodwill

The Company accounts for business combinations using the acquisition method of accounting, which requires the excess cost of an acquisition over the fair value of net assets acquired and identifiable intangible assets to be recorded as goodwill. Goodwill is not amortized, but is subject to impairment reviews annually, or more frequently if necessary, as further described below. See Note 5 ‘‘Goodwill and Other Intangibles’’ for additional information about goodwill.

Intangible Assets

The Company's identifiable intangible assets consist primarily of trademarks, trade names, customer contracts/relationships, covenants not to compete, technology, provider networks and value of business acquired ("VOBA"). These intangible assets arise primarily from the determination of their respective fair market values at the date of acquisition. Amounts assigned to identifiable intangible assets, and their related useful lives, are derived from established valuation techniques and management estimates.

The Company's definite-lived intangible assets are amortized over their estimated useful lives based upon the pattern of future cash flows attributable to the asset. Other than VOBA, definite-lived intangible assets are amortized using the straight-line method. VOBA is amortized over the expected life of the acquired contracts in proportion to estimated premiums. Indefinite-lived intangible assets are not amortized but are tested for impairment annually, or more frequently if necessary, as further described in "Long-Lived Asset Impairment" below.

See Note 5 ''Goodwill and Other Intangibles'' for additional information about intangible assets.

Long-Lived Asset Impairment

The Company evaluates the recoverability of long-lived assets, excluding goodwill and indefinite-lived intangible assets, which are tested for impairment using separate tests described below, whenever events or changes in circumstances indicate that the carrying value of such asset may not be recoverable. The Company groups and evaluates these long-lived assets for impairment at the lowest level at which individual cash flows can be identified. If indicators of impairment are present, the Company first compares the carrying amount of the asset group to the estimated future cash flows associated with the asset group (undiscounted and without interest charges). If the estimated future cash flows used in this analysis are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to the asset group's estimated future cash flows (discounted and with interest charges). If required, an impairment loss is recorded for the portion of the asset group's carrying value that exceeds the asset group's estimated future cash flows (discounted and with interest charges). There were no material impairment charges recognized on long-lived assets in the year ended December 31, 2020. During the year ended December 31, 2019, the Company recorded store rationalization charges of $231 million, primarily related to operating lease right-of-use asset impairment charges. See Note 6 ''Leases'' for additional information about the right-of-use asset impairment charges. During the year ended December 31, 2018, the Company recognized a $43 million long-lived asset impairment charge, primarily related to the impairment of property and equipment.

When evaluating goodwill for potential impairment, the Company compares the fair value of its reporting units to their respective carrying amounts. The Company estimates the fair value of its reporting units using a combination of a discounted cash flow method and a market multiple method. If the carrying amount of a reporting unit exceeds its estimated fair value, an impairment loss is recognized in an amount equal to that excess. During the third quarter of both 2020 and 2019, the Company performed its required annual goodwill impairment tests and concluded there were no goodwill impairments as of the testing dates or during the years ended December 31, 2020 and 2019. See Note 5 ''Goodwill and Other Intangibles'' for additional information about goodwill impairment charges recorded during the year ended December 31, 2018.

Indefinite-lived intangible assets are tested for impairment by comparing the estimated fair value of the asset to its carrying value. The Company estimates the fair value of its indefinite-lived trademarks using the relief from royalty method under the income approach. If the carrying value of the asset exceeds its estimated fair value, an impairment loss is recognized, and the asset is written down to its estimated fair value. There were no impairment losses recognized on indefinite-lived intangible assets in any of the years ended December 31, 2020, 2019 or 2018.

Separate Accounts

Separate Accounts assets and liabilities related to large case pensions products represent funds maintained to meet specific objectives of contract holders who bear the investment risk. These assets and liabilities are carried at fair value. Net investment income (including net realized capital gains and losses) accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from the Company's other businesses. Deposits, withdrawals and net investment income (including net realized and net unrealized capital gains and losses) on Separate Accounts assets are not reflected in the consolidated statements of operations or cash flows. Management fees charged to contract holders are included in services revenue and recognized over the period earned.

Health Care Costs Payable

Health care costs payable consist principally of unpaid fee-for-service medical, dental and pharmacy claims, capitation costs, other amounts due to providers pursuant to risk-sharing arrangements related to the Health Care Benefits segment's Insured Commercial, Medicare and Medicaid products and accruals for state assessments. Unpaid health care claims include an estimate of payments the Company will make for (i) services rendered to the Company's Insured members but not yet reported to the Company and (ii) claims which have been reported to the Company but not yet paid, each as of the financial statement date (collectively, "IBNR"). Health care costs payable also include an estimate of the cost of services that will continue to be rendered after the financial statement date if the Company is obligated to pay for such services in accordance with contractual or regulatory requirements. Such estimates are developed using actuarial principles and assumptions which consider, among other things, historical and projected claim submission and processing patterns, assumed and historical medical cost trends, historical utilization of medical services, claim inventory levels, changes in Insured membership and product mix, seasonality and other relevant factors. The Company reflects changes in these estimates in benefit costs in the Company's consolidated operating results in the period they are determined. Capitation costs represent contractual monthly fees paid to participating physicians and other medical providers for providing medical care, regardless of the volume of medical services provided to the Insured member. Amounts due under risk-sharing arrangements are based on the terms of the underlying contracts with the providers and consider claims experience under the contracts through the financial statement date.

The Company develops its estimate of IBNR using actuarial principles and assumptions that consider numerous factors. Of those factors, the Company considers the analysis of historical and projected claim payment patterns (including claims submission and processing patterns) and the assumed health care cost trend rate (the year-over-year change in per member per month health care costs) to be the most critical assumptions. In developing its IBNR estimate, the Company consistently applies these actuarial principles and assumptions each period, with consideration to the variability of related factors. There have been no significant changes to the methodologies or assumptions used to develop the Company's estimate of IBNR in 2020.

The Company analyzes historical claim payment patterns by comparing claim incurred dates (i.e., the date services were provided) to claim payment dates to estimate "completion factors." The Company uses completion factors predominantly to estimate the ultimate cost of claims incurred more than three months before the financial statement date. The Company estimates completion factors by aggregating claim data based on the month of service and month of claim payment and estimating the percentage of claims incurred for a given month that are complete by each month thereafter. For any given month, substantially all claims are paid within six months of the date of service, but it can take up to 48 months or longer after the date of service before all of the claims are completely resolved and paid. These historically-derived completion factors are then applied to claims paid through the financial statement date to estimate the ultimate claim cost for a given month's incurred claim activity. The difference between the estimated ultimate claim cost and the claims paid through the financial statement date represents the Company's estimate of claims remaining to be paid as of the financial statement date and is included in the Company's health care costs payable. The completion factors the Company uses reflect judgments and possible adjustments based on data such as claim inventory levels, claim submission and processing patterns and, to a lesser extent, other factors such as changes in health care cost trend rates, changes in Insured membership and changes in product mix. If claims are submitted or processed on a faster (slower) pace than prior periods, the actual claims may be more (less) complete than originally estimated using the Company's completion factors, which may result in reserves that are higher (lower) than the ultimate cost of claims.

Because claims incurred within three months before the financial statement date are less mature, the Company uses a combination of historically-derived completion factors and the assumed health care cost trend rate to estimate the ultimate cost of claims incurred for these months. The Company applies its actuarial judgment and places a greater emphasis on the assumed health care cost trend rate for the most recent claim incurred dates as these months may be influenced by seasonal patterns and changes in membership and product mix.

The Company's health care cost trend rate is affected by changes in per member utilization of medical services as well as changes in the unit cost of such services. Many factors influence the health care cost trend rate, including the Company's ability to manage benefit costs through product design, negotiation of favorable provider contracts and medical management programs, as well as the mix of the Company's business. The health status of the Company's Insured members, aging of the population and other demographic characteristics, advances in medical technology and other factors continue to contribute to rising per member utilization and unit costs. Changes in health care practices, inflation, new technologies, increases in the cost of prescription drugs (including specialty pharmacy drugs), direct-to-consumer marketing by pharmaceutical companies, clusters of high-cost cases, claim intensity, changes in the regulatory environment, health care provider or member fraud and numerous other factors also contribute to the cost of health care and the Company's health care cost trend rate.

For each reporting period, the Company uses an extensive degree of judgment in the process of estimating its health care costs payable. As a result, considerable variability and uncertainty is inherent in such estimates, particularly with respect to claims with claim incurred dates of three months or less before the financial statement date; and the adequacy of such estimates is highly sensitive to changes in assumed completion factors and the assumed health care cost trend rates. For each reporting period the Company recognizes the actuarial best estimate of health care costs payable considering the potential volatility in assumed completion factors and health care cost trend rates, as well as other factors. The Company believes its estimate of health care costs payable is reasonable and adequate to cover its obligations at December 31, 2020; however, actual claim payments may differ from the Company's estimates. A worsening (or improvement) of the Company's health care cost trend rates or changes in completion factors from those that the Company assumed in estimating health care costs payable at December 31, 2020 would cause these estimates to change in the near term, and such a change could be material.

Each quarter, the Company re-examines previously established health care costs payable estimates based on actual claim payments for prior periods and other changes in facts and circumstances. Given the extensive degree of judgment in this estimate, it is possible that the Company's estimates of health care costs payable could develop either favorably (that is, its actual benefit costs for the period were less than estimated) or unfavorably. The changes in the Company's estimate of health care costs payable may relate to a prior quarter, prior year or earlier periods. For a roll forward of the Company's health care costs payable, see Note 7 ''Health Care Costs Payable.'' The Company's reserving practice is to consistently recognize the actuarial best estimate of its ultimate liability for health care costs payable.

Other Insurance Liabilities

Unpaid Claims
Unpaid claims consist primarily of reserves associated with certain short-duration group disability and term life insurance contracts, including an estimate for IBNR as of the financial statement date. Reserves associated with certain short-duration group disability and term life insurance contracts are based upon the Company's estimate of the present value of future benefits, which is based on assumed investment yields and assumptions regarding mortality, morbidity and recoveries from the U.S. Social Security Administration. The Company develops its estimate of IBNR using actuarial principles and assumptions which consider, among other things, contractual requirements, claim incidence rates, claim recovery rates, seasonality and other relevant factors. The Company discounts certain claim liabilities related to group long-term disability and life insurance waiver of premium contracts. The discount rates generally reflect the Company's expected investment returns for the investments supporting all incurral years of these liabilities. The discount rates for retrospectively-rated contracts are set at contractually specified levels. The Company's estimates of unpaid claims are subject to change due to changes in the underlying experience of the insurance contracts, changes in investment yields or other factors, and these changes are recorded in current and future benefits in the consolidated statements of operations in the period they are determined. The Company estimates its reserve for claims IBNR for life products largely based on completion factors. The completion factors used are based on the Company's historical experience and reflect judgments and possible adjustments based on data such as claim inventory levels, claim payment patterns, changes in business volume and other factors. If claims are submitted or processed on a faster (slower) pace than historical periods, the actual claims may be more (less) complete than originally estimated using completion factors, which may result in reserves that are higher (lower) than required to cover future life benefit payments. There have been no significant changes to the methodologies or assumptions used to develop the Company's estimate of unpaid claims IBNR in 2020. As of December 31, 2020, unpaid claims balances of $532 million and $1.5 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively. As of December 31, 2019, unpaid claims balances of $704 million and $1.8 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively.

Substantially all life and disability insurance liabilities have been fully ceded to unrelated third parties through indemnity reinsurance agreements; however, the Company remains directly obligated to the policyholders.

Future Policy Benefits
Future policy benefits consist primarily of reserves for limited payment pension and annuity contracts and long-term care insurance contracts. Reserves for limited payment pension and annuity contracts are computed using actuarial principles that consider, among other things, assumptions reflecting anticipated mortality, retirement, expense and interest rate experience. Such assumptions generally vary by plan, year of issue and policy duration. Assumed interest rates on such contracts ranged from 3.3% to 11.3% in the year ended December 31, 2020 and from 3.5% to 11.3% in the year ended December 31, 2019. The Company periodically reviews mortality assumptions against both industry standards and its experience. Reserves for long-duration long-term care contracts represent the Company's estimate of the present value of future benefits to be paid to or on behalf of policyholders less the present value of future net premiums. The assumed interest rate on such contracts was 5.1% in both the years ended December 31, 2020 and 2019. The Company's estimate of the present value of future benefits under such contracts is based upon mortality, morbidity and interest rate assumptions. As of December 31, 2020, future policy benefits

balances of $462 million and $5.5 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively. As of December 31, 2019, future policy benefits balances of $508 million and $5.6 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively.

Premium Deficiency Reserves

The Company evaluates its insurance contracts to determine if it is probable that a loss will be incurred. A premium deficiency loss is recognized when it is probable that expected future claims, including maintenance costs (for example, direct costs such as claim processing costs), will exceed existing reserves plus anticipated future premiums and reinsurance recoveries. Anticipated investment income is considered in the calculation of premium deficiency losses for short-duration contracts. For purposes of determining premium deficiency losses, contracts are grouped consistent with the Company's method of acquiring, servicing and measuring the profitability of such contracts. As of December 31, 2020 and 2019, the Company established a premium deficiency reserve of $11 million and $4 million, respectively, related to Medicaid products in the Health Care Benefits segment.

Policyholders' Funds

Policyholders' funds consist primarily of reserves for pension and annuity investment contracts and customer funds associated with certain health contracts. Reserves for such contracts are equal to cumulative deposits less withdrawals and charges plus interest credited thereon, net of experience-rated adjustments. In 2020, interest rates for pension and annuity investment contracts ranged from 4.1% to 5.1%. In 2019, interest rates for pension and annuity investment contracts ranged from 3.5% to 5.2%. Reserves for contracts subject to experience rating reflect the Company's rights as well as the rights of policyholders and plan participants. The Company also holds funds for health savings accounts ("HSAs") on behalf of members associated with high deductible health plans. These amounts are held to pay for qualified health care expenses incurred by these members. The HSA balances were approximately $2.7 billion and $2.2 billion at December 31, 2020 and 2019, respectively, and are reflected in other current assets with a corresponding liability in policyholders' funds.

Policyholders' funds liabilities that are expected to be paid within twelve months from the balance sheet date are classified as current on the consolidated balance sheets. Policyholders' funds liabilities that are expected to be paid greater than twelve months from the balance sheet date are included in other long-term liabilities on the consolidated balance sheets.

Self-Insurance Liabilities

The Company is self-insured for certain losses related to general liability, workers' compensation and auto liability. The Company obtains third party insurance coverage to limit exposure from these claims. The Company is also self-insured for certain losses related to health and medical liabilities. The Company's self-insurance accruals, which include reported claims and claims incurred but not reported, are calculated using standard insurance industry actuarial assumptions and the Company's historical claims experience. At December 31, 2020 and 2019, self-insurance liabilities totaled $927 million and $856 million, respectively, and were recorded as accrued expenses on the consolidated balance sheets.

Foreign Currency Translation and Transactions

For non-U.S. dollar functional currency locations, (i) assets and liabilities are translated at end-of-period exchange rates, (ii) revenues and expenses are translated at average exchange rates in effect during the period and (iii) equity is translated at historical exchange rates. The resulting cumulative translation adjustments are included as a component of accumulated other comprehensive income (loss).

For U.S. dollar functional currency locations, foreign currency assets and liabilities are remeasured into U.S. dollars at end-of-period exchange rates, except for nonmonetary balance sheet accounts which are remeasured at historical exchange rates. Revenues and expenses are remeasured at average exchange rates in effect during each period, except for those expenses related to the nonmonetary balance sheet amounts which are remeasured at historical exchange rates. Gains or losses from foreign currency remeasurement are included in net income (loss).

Gains and losses from foreign currency transactions and the effects of foreign currency remeasurements were not material in the years ended December 31, 2020 or 2018. On July 1, 2019, the Company sold its Brazilian subsidiary, Drogaria Onofre Ltda. ("Onofre") for an immaterial amount. The Company recorded a loss on the divestiture, which included the elimination of the subsidiary's $154 million cumulative translation adjustment from accumulated other comprehensive income during the year ended December 31, 2019.

Revenue Recognition

Pharmacy Services Segment
The Pharmacy Services segment sells prescription drugs directly through its mail service dispensing pharmacies and indirectly through the Company's retail pharmacy network. The Company's pharmacy benefit arrangements are accounted for in a manner consistent with a master supply arrangement as there are no contractual minimum volumes and each prescription is considered a separate purchasing decision and distinct performance obligation transferred at a point in time. PBM services performed in connection with each prescription claim are considered part of a single performance obligation which culminates in the dispensing of prescription drugs.

The Company recognizes revenue using the gross method at the contract price negotiated with its clients when the Company has concluded it controls the prescription drug before it is transferred to the client plan members. The Company controls prescriptions dispensed indirectly through its retail pharmacy network because it has separate contractual arrangements with those pharmacies, has discretion in setting the price for the transaction and assumes primary responsibility for fulfilling the promise to provide prescription drugs to its client plan members while also performing the related PBM services.

Revenues include (i) the portion of the price the client pays directly to the Company, net of any discounts earned on brand name drugs or other discounts and refunds paid back to the client (see "Drug Discounts" and "Guarantees" below), (ii) the price paid to the Company by client plan members for mail order prescriptions and the price paid to retail network pharmacies by client plan members for retail prescriptions ("retail co-payments"), and (iii) claims based administrative fees for retail pharmacy network contracts. Sales taxes are not included in revenues.

The Company recognizes revenue when control of the prescription drugs is transferred to customers, in an amount that reflects the consideration the Company expects to be entitled to receive in exchange for those prescription drugs. The Company has established the following revenue recognition policies for the Pharmacy Services segment:

- Revenues generated from prescription drugs sold by mail service dispensing pharmacies are recognized when the prescription drug is delivered to the client plan member. At the time of delivery, the Company has performed substantially all of its performance obligations under its client contracts and does not experience a significant level of returns or reshipments.
- Revenues generated from prescription drugs sold by third party pharmacies in the Company's retail pharmacy network and associated administrative fees are recognized at the Company's point-of-sale, which is when the claim is adjudicated by the Company's online claims processing system and the Company has transferred control of the prescription drug and performed all of its performance obligations.

For contracts under which the Company acts as an agent or does not control the prescription drugs prior to transfer to the client plan member, revenue is recognized using the net method.

Drug Discounts
The Company records revenue net of manufacturers' rebates earned by its clients based on their plan members' utilization of brand-name formulary drugs. The Company estimates these rebates at period-end based on actual and estimated claims data and its estimates of the manufacturers' rebates earned by its clients. The estimates are based on the best available data at period-end and recent history for the various factors that can affect the amount of rebates due to the client. The Company adjusts its rebates payable to clients to the actual amounts paid when these rebates are paid or as significant events occur. Any cumulative effect of these adjustments is recorded against revenues at the time it is identified. Adjustments generally result from contract changes with clients or manufacturers that have retroactive rebate adjustments, differences between the estimated and actual product mix subject to rebates, or whether the brand name drug was included in the applicable formulary. The effect of adjustments between estimated and actual manufacturers' rebate amounts has not been material to the Company's operating results or financial condition.

Guarantees
The Company also adjusts revenues for refunds owed to clients resulting from pricing guarantees and performance against defined service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's operating results or financial condition.

Retail/LTC Segment

Retail Pharmacy

The Company's retail drugstores recognize revenue at the time the customer takes possession of the merchandise. For pharmacy sales, each prescription claim is its own arrangement with the customer and is a performance obligation, separate and distinct from other prescription claims under other retail network arrangements. Revenues are adjusted for refunds owed to third party payers resulting from pricing guarantees and performance against defined value-based service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's operating results or financial condition.

Revenue from Company gift cards purchased by customers is deferred as a contract liability until goods or services are transferred. Any amounts not expected to be redeemed by customers (i.e., breakage) are recognized based on historical redemption patterns.

Customer returns are not material to the Company's operating results or financial condition. Sales taxes are not included in revenues.

Loyalty and Other Programs

The Company's customer loyalty program, ExtraCare®, consists of two components, ExtraSavings™ and ExtraBucks® Rewards. ExtraSavings are coupons that are recorded as a reduction of revenue when redeemed as the Company concluded that they do not represent a promise to the customer to deliver additional goods or services at the time of issuance because they are not tied to a specific transaction or spending level.

ExtraBucks Rewards are accumulated by customers based on their historical spending levels. Thus, the Company has determined that there is an additional performance obligation to those customers at the time of the initial transaction. The Company allocates the transaction price to the initial transaction and the ExtraBucks Rewards transaction based upon the relative standalone selling price, which considers historical redemption patterns for the rewards. Revenue allocated to ExtraBucks Rewards is recognized as those rewards are redeemed. At the end of each period, unredeemed ExtraBucks Rewards are reflected as a contract liability.

The Company also offers a subscription-based membership program, CarePass®, under which members are entitled to a suite of benefits delivered over the course of the subscription period, as well as a promotional reward that can be redeemed for future goods and services. Subscriptions are paid for on a monthly or annual basis at the time of or in advance of the Company delivering the goods and services. Revenue from these arrangements is recognized as the performance obligations are satisfied.

Long-term Care

Revenue is recognized when control of the promised goods or services is transferred to customers in an amount that reflects the consideration the Company expects to be entitled to receive in exchange for those goods or services. Each prescription claim represents a separate performance obligation of the Company, separate and distinct from other prescription claims under customer arrangements. A significant portion of Long-term Care revenue from sales of pharmaceutical and medical products is reimbursed by the federal Medicare Part D program and, to a lesser extent, state Medicaid programs. The Company monitors its revenues and receivables from these reimbursement sources, as well as long-term care facilities and other third party insurance payors, and reduces revenue at the revenue recognition date to properly account for the variable consideration due to anticipated differences between billed and reimbursed amounts. Accordingly, the total revenues and receivables reported in the Company's consolidated financial statements are recorded at the amount expected to be ultimately received from these payors.

Patient co-payments associated with Medicare Part D, certain state Medicaid programs, Medicare Part B and certain third party payors typically are not collected at the time products are delivered or services are rendered, but are billed to the individuals as part of normal billing procedures and subject to normal accounts receivable collections procedures.

Walk-In Medical Clinics

For services provided by the Company's walk-in medical clinics, revenue recognition occurs for completed services provided to patients, with adjustments taken for third party payor contractual obligations and patient direct bill historical collection rates.

Health Care Benefits Segment

Health Care Benefits revenue is principally derived from insurance premiums and fees billed to customers. Revenue is recognized based on customer billings, which reflect contracted rates per employee and the number of covered employees

recorded in the Company's records at the time the billings are prepared. Billings are generally sent monthly for coverage during the following month.

The Company's billings may be subsequently adjusted to reflect enrollment changes due to member terminations or other factors. These adjustments are known as retroactivity adjustments. In each period, the Company estimates the amount of future retroactivity and adjusts the recorded revenue accordingly. As information regarding actual retroactivity amounts becomes known, the Company refines its estimates and records any required adjustments to revenues in the period in which they arise.

Premium Revenue

Premiums are recognized as revenue in the month in which the enrollee is entitled to receive health care services. Premiums are reported net of an allowance for estimated terminations and uncollectible amounts. Additionally, premium revenue subject to the minimum medical loss ratio ("MLR") rebate requirements of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (as amended, collectively, the "ACA") is recorded net of the estimated minimum MLR rebates for the current calendar year. Premiums related to unexpired contractual coverage periods (unearned premiums) are reported as other insurance liabilities on the consolidated balance sheets and recognized as revenue when earned.

Some of the Company's contracts allow for premiums to be adjusted to reflect actual experience or the relative health status of Insured members. Such adjustments are reasonably estimable at the outset of the contract, and adjustments to those estimates are made based on actual experience of the customer emerging under the contract and the terms of the underlying contract.

Services Revenue

Services revenue relates to contracts that can include various combinations of services or series of services which generally are capable of being distinct and accounted for as separate performance obligations. The Health Care Benefits segment's services revenue primarily consists of ASC fees received in exchange for performing certain claim processing and member services for ASC members. ASC fee revenue is recognized over the period the service is provided. Some of the Company's administrative services contracts include guarantees with respect to certain functions, such as customer service response time, claim processing accuracy and claim processing turnaround time, as well as certain guarantees that a plan sponsor's benefit claim experience will fall within a certain range. With any of these guarantees, the Company is financially at risk if the conditions of the arrangements are not met, although the maximum amount at risk typically is limited to a percentage of the fees otherwise payable to the Company by the customer involved. Each period the Company estimates its obligations under the terms of these guarantees and records its estimate as an offset to services revenues.

Accounting for Medicare Part D

Revenues include insurance premiums earned by the Company's PDPs, which are determined based on the PDP's annual bid and related contractual arrangements with the U.S. Centers for Medicare & Medicaid Services ("CMS"). The insurance premiums include a beneficiary premium, which is the responsibility of the PDP member, and can be subsidized by CMS in the case of low-income members, and a direct premium paid by CMS. Premiums collected in advance are initially recorded within other insurance liabilities and are then recognized ratably as revenue over the period in which members are entitled to receive benefits.

Revenues also include a risk-sharing feature of the Medicare Part D program design referred to as the risk corridor. The Company estimates variable consideration in the form of amounts payable to, or receivable from, CMS under the risk corridor, and adjusts revenue based on calculations of additional subsidies to be received from or owed to CMS at the end of the reporting year.

In addition to Medicare Part D premiums, the Company receives additional payments each month from CMS related to catastrophic reinsurance, low-income cost-sharing subsidies and coverage gap benefits. If the subsidies received differ from the amounts earned from actual prescriptions transferred, the difference is recorded in either accounts receivable, net or accrued expenses.

Disaggregation of Revenue

The following table disaggregates the Company's revenue by major source in each segment for the years ended December 31, 2020, 2019 and 2018:

In millions	**Pharmacy Services**	**Retail/ LTC**	**Health Care Benefits**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
2020						
Major goods/services lines:						
Pharmacy	$ 141,116	$ 70,176	$ —	$ —	$ (40,003)	$ 171,289
Front Store	—	19,655	—	—	—	19,655
Premiums	—	—	69,301	63	—	69,364
Net investment income	—	—	483	315	—	798
Other	822	1,367	5,683	48	(320)	7,600
Total	$ 141,938	$ 91,198	$ 75,467	$ 426	$ (40,323)	$ 268,706
Pharmacy Services distribution channel:						
Pharmacy network [1]	$ 85,045					
Mail choice [2]	56,071					
Other	822					
Total	$ 141,938					
2019						
Major goods/services lines:						
Pharmacy [3]	$ 140,896	$ 66,442	$ —	$ —	$ (41,413)	$ 165,925
Front Store	—	19,422	—	—	—	19,422
Premiums	—	—	63,031	91	—	63,122
Net investment income	—	—	599	412	—	1,011
Other [3]	595	744	5,974	9	(26)	7,296
Total	$ 141,491	$ 86,608	$ 69,604	$ 512	$ (41,439)	$ 256,776
Pharmacy Services distribution channel:						
Pharmacy network [1]	$ 88,755					
Mail choice [2]	52,141					
Other	595					
Total	$ 141,491					
2018						
Major goods/services lines:						
Pharmacy	$ 134,216	$ 64,179	$ 164	$ —	$ (33,714)	$ 164,845
Front Store	—	19,055	—	—	—	19,055
Premiums	—	—	8,180	4	—	8,184
Net investment income	—	—	58	602	—	660
Other	520	755	560	—	—	1,835
Total	$ 134,736	$ 83,989	$ 8,962	$ 606	$ (33,714)	$ 194,579
Pharmacy Services distribution channel:						
Pharmacy network [1]	$ 87,167					
Mail choice [2]	47,049					
Other	520					
Total	$ 134,736					

(1) Pharmacy Services pharmacy network is defined as claims filled at retail and specialty retail pharmacies, including the Company's retail pharmacies and LTC pharmacies, but excluding Maintenance Choice® activity, which is included within the mail choice category. Maintenance Choice permits eligible client plan members to fill their maintenance prescriptions through mail order delivery or at a CVS pharmacy retail store for the same price as mail order.
(2) Pharmacy Services mail choice is defined as claims filled at a Pharmacy Services mail order facility, which includes specialty mail claims inclusive of Specialty Connect® claims picked up at a retail pharmacy, as well as prescriptions filled at the Company's retail pharmacies under the Maintenance Choice program.
(3) Certain prior year amounts have been reclassified for consistency with the current period presentation.

Contract Balances
Contract liabilities primarily represent the Company's obligation to transfer additional goods or services to a customer for which the Company has received consideration, and include ExtraBucks Rewards and unredeemed Company gift cards. The consideration received remains a contract liability until goods or services have been provided to the customer. In addition, the Company recognizes breakage on Company gift cards based on historical redemption patterns.

The following table provides information about receivables and contract liabilities from contracts with customers as of December 31, 2020 and 2019:

In millions	**2020**	**2019**
Trade receivables (included in accounts receivable, net)	$ 7,101	$ 6,717
Contract liabilities (included in accrued expenses)	71	73

During the years ended December 31, 2020 and 2019, the contract liabilities balance includes increases related to customers' earnings in ExtraBucks Rewards or issuances of Company gift cards and decreases for revenues recognized during the period as a result of the redemption of ExtraBucks Rewards or Company gift cards and breakage of Company gift cards. Below is a summary of such changes:

In millions	**2020**	**2019**
Contract liabilities, beginning of period	$ 73	$ 67
Rewards earnings and gift card issuances	357	365
Redemption and breakage	(359)	(359)
Contract liabilities, end of period	$ 71	$ 73

Cost of Products Sold

The Company accounts for cost of products sold as follows:

Pharmacy Services Segment
Cost of products sold includes: (i) the cost of prescription drugs sold during the reporting period directly through the Company's mail service dispensing pharmacies and indirectly through the Company's retail pharmacy network, (ii) shipping and handling costs, and (iii) the operating costs of the Company's mail service dispensing pharmacies and client service operations and related information technology support costs including depreciation and amortization. The cost of prescription drugs sold component of cost of products sold includes: (i) the cost of the prescription drugs purchased from manufacturers or distributors and shipped to members in clients' benefit plans from the Company's mail service dispensing pharmacies, net of any volume-related or other discounts (see "Vendor Allowances and Purchase Discounts" below) and (ii) the cost of prescription drugs sold (including retail co-payments) through the Company's retail pharmacy network under contracts where the Company is the principal, net of any volume-related or other discounts.

Retail/LTC Segment
Cost of products sold includes: the cost of merchandise sold during the reporting period, including prescription drug costs, and the related purchasing costs, warehousing and delivery costs (including depreciation and amortization) and actual and estimated inventory losses.

Vendor Allowances and Purchase Discounts

The Company accounts for vendor allowances and purchase discounts as follows:

Pharmacy Services Segment
The Pharmacy Services segment receives purchase discounts on products purchased. Contractual arrangements with vendors, including manufacturers, wholesalers and retail pharmacies, normally provide for the Pharmacy Services segment to receive purchase discounts from established list prices in one, or a combination, of the following forms: (i) a direct discount at the time of purchase, (ii) a discount for the prompt payment of invoices or (iii) when products are purchased indirectly from a manufacturer (e.g., through a wholesaler or retail pharmacy), a discount (or rebate) paid subsequent to dispensing. These rebates are recognized when prescriptions are dispensed and are generally calculated and billed to manufacturers within 30 days of the end of each completed quarter. Historically, the effect of adjustments resulting from the reconciliation of rebates recognized to the amounts billed and collected has not been material to the Company's operating results or financial condition. The Company accounts for the effect of any such differences as a change in accounting estimate in the period the reconciliation is completed. The Pharmacy Services segment also receives additional discounts under its wholesaler contracts if it exceeds contractually defined purchase volumes. In addition, the Pharmacy Services segment receives fees from pharmaceutical manufacturers for administrative services. Purchase discounts and administrative service fees are recorded as a reduction of cost of products sold.

Retail/LTC Segment
Vendor allowances received by the Retail/LTC segment reduce the carrying cost of inventory and are recognized in cost of products sold when the related inventory is sold, unless they are specifically identified as a reimbursement of incremental costs for promotional programs and/or other services provided. Amounts that are directly linked to advertising commitments are recognized as a reduction of advertising expense (included in operating expenses) when the related advertising commitment is satisfied. Any amounts received in excess of the actual cost incurred also reduce the carrying cost of inventory. The total value of any upfront payments received from vendors that are linked to purchase commitments is initially deferred. The deferred amounts are then amortized to reduce cost of products sold over the life of the contract based upon purchase volume. The total value of any upfront payments received from vendors that are not linked to purchase commitments is also initially deferred. The deferred amounts are then amortized to reduce cost of products sold on a straight-line basis over the life of the related contract. The total amortization of these upfront payments was not material to the Company's consolidated financial statements in any of the periods presented.

Health Care Reform

Health Insurer Fee
Since January 1, 2014, the ACA has imposed an annual premium-based health insurer fee ("HIF") for each calendar year, payable in September, which was not deductible for tax purposes. The Company has been required to estimate a liability for the HIF at the beginning of the calendar year in which the fee was payable with a corresponding deferred asset that was amortized ratably to operating expenses over the calendar year. The Company recorded the liability for the HIF in accrued expenses and recorded the deferred asset in other current assets. In the years ended December 31, 2020 and 2018, operating expenses included $1.0 billion and $157 million, respectively, related to the Company's share of the HIF. There was no expense related to the HIF in 2019, since there was a one-year suspension of the HIF for 2019. In December 2019, the HIF was repealed for calendar years after 2020.

Risk Adjustment
The ACA established a permanent risk adjustment program to transfer funds from qualified individual and small group insurance plans with below average risk scores to plans with above average risk scores. Based on the risk of the Company's qualified plan members relative to the average risk of members of other qualified plans in comparable markets, as defined by the ACA, the Company estimates its ultimate risk adjustment receivable (recorded in accounts receivable) or payable (recorded in accrued expenses) for the current calendar year and reflects the pro-rata year-to-date impact as an adjustment to premium revenue.

Risk Corridor
The ACA established a temporary risk corridor program, which expired at the end of 2016, for qualified individual and small group health insurance plans. Under this program, health insurance companies were to make payments to, or receive payments from, the U.S. Department of Health and Human Services ("HHS") based on their ratio of allowable costs to target costs (as defined by the ACA).

The Company filed a lawsuit in August 2019 to recover the $313 million it was owed under the ACA's risk corridor program, which had been stayed pending the Supreme Court decision. In April 2020, the U.S. Supreme Court ruled that health insurance companies may sue the federal government for amounts owed as calculated under the ACA's temporary risk corridor program.

In October 2020, the Company received the $313 million it was owed under the ACA's risk corridor program. The Company recorded the risk corridor payment as an increase to premium revenue in the year ended December 31, 2020. After considering offsetting items such as the ACA's minimum MLR rebate requirements and premium taxes, the Company recorded pre-tax income of $307 million and after-tax income of $223 million during the year ended December 31, 2020.

At December 31, 2019, the Company did not record any ACA risk corridor receivables because payment was uncertain.

Advertising Costs

Advertising costs, which are reduced by the portion funded by vendors, are expensed when the related advertising takes place. Net advertising costs, which are included in operating expenses, were $461 million, $396 million and $364 million in 2020, 2019 and 2018, respectively.

Stock-Based Compensation

Stock-based compensation is measured at the grant date based on the fair value of the award and is recognized as expense over the requisite service period of the stock award (generally three to five years) using the straight-line method.

Income Taxes

The Company accounts for income taxes under the asset and liability method, which requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of events that have been included in the consolidated financial statements. Under this method, deferred tax assets and liabilities are determined on the basis of the differences between the consolidated financial statements and tax basis of assets and liabilities using enacted tax rates in effect for the year or years in which the differences are expected to reverse. The effect of a change in the tax rates on deferred tax assets and liabilities is recognized in income in the period that includes the enactment date of such change.
The Tax Cuts and Jobs Act (the "TCJA") was enacted on December 22, 2017. Among numerous changes to existing tax laws, the TCJA permanently reduced the federal corporate income tax rate from 35% to 21% effective January 1, 2018. The effects of changes in tax rates on deferred tax balances are required to be taken into consideration in the period in which the changes are enacted, regardless of when they are effective. As a result of the reduction of the corporate income tax rate under the TCJA, the Company estimated the revaluation of its net deferred tax liabilities and recorded a provisional income tax benefit of approximately $1.5 billion for year ended December 31, 2017. In 2018, the Company completed its process of determining the TCJA's final impact and recorded an additional income tax benefit of $100 million.

The Company recognizes deferred tax assets to the extent that it believes these assets are more likely than not to be realized. In making such a determination, the Company considers all available positive and negative evidence, including future reversals of existing taxable temporary differences, projected future taxable income, tax planning strategies, and the Company's recent operating results. The Company establishes a valuation allowance when it does not consider it more likely than not that a deferred tax asset will be recovered.

The Company records uncertain tax positions on the basis of a two-step process whereby (1) the Company determines whether it is more likely than not that the tax positions will be sustained on the basis of the technical merits of the position and (2) for those tax positions that meet the more-likely-than-not recognition threshold, the Company recognizes the largest amount of tax benefit that is more than 50% likely to be realized upon ultimate settlement with the related tax authority.

Interest and/or penalties related to uncertain tax positions are recognized in the income tax provision.

Measurement of Defined Benefit Pension and Other Postretirement Employee Benefit Plans

The Company sponsors defined benefit pension plans ("pension plans") and other postretirement employee benefit plans ("OPEB plans") for its employees and retirees. The Company recognizes the funded status of its pension and OPEB plans on the consolidated balance sheets based on the year-end measurements of plan assets and benefit obligations. When the fair value of plan assets are in excess of the plan benefit obligations, the amounts are reported in other current assets and other assets. When the fair value of plan benefit obligations are in excess of plan assets, the amounts are reported in accrued expenses and other long-term 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. The net periodic benefit cost (income) for the Company's pension and OPEB plans do not contain a service cost component as these plans have been frozen for an extended

period of time. Non-service cost components of pension and postretirement net periodic benefit cost (income) are included in other income in the consolidated statements of operations.

Earnings (Loss) per Common Share

Earnings (loss) per share is computed using the two-class method. The Company calculates basic earnings (loss) per share based on the weighted average number of common shares outstanding for the period. See Note 14 ‘‘Earnings (Loss) Per Share’’ for additional information.

Shares Held in Trust

The Company maintains grantor trusts, which held approximately one million shares of its common stock at both December 31, 2020 and 2019. These shares are designated for use under various employee compensation plans. Since the Company holds these shares, they are excluded from the computation of basic and diluted shares outstanding.

Variable Interest Entities

The Company has investments in (i) a generic pharmaceutical sourcing entity, (ii) certain hedge fund and private equity investments and (iii) certain real estate partnerships that are considered VIEs. The Company does not have a future obligation to fund losses or debts on behalf of these investments; however, it may voluntarily contribute funds. In evaluating whether the Company is the primary beneficiary of a VIE, the Company considers several factors, including whether the Company has (a) the power to direct the activities that most significantly impact the VIE’s economic performance and (b) the obligation to absorb losses and the right to receive benefits that could potentially be significant to the VIE.

Variable Interest Entities - Primary Beneficiary
In 2014, the Company and Cardinal Health, Inc. (“Cardinal”) established Red Oak Sourcing, LLC (“Red Oak”), a generic pharmaceutical sourcing entity in which the Company and Cardinal each own 50%. The Red Oak arrangement has an initial term of 10 years. Under this arrangement, the Company and Cardinal contributed their sourcing and supply chain expertise to Red Oak and agreed to source and negotiate generic pharmaceutical supply contracts for both companies through Red Oak; however, Red Oak does not own or hold inventory on behalf of either company. No physical assets (e.g., property and equipment) were contributed to Red Oak by either company, and minimal funding was provided to capitalize Red Oak. The Company has determined that it is the primary beneficiary of this VIE because it has the ability to direct the activities of Red Oak. Consequently, the Company consolidates Red Oak in its consolidated financial statements within the Retail/LTC segment.

Cardinal is required to pay the Company 39 quarterly payments beginning in October 2014. As milestones are met, the quarterly payments increase. The Company received from Cardinal $183 million during each of the years ended December 31, 2020, 2019 and 2018. The payments reduce the Company’s carrying value of inventory and are recognized in cost of products sold when the related inventory is sold. Revenues associated with Red Oak expenses reimbursed by Cardinal for the years ended December 31, 2020, 2019 and 2018, and amounts due to or due from Cardinal at December 31, 2020 and 2019 were immaterial.

Variable Interest Entities - Other Variable Interest Holder
The Company has invested in certain VIEs for which it has determined that it is not the primary beneficiary, consisting of the following:

- *Hedge fund and private equity investments* - The Company invests in hedge fund and private equity investments in order to generate investment returns for its investment portfolio supporting its insurance businesses.
- *Real estate partnerships* - The Company invests in various real estate partnerships, including those that construct, own and manage low-income housing developments. For the low income housing development investments, substantially all of the projected benefits to the Company are from tax credits and other tax benefits.

The Company is not the primary beneficiary of these VIEs because the nature of the Company’s involvement with the activities of these VIEs does not give the Company the power to direct the activities that most significantly impact their economic performance. The Company records the amount of its investment in these VIEs as long-term investments on the consolidated balance sheets and recognizes its share of each VIE’s income or losses in net income (loss). The Company’s maximum exposure to loss from these VIEs is limited to its investment balances as disclosed below and the risk of recapture of previously recognized tax credits related to the real estate partnerships, which the Company does not consider significant.

The total amount of other variable interest holder VIE assets included in long-term investments on the consolidated balance sheets at December 31, 2020 and 2019 was as follows:

In millions	**2020**	**2019**
Hedge fund investments	$ 342	$ 271
Private equity investments	547	538
Real estate partnerships	200	212
Total	$ 1,089	$ 1,021

Related Party Transactions

The Company has an equity method investment in SureScripts, LLC ("SureScripts"), which operates a clinical health information network. The Company utilizes this clinical health information network in providing services to its client plan members and retail customers. The Company expensed fees for the use of this network of $56 million, $32 million and $45 million in the years ended December 31, 2020, 2019 and 2018, respectively. The Company's investment in and equity in the earnings of SureScripts for all periods presented is immaterial.

The Company has an equity method investment in Heartland Healthcare Services, LLC ("Heartland"). Heartland operates several LTC pharmacies in four states. Heartland paid the Company $77 million, $96 million and $135 million for pharmaceutical inventory purchases during the years ended December 31, 2020, 2019 and 2018, respectively. Additionally, the Company performs certain collection functions for Heartland and then transfers those customer cash collections to Heartland. The Company's investment in and equity in the earnings of Heartland for all periods presented is immaterial.

During the years ended December 31, 2020 and 2019, the Company made charitable contributions of $50 million and $30 million, respectively, to the CVS Health Foundation, a non-profit entity that focuses on health, education and community involvement programs. The charitable contributions were recorded as operating expenses in the consolidated statements of operations within the Corporate/Other segment for the years ended December 31, 2020 and 2019.

Discontinued Operations

In connection with certain business dispositions completed between 1995 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Linens 'n Things and Bob's Stores, each of which subsequently filed for bankruptcy. The Company's loss from discontinued operations includes lease-related costs that the Company believes it will likely be required to satisfy pursuant to these lease guarantees. See "Lease Guarantees" in Note 16 ''Commitments and Contingencies'' for additional information.

Below is a summary of the results of discontinued operations for the year ended December 31, 2020.

In millions	**2020**
Loss from discontinued operations	$ (12)
Income tax benefit	3
Loss from discontinued operations, net of tax	$ (9)

Results from discontinued operations were immaterial for the years ended December 31, 2019 and 2018.

New Accounting Pronouncements Recently Adopted

Measurement of Credit Losses on Financial Instruments
In June 2016, the Financial Accounting Standards Board ("FASB") issued ASU 2016-13, *Financial Instruments - Credit Losses* (Topic 326). This standard requires the use of a forward-looking expected credit loss impairment model for trade and other receivables, held-to-maturity debt securities, loans and other instruments. This standard also requires impairments and recoveries for available-for-sale debt securities to be recorded through an allowance account and revises certain disclosure requirements. The Company adopted this new accounting standard on January 1, 2020. The Company adopted the credit loss impairment model on a modified retrospective basis and recorded a $3 million cumulative effect adjustment to reduce retained earnings as of the adoption date. The Company adopted the available-for-sale debt security impairment model on a prospective

basis. The adoption of this standard did not have a material impact on the Company's consolidated operating results, cash flows or financial condition.

Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement that is a Service Contract
In August 2018, the FASB issued ASU 2018-15, *Intangibles - Goodwill and other - Internal-Use Software* (Topic 350-40): *Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement that is a Service Contract.* This standard requires a customer in a cloud computing arrangement that is a service contract to follow the internal-use software guidance in Topic 350-40 to determine which implementation costs to capitalize as assets. The Company adopted this new accounting guidance on January 1, 2020 on a prospective basis. The adoption of this standard did not have a material impact on the Company's consolidated operating results, cash flows, financial condition or related disclosures.

New Accounting Pronouncements Not Yet Adopted

Simplifying the Accounting for Income Taxes
In December 2019, the FASB issued ASU 2019-12, *Simplifying the Accounting for Income Taxes* (Topic 740). This standard simplifies the accounting for income taxes by eliminating certain exceptions to the guidance in Accounting Standards Codification ("ASC") 740 related to the approach for intraperiod tax allocation, the methodology for calculating income taxes in an interim period and the recognition of deferred tax liabilities for outside basis differences. The standard also simplifies aspects of the accounting for franchise taxes and enacted changes in tax laws or rates and clarifies the accounting for transactions that result in a step-up in the tax basis of goodwill. The Company adopted this new accounting standard on January 1, 2021. The adoption of this standard did not have a material impact on the Company's consolidated operating results, cash flows, financial condition or related disclosures.

Targeted Improvements to the Accounting for Long-Duration Insurance Contracts
In August 2018, the FASB issued ASU 2018-12, *Targeted Improvements to the Accounting for Long-Duration Contracts* (Topic 944). 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 liability 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 and requires additional disclosures regarding the long duration insurance contract liabilities in the Company's interim and annual financial statements. The standard is effective for public companies for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2022. The Company is currently evaluating the effect that implementation of this standard will have on the Company's consolidated operating results, cash flows, financial condition and related disclosures.

2. Acquisitions and Divestitures

Acquisition of Aetna

On the Aetna Acquisition Date, the Company acquired 100% of the outstanding shares and voting interests of Aetna for a combination of cash and stock. Under the terms of the merger agreement, Aetna shareholders received $145.00 in cash and 0.8378 CVS Health shares for each Aetna share. The transaction valued Aetna at approximately $212 per share or approximately $70 billion. Including the assumption of Aetna's debt, the total value of the transaction was approximately $78 billion. The Company financed the cash portion of the purchase price through a combination of cash on hand and by issuing approximately $45 billion of new debt, including senior notes and term loans. The Company acquired Aetna to help improve the consumer health care experience by combining Aetna's health care benefits products and services with CVS Health's more than 9,900 retail locations, approximately 1,100 walk-in medical clinics and integrated pharmacy capabilities with the goal of becoming the new, trusted front door to health care.

The transaction has been accounted for using the acquisition method of accounting which requires, among other things, the assets acquired and liabilities assumed to be recognized at their fair values at the date of acquisition. The following table summarizes the fair values of the assets acquired and liabilities assumed at the date of acquisition:

In millions	
Cash and cash equivalents	$ 6,565
Accounts receivable	4,094
Other current assets	3,894
Investments (current and long-term)	17,984
Goodwill	47,755
Intangible assets	22,571
Other assets	8,249
Total assets acquired	111,112
Health care costs payable	5,302
Other current liabilities	9,940
Debt (current and long-term)	8,098
Deferred income taxes	4,608
Other long-term liabilities	13,078
Total liabilities assumed	41,026
Noncontrolling interests	320
Total consideration transferred	$ 69,766

The Company's assessment of the fair value of assets acquired and liabilities assumed was finalized during the fourth quarter of 2019. Measurement period adjustments to assets acquired and liabilities assumed during the year ended December 31, 2019 primarily were due to additional information received related to certain intangible asset valuations and contingencies and the related impact on the accounting for income taxes and goodwill. There were no material income statement measurement period adjustments recorded during the year ended December 31, 2019.

Consolidated Results of Operations

The Company's consolidated operating results for the year ended December 31, 2018, included $5.6 billion of revenues and $146 million of income before income tax provision associated with the operating results of Aetna from the Aetna Acquisition Date to December 31, 2018. During the year ended December 31, 2018, the Company incurred transaction costs of $147 million associated with the Aetna Acquisition that were recorded within operating expenses.

Unaudited Pro Forma Financial Information

The following unaudited pro forma information presents a summary of the Company's combined operating results for the year ended December 31, 2018 as if the Aetna acquisition and the related financing transactions had occurred on January 1, 2018. The following pro forma financial information is not necessarily indicative of the Company's operating results as they would have been had the acquisition been effected on the assumed date, nor is it necessarily an indication of trends in future results for a number of reasons, including differences between the assumptions used to prepare the pro forma financial information, basic shares outstanding and dilutive equivalents, cost savings from operating efficiencies, potential synergies, and the impact of incremental costs incurred in integrating the businesses.

In millions, except per share data	**Year Ended December 31, 2018**
Total revenues	$ 243,232
Income from continuing operations	1,152
Basic earnings per share from continuing operations attributable to CVS Health	$ 0.89
Diluted earnings per share from continuing operations attributable to CVS Health	$ 0.88

The pro forma results for the year ended December 31, 2018 include adjustments related to the following purchase accounting and acquisition-related items:

- Elimination of intercompany transactions between CVS Health and Aetna;
- Elimination of estimated foregone interest income associated with (i) cash assumed to have been used to partially fund the Aetna Acquisition and (ii) adjusting the amortized cost of Aetna's investment portfolio to fair value as of the completion of the Aetna Acquisition;
- Elimination of historical intangible asset, deferred acquisition cost and capitalized software amortization expense and addition of amortization expense based on the values of identified intangible assets;
- Additional interest expense from (i) the long-term debt issued to partially fund the Aetna Acquisition and (ii) the amortization of the fair value adjustment to assumed long-term debt.
- Additional depreciation expense related to the adjustment of Aetna's property and equipment to fair value;
- Adjustments to align CVS Health's and Aetna's accounting policies;
- Elimination of transaction related costs; and
- Tax effects of the adjustments noted above.

Divestiture of Workers' Compensation Business

On July 31, 2020, the Company sold its Workers' Compensation business for approximately $850 million. The results of this business have historically been reported within the Health Care Benefits segment. The Company recorded a pre-tax gain on the divestiture of $269 million in the year ended December 31, 2020, which is reflected as a reduction in operating expenses in the Company's consolidated statement of operations within the Health Care Benefits segment.

Divestiture of Brazilian Subsidiary

On July 1, 2019, the Company sold its Brazilian subsidiary, Onofre, for an immaterial amount. Onofre operated 50 retail pharmacy stores, the results of which historically had been reported within the Retail/LTC segment. The Company recorded a pre-tax loss on the divestiture of $205 million in the year ended December 31, 2019, which primarily relates to the elimination of the cumulative translation adjustment from accumulated other comprehensive income and is reflected in operating expenses in the Company's consolidated statement of operations within the Retail/LTC segment.

Divestiture of RxCrossroads Subsidiary

On January 2, 2018, the Company sold its RxCrossroads subsidiary, the results of which had historically been reported within the Retail/LTC segment, to McKesson Corporation for $725 million. The Company recorded a pre-tax loss on the divestiture of $86 million in the year ended December 31, 2018 which was reflected in operating expenses in the Company's consolidated statement of operations within the Retail/LTC segment.

3. Investments

Total investments at December 31, 2020 and 2019 were as follows:

	2020			2019		
In millions	**Current**	**Long-term**	**Total**	**Current**	**Long-term**	**Total**
Debt securities available for sale	$ 2,774	$ 18,414	$ 21,188	$ 2,251	$ 14,671	$ 16,922
Mortgage loans	226	821	1,047	122	1,091	1,213
Other investments	—	1,577	1,577	—	1,552	1,552
Total investments	$ 3,000	$ 20,812	$ 23,812	$ 2,373	$ 17,314	$ 19,687

At December 31, 2020 and 2019, the Company held investments of $524 million and $537 million, respectively, related to the 2012 conversion of an existing group annuity contract from a participating to a non-participating contract. The conversion occurred prior to the Aetna Acquisition. These investments are included in the total investments of large case pensions supporting non-experience-rated products. Although these investments are not accounted for as Separate Accounts assets, they are legally segregated and are not subject to claims that arise out of the Company's business and only support future policy benefits obligations under that group annuity contract.

Debt Securities

Debt securities available for sale at December 31, 2020 and 2019 were as follows:

In millions	Amortized Cost [1]	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2020				
Debt securities:				
U.S. government securities	$ 2,341	$ 128	$ —	$ 2,469
States, municipalities and political subdivisions	2,556	172	—	2,728
U.S. corporate securities	7,879	1,023	(8)	8,894
Foreign securities	2,595	324	(1)	2,918
Residential mortgage-backed securities	673	32	—	705
Commercial mortgage-backed securities	962	84	—	1,046
Other asset-backed securities	2,369	36	(2)	2,403
Redeemable preferred securities	21	4	—	25
Total debt securities [2]	$ 19,396	$ 1,803	$ (11)	$ 21,188
December 31, 2019				
Debt securities:				
U.S. government securities	$ 1,791	$ 62	$ (1)	$ 1,852
States, municipalities and political subdivisions	2,202	108	(1)	2,309
U.S. corporate securities	7,167	573	(3)	7,737
Foreign securities	2,149	200	(1)	2,348
Residential mortgage-backed securities	508	25	—	533
Commercial mortgage-backed securities	654	46	—	700
Other asset-backed securities	1,397	13	(5)	1,405
Redeemable preferred securities	30	8	—	38
Total debt securities [2]	$ 15,898	$ 1,035	$ (11)	$ 16,922

(1) Effective January 1, 2020, the Company adopted the available-for-sale debt security impairment model under ASU 2016-13, *Financial Instruments -Credit Losses* (Topic 326). The new impairment model requires the write down of amortized cost through an allowance for credit losses, rather than through a reduction of the amortized cost basis of the available-for-sale debt security. There was no allowance for credit losses recorded on available-for-sale debt securities at December 31, 2020. As the Company adopted the new available-for-sale debt security impairment model on a prospective basis, there was no allowance for credit losses recorded on available-for-sale debt securities at December 31, 2019.

(2) Investment risks associated with the Company's experience-rated products generally do not impact the Company's consolidated operating results. At December 31, 2020, debt securities with a fair value of $919 million, gross unrealized capital gains of $135 million and no gross unrealized capital losses and at December 31, 2019, debt securities with a fair value of $965 million, gross unrealized capital gains of $83 million and no gross unrealized capital losses were included in total debt securities, but support experience-rated products. Changes in net unrealized capital gains (losses) on these securities are not reflected in accumulated other comprehensive income.

The amortized cost and fair value of debt securities at December 31, 2020 are shown below by contractual maturity. Actual maturities may differ from contractual maturities because securities may be restructured, called or prepaid, or the Company intends to sell a security prior to maturity.

In millions	Amortized Cost	Fair Value
Due to mature:		
Less than one year	$ 1,276	$ 1,291
One year through five years	6,346	6,698
After five years through ten years	3,748	4,121
Greater than ten years	4,022	4,924
Residential mortgage-backed securities	673	705
Commercial mortgage-backed securities	962	1,046
Other asset-backed securities	2,369	2,403
Total	$ 19,396	$ 21,188

Mortgage-Backed and Other Asset-Backed Securities
All of the Company's residential mortgage-backed securities at December 31, 2020 were issued by the Government National Mortgage Association, the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation and carry agency guarantees and explicit or implicit guarantees by the U.S. Government. At December 31, 2020, the Company's residential mortgage-backed securities had an average credit quality rating of AAA and a weighted average duration of 2.4 years.

The Company's commercial mortgage-backed securities have underlying loans that are dispersed throughout the United States. Significant market observable inputs used to value these securities include loss severity and probability of default. At December 31, 2020, these securities had an average credit quality rating of AAA and a weighted average duration of 6.1 years.

The Company's other asset-backed securities have a variety of underlying collateral (e.g., automobile loans, credit card receivables, home equity loans and commercial loans). Significant market observable inputs used to value these securities include the unemployment rate, loss severity and probability of default. At December 31, 2020, these securities had an average credit quality rating of AA and a weighted average duration of 1.1 years.

Summarized below are the debt securities the Company held at December 31, 2020 and 2019 that were in an unrealized capital loss position, aggregated by the length of time the investments have been in that position:

	Less than 12 months			Greater than 12 months			Total		
In millions, except number of securities	**Number of Securities**	**Fair Value**	**Unrealized Losses**	**Number of Securities**	**Fair Value**	**Unrealized Losses**	**Number of Securities**	**Fair Value**	**Unrealized Losses**
December 31, 2020									
Debt securities:									
U.S. government securities	32	$ 205	$ —	—	$ —	$ —	32	$ 205	$ —
States, municipalities and political subdivisions	49	83	—	—	—	—	49	83	—
U.S. corporate securities	145	155	8	2	—	—	147	155	8
Foreign securities	41	69	1	5	5	—	46	74	1
Residential mortgage-backed securities	23	26	—	3	—	—	26	26	—
Commercial mortgage-backed securities	22	75	—	—	—	—	22	75	—
Other asset-backed securities	156	256	1	49	41	1	205	297	2
Total debt securities	468	$ 869	$ 10	59	$ 46	$ 1	527	$ 915	$ 11
December 31, 2019									
Debt securities:									
U.S. government securities	52	$ 168	$ 1	—	$ —	$ —	52	$ 168	$ 1
States, municipalities and political subdivisions	66	115	1	2	5	—	68	120	1
U.S. corporate securities	181	305	2	2	—	1	183	305	3
Foreign securities	39	75	1	—	—	—	39	75	1
Residential mortgage-backed securities	30	16	—	9	—	—	39	16	—
Commercial mortgage-backed securities	16	49	—	—	—	—	16	49	—
Other asset-backed securities	138	254	1	187	182	4	325	436	5
Total debt securities	522	$ 982	$ 6	200	$ 187	$ 5	722	$ 1,169	$ 11

The Company reviewed the securities in the table above and concluded that they are performing assets generating investment income to support the needs of the Company's business. In performing this review, the Company considered factors such as the quality of the investment security based on research performed by the Company's internal credit analysts and external rating agencies and the prospects of realizing the carrying value of the security based on the investment's current prospects for recovery. As of December 31, 2020, the Company did not intend to sell these securities, and did not believe it was more likely than not that it would be required to sell these securities prior to the anticipated recovery of their amortized cost basis.

The maturity dates for debt securities in an unrealized capital loss position at December 31, 2020 were as follows:

	Supporting experience-rated products		Supporting remaining products		Total	
In millions	**Fair Value**	**Unrealized Losses**	**Fair Value**	**Unrealized Losses**	**Fair Value**	**Unrealized Losses**
Due to mature:						
Less than one year	$ —	$ —	$ 9	$ —	$ 9	$ —
One year through five years	—	—	300	4	300	4
After five years through ten years	4	—	165	4	169	4
Greater than ten years	3	—	36	1	39	1
Residential mortgage-backed securities	—	—	26	—	26	—
Commercial mortgage-backed securities	2	—	73	—	75	—
Other asset-backed securities	5	—	292	2	297	2
Total	$ 14	$ —	$ 901	$ 11	$ 915	$ 11

Mortgage Loans

The Company's mortgage loans are collateralized by commercial real estate. During the years ended December 31, 2020 and 2019, the Company had the following activity in its mortgage loan portfolio:

In millions	**2020**	**2019**
New mortgage loans	$ 63	$ 131
Mortgage loans fully repaid	187	234
Mortgage loans foreclosed	—	—

The Company assesses mortgage loans on a regular basis for credit impairments, and assigns a credit quality indicator to each loan. The Company's credit quality indicator is internally developed and categorizes each loan in its portfolio on a scale from 1 to 7. These indicators are based upon several factors, including current loan-to-value ratios, current and future property cash flow, property condition, market trends, creditworthiness of the borrower and deal structure.

- *Category 1* - Represents loans of superior quality.
- *Categories 2 to 4* - Represent loans where credit risk is minimal to acceptable; however, these loans may display some susceptibility to economic changes.
- *Categories 5 and 6* - Represent loans where credit risk is not substantial, but these loans warrant management's close attention.
- *Category 7* - Represents loans where collections are potentially at risk; if necessary, an impairment is recorded.

Based upon the Company's assessments at December 31, 2020 and 2019, the amortized cost basis of the Company's mortgage loans within each credit quality indicator by year of origination was as follows:

	Amortized Cost Basis by Year of Origination						
In millions, except credit quality indicator	**2020**	**2019**	**2018**	**2017**	**2016**	**Prior**	**Total**
December 31, 2020							
1	$ —	$ —	$ —	$ 22	$ —	$ 37	$ 59
2 to 4	46	96	91	124	101	494	952
5 and 6	—	—	3	4	—	29	36
7	—	—	—	—	—	—	—
Total	$ 46	$ 96	$ 94	$ 150	$ 101	$ 560	$ 1,047
December 31, 2019							
1		$ —	$ —	$ 15	$ —	$ 43	$ 58
2 to 4		93	93	206	140	611	1,143
5 and 6		—	—	—	—	12	12
7		—	—	—	—	—	—
Total		$ 93	$ 93	$ 221	$ 140	$ 666	$ 1,213

At December 31, 2020 scheduled mortgage loan principal repayments were as follows:

In millions	
2021	$ 226
2022	147
2023	121
2024	172
2025	93
Thereafter	288
Total	$ 1,047

Net Investment Income

Sources of net investment income for the years ended December 31, 2020, 2019 and 2018 were as follows:

In millions	**2020**	**2019**	**2018**
Debt securities	$ 598	$ 589	$ 61
Mortgage loans	60	71	6
Other investments	123	194	593
Gross investment income	781	854	660
Investment expenses	(35)	(42)	(3)
Net investment income (excluding net realized capital gains or losses)	746	812	657
Net realized capital gains [(1)]	52	199	3
Net investment income [(2)]	$ 798	$ 1,011	$ 660

(1) Net realized capital gains are net of yield-related impairment losses on debt securities of $49 million for the year ended December 31, 2020. There were no credit-related losses on debt securities in the year ended December 31, 2020. Net realized capital gains are net of other-than-temporary impairment ("OTTI") losses on debt securities of $24 million for the year ended December 31, 2019. There were no material OTTI losses on debt securities for the year ended December 31, 2018.

(2) Net investment income includes $42 million, $44 million and $4 million for the years ended December 31, 2020, 2019 and 2018, respectively, related to investments supporting experience-rated products.

Capital gains and losses recognized during the year ended December 31, 2020 related to investments in equity securities held as of December 31, 2020 were not material.

Excluding amounts related to experience-rated products, proceeds from the sale of available for sale debt securities and the related gross realized capital gains and losses in the years ended December 31, 2020, 2019 and subsequent to the Aetna Acquisition Date in 2018 were as follows:

In millions	**2020**	**2019**	**2018**
Proceeds from sales	$ 3,913	$ 4,773	$ 389
Gross realized capital gains	80	146	2
Gross realized capital losses	62	17	2

4. Fair Value

The preparation of the Company's consolidated financial statements in accordance with GAAP requires certain assets and liabilities to be reflected at their fair value and others to be reflected on another basis, such as an adjusted historical cost basis. In this note, the Company provides details on the fair value of financial assets and liabilities and how it determines those fair values. The Company presents this information for those financial instruments that are measured at fair value for which the change in fair value impacts net income (loss) attributable to CVS Health or other comprehensive income separately from other financial assets and liabilities.

Financial Instruments Measured at Fair Value on the Consolidated Balance Sheets

Certain of the Company's financial instruments are measured at fair value on the consolidated balance sheets. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by GAAP. The following are the levels of the hierarchy and a brief description of the type of valuation information ("valuation inputs") that qualifies a financial asset or liability for each level:

- Level 1 – Unadjusted quoted prices for identical assets or liabilities in active markets.
- Level 2 – Valuation inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, valuation inputs that are observable that are not prices (such as interest rates and credit risks) and valuation inputs that are derived from or corroborated by observable markets.
- Level 3 – Developed from unobservable data, reflecting the Company's assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, the Company uses these quoted market prices to determine the fair value of financial assets and liabilities and classifies these assets and liabilities in Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, the Company estimates fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities are classified in Level 2. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

The following is a description of the valuation methodologies used for the Company's financial assets and liabilities that are measured at fair value, including the general classification of such assets and liabilities pursuant to the valuation hierarchy.

Cash and Cash Equivalents – The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. When quoted prices are available in an active market, cash equivalents are classified in Level 1 of the fair value hierarchy. Fair values of cash equivalent instruments that do not trade on a regular basis in active markets are classified as Level 2.

Debt Securities – Where quoted prices are available in an active market, debt securities are classified in Level 1 of the fair value hierarchy. The Company's Level 1 debt securities consist primarily of U.S. Treasury securities.

The fair values of the Company's Level 2 debt securities are obtained using models, such as matrix pricing, which use quoted market prices of debt securities with similar characteristics or discounted cash flows to estimate fair value. The Company reviews these prices to ensure they are based on observable market inputs that include quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets and inputs that are observable that are not prices (such as interest rates and credit risks). The Company also reviews the methodologies and the assumptions used to calculate prices from these observable inputs. On a quarterly basis, the Company selects a sample of its Level 2 debt securities' prices and compares them to prices provided by a secondary source. Variances over a specified threshold are identified and reviewed to confirm the price provided by the primary source represents an appropriate estimate of fair value. In addition, the Company's internal investment team consistently compares the prices obtained for select Level 2 debt securities to the team's own independent estimates of fair value for those securities. The Company obtained one price for each of its Level 2 debt securities and did not adjust any of those prices at December 31, 2020 or 2019.

The Company also values certain debt securities using Level 3 inputs. For Level 3 debt securities, fair values are determined by outside brokers or, in the case of certain private placement securities, are priced internally. Outside brokers determine the value of these debt securities through a combination of their knowledge of the current pricing environment and market flows. The Company did not have any broker quoted debt securities for the years ended December 31, 2020 and 2019. For some private placement securities, the Company's internal staff determines the value of these debt securities by analyzing spreads of corporate and sector indices as well as interest spreads of comparable public bonds. Examples of these private placement Level 3 debt securities include certain U.S. and foreign securities and certain tax-exempt municipal securities.

Equity Securities – The Company currently has two classifications of equity securities: those that are publicly traded and those that are privately placed. Publicly-traded equity securities are classified in Level 1 because quoted prices are available for these securities in an active market. For privately placed equity securities, there is no active market; therefore, these securities are classified in Level 3 because the Company prices these securities through an internal analysis of each investment's financial statements and cash flow projections. Significant unobservable inputs consist of earnings and revenue multiples, discount for lack of marketability and comparability adjustments. An increase or decrease in any of these unobservable inputs would have resulted in a change in the fair value measurement.

There were no financial liabilities measured at fair value on a recurring basis on the consolidated balance sheets at December 31, 2020 or 2019. Financial assets measured at fair value on a recurring basis on the consolidated balance sheets at December 31, 2020 and 2019 were as follows:

In millions	**Level 1**	**Level 2**	**Level 3**	**Total**
December 31, 2020				
Cash and cash equivalents	$ 4,210	$ 3,869	$ —	$ 8,079
Debt securities:				
U.S. government securities	2,370	99	—	2,469
States, municipalities and political subdivisions	—	2,727	1	2,728
U.S. corporate securities	—	8,842	52	8,894
Foreign securities	—	2,918	—	2,918
Residential mortgage-backed securities	—	705	—	705
Commercial mortgage-backed securities	—	1,046	—	1,046
Other asset-backed securities	—	2,403	—	2,403
Redeemable preferred securities	—	24	1	25
Total debt securities	2,370	18,764	54	21,188
Equity securities	17	—	30	47
Total	$ 6,597	$ 22,633	$ 84	$ 29,314
December 31, 2019				
Cash and cash equivalents	$ 3,397	$ 2,286	$ —	$ 5,683
Debt securities:				
U.S. government securities	1,785	67	—	1,852
States, municipalities and political subdivisions	—	2,309	—	2,309
U.S. corporate securities	—	7,700	37	7,737
Foreign securities	—	2,348	—	2,348
Residential mortgage-backed securities	—	533	—	533
Commercial mortgage-backed securities	—	700	—	700
Other asset-backed securities	—	1,405	—	1,405
Redeemable preferred securities	—	26	12	38
Total debt securities	1,785	15,088	49	16,922
Equity securities	34	—	39	73
Total	$ 5,216	$ 17,374	$ 88	$ 22,678

The changes in the balances of Level 3 financial assets during the year ended December 31, 2020 were as follows:

In millions	States, municipalities and political subdivisions	U.S. corporate securities	Equity securities	Redeemable preferred securities	Total
Beginning balance	$ —	$ 37	$ 39	$ 12	$ 88
Net realized and unrealized capital gains (losses):					
Included in earnings	—	(11)	(3)	18	4
Included in other comprehensive income	—	—	—	(5)	(5)
Purchases	—	27	3	—	30
Sales	—	—	(9)	(24)	(33)
Settlements	—	(1)	—	—	(1)
Transfers into Level 3, net	1	—	—	—	1
Ending balance	$ 1	$ 52	$ 30	$ 1	$ 84

The change in unrealized capital losses included in other comprehensive income associated with Level 3 financial assets which were held as of December 31, 2020 was $4 million during the year ended December 31, 2020.

The changes in the balances of Level 3 financial assets during the year ended December 31, 2019 were as follows:

In millions	Foreign securities	U.S. corporate securities	Equity securities	Redeemable preferred securities	Total
Beginning balance	$ 3	$ 67	$ 54	$ 7	$ 131
Net realized and unrealized capital gains (losses):					
Included in earnings	—	(33)	13	—	(20)
Included in other comprehensive income	—	18	—	5	23
Purchases	2	3	13	—	18
Sales	—	(6)	(41)	—	(47)
Settlements	(1)	(12)	—	—	(13)
Transfers out of Level 3, net	(4)	—	—	—	(4)
Ending balance	$ —	$ 37	$ 39	$ 12	$ 88

The total gross transfers into (out of) Level 3 during the years ended December 31, 2020 and 2019 were as follows:

In millions	2020	2019
Gross transfers into Level 3	$ 1	$ —
Gross transfers out of Level 3	—	(4)
Net transfers out of Level 3	$ 1	$ (4)

Financial Instruments Not Measured at Fair Value on the Consolidated Balance Sheets

The carrying value and estimated fair value classified by level of fair value hierarchy for financial instruments carried on the consolidated balance sheets at adjusted cost or contract value at December 31, 2020 and 2019 were as follows:

	Carrying	Estimated Fair Value			
In millions	**Value**	**Level 1**	**Level 2**	**Level 3**	**Total**
December 31, 2020					
Assets:					
Mortgage loans	$ 1,047	$ —	$ —	$ 1,070	$ 1,070
Equity securities [1]	145	N/A	N/A	N/A	N/A
Liabilities:					
Investment contract liabilities:					
With a fixed maturity	5	—	—	5	5
Without a fixed maturity	322	—	—	371	371
Long-term debt	64,647	75,940	—	—	75,940
December 31, 2019					
Assets:					
Mortgage loans	$ 1,213	$ —	$ —	$ 1,239	$ 1,239
Equity securities [1]	149	N/A	N/A	N/A	N/A
Liabilities:					
Investment contract liabilities:					
With a fixed maturity	5	—	—	5	5
Without a fixed maturity	372	—	—	392	392
Long-term debt	68,480	74,306	—	—	74,306

(1) It was not practical to estimate the fair value of these cost-method investments as it represents shares of unlisted companies. See Note 1 ‘‘Significant Accounting Policies’’ for additional information regarding the valuation of cost method investments.

Separate Accounts Measured at Fair Value on the Consolidated Balance Sheets

Separate Accounts assets relate to the Company’s large case pensions products which represent funds maintained to meet specific objectives of contract holders. Since contract holders bear the investment risk of these assets, a corresponding Separate Accounts liability has been established equal to the assets. These assets and liabilities are carried at fair value. Net investment income and capital gains and losses on Separate Accounts assets accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from the Company’s other businesses. Deposits, withdrawals, net investment income and realized and unrealized capital gains and losses on Separate Accounts assets are not reflected in the consolidated statements of operations, shareholders’ equity or cash flows.

Separate Accounts assets include debt and equity securities. The valuation methodologies used for these assets are similar to the methodologies described above in this Note 4 ‘‘Fair Value.’’ Separate Accounts assets also include investments in common/collective trusts that are carried at fair value. Common/collective trusts invest in other investment funds otherwise known as the underlying funds. The Separate Accounts’ interests in the common/collective trust funds are based on the fair values of the investments of the underlying funds and therefore are classified in Level 2. The assets in the underlying funds primarily consist of equity securities. Investments in common/collective trust funds are valued at their respective net asset value (“NAV”) per share/unit on the valuation date.

Separate Accounts financial assets at December 31, 2020 and 2019 were as follows:

	December 31, 2020				December 31, 2019			
In millions	**Level 1**	**Level 2**	**Level 3**	**Total**	**Level 1**	**Level 2**	**Level 3**	**Total**
Cash and cash equivalents	$ 2	$ 186	$ —	$ 188	$ 2	$ 143	$ —	$ 145
Debt securities	1,465	2,634	—	4,099	1,224	2,589	—	3,813
Equity securities	—	2	—	2	—	2	—	2
Common/collective trusts	—	563	—	563	—	499	—	499
Total [1]	$ 1,467	$ 3,385	$ —	$ 4,852	$ 1,226	$ 3,233	$ —	$ 4,459

(1) Excludes $29 million of other receivables at December 31, 2020.

During the years ended December 31, 2020 and 2019, the Company had no gross transfers of Separate Accounts financial assets into or out of Level 3.

Offsetting Financial Assets and Liabilities

Certain financial assets and liabilities are offset in the Company's consolidated balance sheets or are subject to master netting arrangements or similar agreements with the applicable counterparty. Financial assets subject to offsetting and enforceable master netting arrangements were $2 million as of December 31, 2020. Financial liabilities subject to offsetting and enforceable master netting arrangements were $3 million as of December 31, 2019.

5. Goodwill and Other Intangibles

Goodwill

Below is a summary of the changes in the carrying amount of goodwill by segment for the years ended December 31, 2020 and 2019:

In millions	**Pharmacy Services**	**Retail/ LTC**	**Health Care Benefits**	**Total**
Balance at December 31, 2018	$ 23,388	$ 10,806	$ 44,484	$ 78,678
Segment realignment	194	—	(194)	—
Purchase accounting adjustments	—	—	1,071	1,071
Other	(1)	1	—	—
Balance at December 31, 2019	23,581	10,807	45,361	79,749
Acquisitions	34	—	274	308
Divestiture of Workers' Compensation business	—	—	(505)	(505)
Balance at December 31, 2020	$ 23,615	$ 10,807	$ 45,130	$ 79,552

During the year ended December 31, 2020, the decrease in the carrying amount of goodwill was primarily driven by the divestiture of the Workers' Compensation business, partially offset by goodwill associated with immaterial acquisitions. During the year ended December 31, 2019, the increase in the carrying amount of goodwill was primarily driven by purchase accounting adjustments associated with the Aetna Acquisition. See Note 2 ''Acquisitions and Divestitures'' for further discussion regarding the Workers' Compensation business divestiture and the Aetna Acquisition.

During 2019, the Company also realigned the composition of its segments to correspond with changes to its operating model and to reflect how the Chief Operating Decision Maker (the "CODM") reviews information and manages the business. As a result of this realignment, the Company reallocated the associated goodwill balance to the Pharmacy Services and Health Care Benefits segments based on a relative fair value approach.

Goodwill Impairment
During the third quarter of both 2020 and 2019, the Company performed its required annual impairment tests of goodwill. The results of these impairment tests indicated that there was no impairment of goodwill. At both December 31, 2020 and 2019, cumulative goodwill impairments were $6.1 billion.

The LTC reporting unit has experienced industry-wide challenges that have impacted management's ability to grow the business at the rate that was originally estimated when the Company acquired Omnicare, Inc. ("Omnicare") in 2015. Those challenges include lower client retention rates, lower occupancy rates in skilled nursing facilities, the deteriorating financial health of numerous skilled nursing facility customers which resulted in a number of customer bankruptcies in 2018, and continued facility reimbursement pressures.

Following the update of its current and long-term forecasts in June 2018, management determined that there were indicators that the LTC reporting unit's goodwill may be impaired and, accordingly, management performed an interim goodwill impairment test as of June 30, 2018. The results of that interim impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in a $3.9 billion pre-tax goodwill impairment charge in the second quarter of 2018.

During the third quarter of 2018, the Company performed its required annual impairment tests of goodwill and concluded there was no impairment of goodwill or trade names.

During the fourth quarter of 2018, the LTC reporting unit missed its forecast primarily due to operational issues and customer liquidity issues, including one significant customer bankruptcy. Additionally, LTC management submitted updated projected financial results which showed significant additional deterioration primarily due to continued industry and operational challenges including lower occupancy rates in skilled nursing facilities, significant deterioration in the financial health of numerous skilled nursing facility customers and continued facility reimbursement pressures. Based on these updated projections, management determined that there were indicators that the LTC reporting unit's goodwill may be further impaired and, accordingly, management performed an interim goodwill impairment test during the fourth quarter of 2018. The results of that interim impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in an additional $2.2 billion pre-tax goodwill impairment charge in the fourth quarter of 2018.

As of December 31, 2020, the remaining goodwill balance in the LTC reporting unit was $431 million.

Intangible Assets

The following table is a summary of the Company's intangible assets as of December 31, 2020 and 2019:

In millions, except weighted average life	**Gross Carrying Amount**	**Accumulated Amortization**	**Net Carrying Amount**	**Weighted Average Life (years)**
2020				
Trademarks (indefinite-lived)	$ 10,498	$ —	$ 10,498	N/A
Customer contracts/relationships and covenants not to compete	24,952	(8,923)	16,029	14.9
Technology	1,060	(739)	321	3.0
Provider networks	4,203	(440)	3,763	20.0
Value of Business Acquired	590	(119)	471	20.0
Other	320	(260)	60	7.7
Total	$ 41,623	$ (10,481)	$ 31,142	15.2
2019				
Trademarks (indefinite-lived)	$ 10,498	$ —	$ 10,498	N/A
Customer contracts/relationships and covenants not to compete	25,447	(8,128)	17,319	14.8
Technology	1,060	(386)	674	3.0
Provider networks	4,200	(229)	3,971	20.0
Value of Business Acquired	590	(63)	527	20.0
Other	364	(232)	132	8.1
Total	$ 42,159	$ (9,038)	$ 33,121	15.1

Amortization expense for intangible assets totaled $2.3 billion, $2.4 billion and $1.0 billion for the years ended December 31, 2020, 2019 and 2018, respectively. The projected annual amortization expense for the Company's intangible assets for the next five years is as follows:

In millions	
2021	$ 2,249
2022	1,842
2023	1,812
2024	1,770
2025	1,718

6. Leases

The Company adopted ASU 2016-02, *Leases* (Topic 842) ("ASC 842") on January 1, 2019 on a modified retrospective basis. As a result, the Company's lease disclosures as of and for the years ended December 31, 2020 and 2019 are reported under ASC 842. Comparative financial information for the year ended December 31, 2018 has not been restated and continues to be reported under ASC 840, the lease accounting standard in effect for that period.

Disclosure Subsequent to the Adoption of the New Lease Accounting Standard (ASU 2016-02)

The Company leases most of its retail stores and mail order facilities and certain distribution centers and corporate offices under operating or finance leases, typically with initial terms of 15 to 25 years. The Company also leases certain equipment and other assets under operating or finance leases, typically with initial terms of 3 to 10 years**.**

In addition, the Company leases pharmacy space at the stores of another retail chain for which the noncancelable contractual term of the pharmacy lease arrangement exceeds the remaining estimated economic life of the buildings. For these pharmacy lease arrangements, the Company concluded that for accounting purposes the lease term was the remaining estimated economic life of the buildings. Consequently, most of these individual pharmacy leases are finance leases.

The following table is a summary of the components of net lease cost for the years ended December 31, 2020 and 2019:

In millions	**2020**	**2019**
Operating lease cost	$ 2,670	$ 2,720
Finance lease cost:		
Amortization of right-of-use assets	56	38
Interest on lease liabilities	58	44
Total finance lease costs	114	82
Short-term lease costs	22	24
Variable lease costs	599	581
Less: sublease income	55	50
Net lease cost	$ 3,350	$ 3,357

Supplemental cash flow information related to leases for the years ended December 31, 2020 and 2019 is as follows:

In millions	**2020**	**2019**
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flows paid for operating leases	$ 2,724	$ 2,701
Operating cash flows paid for interest portion of finance leases	58	44
Financing cash flows paid for principal portion of finance leases	34	26
Right-of-use assets obtained in exchange for lease obligations:		
Operating leases	1,679	1,824
Finance leases	313	283

Supplemental balance sheet information related to leases as of December 31, 2020 and 2019 is as follows:

In millions, except remaining lease term and discount rate	2020	2019
Operating leases:		
Operating lease right-of-use assets	$ 20,729	$ 20,860
Current portion of operating lease liabilities	$ 1,638	$ 1,596
Long-term operating lease liabilities	18,757	18,926
Total operating lease liabilities	$ 20,395	$ 20,522
Finance leases:		
Property and equipment, gross	$ 1,107	$ 790
Accumulated depreciation	(106)	(38)
Property and equipment, net	$ 1,001	$ 752
Current portion of long-term debt	$ 33	$ 27
Long-term debt	1,050	781
Total finance lease liabilities	$ 1,083	$ 808
Weighted average remaining lease term *(in years)*		
Operating leases	13.3	13.8
Finance leases	20.3	20.5
Weighted average discount rate		
Operating leases	4.5 %	4.6 %
Finance leases	5.6 %	6.7 %

The following table summarizes the maturity of lease liabilities under finance and operating leases as of December 31, 2020:

In millions	Finance Leases	Operating Leases [1]	Total
2021	$ 100	$ 2,688	$ 2,788
2022	98	2,583	2,681
2023	96	2,496	2,592
2024	95	2,269	2,364
2025	95	2,089	2,184
Thereafter	1,328	15,017	16,345
Total lease payments [2]	1,812	27,142	28,954
Less: imputed interest	(729)	(6,747)	(7,476)
Total lease liabilities	$ 1,083	$ 20,395	$ 21,478

(1) Future operating lease payments have not been reduced by minimum sublease rentals of $306 million due in the future under noncancelable subleases.

(2) The Company leases pharmacy and clinic space from Target Corporation. Amounts related to such finance and operating leases are reflected above. Pharmacy lease amounts due in excess of the remaining estimated economic life of the buildings of approximately $2.3 billion are not reflected in this table since the estimated economic life of the buildings is shorter than the contractual term of the pharmacy lease arrangement.

Sale-Leaseback Transactions

The Company finances a portion of its store development program through sale-leaseback transactions. The properties are generally sold at net book value, which generally approximates fair value, and the resulting leases generally qualify and are accounted for as operating leases. The operating leases that resulted from these transactions are included in the tables above.

The Company does not have any retained or contingent interests in the stores and does not provide any guarantees, other than a guarantee of lease payments, in connection with the sale-leaseback transactions. Proceeds from sale-leaseback transactions totaled $101 million and $5 million in the years ended December 31, 2020 and 2019, respectively. Gains from sale-leaseback transactions totaled $3 million in the year ended December 31, 2020. There were no material gains from sale-leaseback transactions in the year ended December 31, 2019.

Store Rationalization Charges
During the first quarter of 2019, the Company performed a review of its retail stores and determined it would close 46 underperforming retail pharmacy stores during the second quarter of 2019. As a result, management determined that there were indicators of impairment with respect to the impacted stores, including the associated operating lease right-of-use assets. Accordingly, an interim long-lived asset impairment test was performed. The results of the impairment test indicated that the fair value of each store asset group was lower than the carrying value. The fair value was determined using a discounted cash flow method based on estimated sublease income. In the three months ended March 31, 2019, the Company recorded a store rationalization charge of $135 million, primarily related to these operating lease right-of-use asset impairment charges, which was recorded within operating expenses in the Retail/LTC segment.

During the third quarter of 2019, in connection with its annual budgeting process, the Company performed an updated review of its retail stores and determined it would close an additional 22 underperforming retail pharmacy stores during the first quarter of 2020. As a result, management determined that there were indicators of impairment with respect to the impacted stores, including the associated operating lease right-of-use assets. Accordingly, an interim long-lived asset impairment test was performed. The results of the impairment test indicated that the fair value of each store asset group was lower than the carrying value. The fair value was determined using a discounted cash flow method based on estimated sublease income. In the three months ended September 30, 2019, the Company recorded a store rationalization charge of $96 million, primarily related to these operating lease right-of-use asset impairment charges, which was recorded within operating expenses in the Retail/LTC segment.

Comparative Disclosure Prior to the Adoption of the New Lease Accounting Standard (ASU 2016-02)

The following table is a summary of the Company's net rental expense for operating leases for the year ended December 31, 2018:

In millions	**2018**
Minimum rentals	$ 2,528
Contingent rentals	28
Rental expense	2,556
Less: sublease income	(21)
Total rental expense, net	$ 2,535

7. Health Care Costs Payable

The following is information about incurred and cumulative paid health care claims development as of December 31, 2020, net of reinsurance, and the total IBNR liabilities plus expected development on reported claims included within the net incurred claims amounts. See Note 1 ‘‘Significant Accounting Policies’’ for information on how the Company estimates IBNR reserves and health care costs payable as well as changes to those methodologies, if any. The Company’s estimate of IBNR liabilities is primarily based on trend and completion factors. Claim frequency is not used in the calculation of the Company’s liability. In addition, it is impracticable to disclose claim frequency information for health care claims due to the Company’s inability to gather consistent claim frequency information across its multiple claims processing systems. Any claim frequency count disclosure would not be comparable across the Company’s different claim processing systems and would not be consistent from period to period based on the volume of claims processed through each system. As a result, health care claim count frequency is not included in the disclosures below.

The information about incurred and paid health care claims development for the year ended December 31, 2019 is presented as required unaudited supplemental information.

In millions	**Incurred Health Care Claims, Net of Reinsurance For the Years Ended December 31,**	
Date of Service	**2019**	**2020**
	(Unaudited)	
2019	$ 51,426	$ 51,056
2020		54,529
	Total	$ 105,585

In millions	**Cumulative Paid Health Care Claims, Net of Reinsurance For the Years Ended December 31,**	
Date of Service	**2019**	**2020**
	(Unaudited)	
2019	$ 44,987	$ 50,394
2020		47,567
	Total	$ 97,961
All outstanding liabilities for health care costs payable prior to 2019, net of reinsurance		144
Total outstanding liabilities for health care costs payable, net of reinsurance		$ 7,768

At December 31, 2020, the Company’s liabilities for IBNR plus expected development on reported claims totaled approximately $6.1 billion. Substantially all of the Company’s liabilities for IBNR plus expected development on reported claims at December 31, 2020 related to the current calendar year.

The reconciliation of the December 31, 2020 health care net incurred and paid claims development tables to the health care costs payable liability on the consolidated balance sheet is as follows:

In millions	**December 31, 2020**
Short-duration health care costs payable, net of reinsurance	$ 7,768
Reinsurance recoverables	10
Premium deficiency reserve	11
Insurance lines other than short duration	147
Total health care costs payable	$ 7,936

Prior to the Aetna Acquisition on November 28, 2018, the Company's health care costs payable balance was immaterial and related to unpaid pharmacy claims for its SilverScript PDP. The following table shows the components of the change in health care costs payable during the years ended December 31, 2020, 2019 and 2018:

In millions	**2020**	**2019**	**2018**
Health care costs payable, beginning of period	$ 6,879	$ 6,147	$ 5
Less: Reinsurance recoverables	5	4	—
Health care costs payable, beginning of period, net	6,874	6,143	5
Acquisitions, net	414	—	5,357
Reclassification from pharmacy claims and discounts payable [1]	—	—	776
Add: Components of incurred health care costs			
Current year	55,835	52,723	6,594
Prior years	(429)	(524)	(42)
Total incurred health care costs [2]	55,406	52,199	6,552
Less: Claims paid			
Current year	48,770	46,158	6,303
Prior years	6,009	5,314	260
Total claims paid	54,779	51,472	6,563
Add: Premium deficiency reserve	11	4	16
Health care costs payable, end of period, net	7,926	6,874	6,143
Add: Reinsurance recoverables	10	5	4
Health care costs payable, end of period	$ 7,936	$ 6,879	$ 6,147

(1) As of the Aetna Acquisition Date, the Company reclassified $776 million of the Pharmacy Services segment's unpaid retail pharmacy claims to third parties from pharmacy claims and discounts payable to health care costs payable as the third party liability was incurred to support the Health Care Benefits segment's insured members.

(2) Total incurred health care costs for the years ended December 31, 2020, 2019 and 2018 in the table above exclude (i) $11 million, $4 million and $16 million, respectively, for a premium deficiency reserve related to the Company's Medicaid products, (ii) $41 million, $41 million and $4 million, respectively, of benefit costs recorded in the Health Care Benefits segment that are included in other insurance liabilities on the consolidated balance sheets and (iii) $221 million, $285 million and $22 million, respectively, of benefit costs recorded in the Corporate/Other segment that are included in other insurance liabilities on the consolidated balance sheets.

The Company's estimates of prior years' health care costs payable decreased by $429 million and $524 million in 2020 and 2019, respectively, because claims were settled for amounts less than originally estimated (i.e., the amount of claims incurred was lower than originally estimated), primarily due to lower health care cost trends as well as the actual claim submission time being faster than originally assumed (i.e., the Company's completion factors were higher than originally assumed) in estimating health care costs payable at the end of the prior year. This development does not directly correspond to an increase in the Company's operating results as these reductions were offset by estimated current period health care costs when the Company established the estimate of the current year health care costs payable.

8. Borrowings and Credit Agreements

The following table is a summary of the Company's borrowings as of December 31, 2020 and 2019:

In millions	2020	2019
Long-term debt		
3.125% senior notes due March 2020	$ —	$ 723
Floating rate notes due March 2020 (2.515% at December 31, 2019)	—	277
2.8% senior notes due July 2020	—	2,750
3.35% senior notes due March 2021	2,038	2,038
Floating rate notes due March 2021 (0.950% and 2.605% at December 31, 2020 and 2019, respectively)	1,000	1,000
4.125% senior notes due May 2021	222	222
2.125% senior notes due June 2021	1,750	1,750
4.125% senior notes due June 2021	203	203
5.45% senior notes due June 2021	187	187
3.5% senior notes due July 2022	1,500	1,500
2.75% senior notes due November 2022	1,000	1,000
2.75% senior notes due December 2022	1,250	1,250
4.75% senior notes due December 2022	399	399
3.7% senior notes due March 2023	2,336	6,000
2.8% senior notes due June 2023	1,300	1,300
4% senior notes due December 2023	414	1,250
3.375% senior notes due August 2024	650	650
2.625% senior notes due August 2024	1,000	1,000
3.5% senior notes due November 2024	750	750
5% senior notes due December 2024	299	299
4.1% senior notes due March 2025	950	5,000
3.875% senior notes due July 2025	2,828	2,828
2.875% senior notes due June 2026	1,750	1,750
3% senior notes due August 2026	750	750
3.625% senior notes due April 2027	750	—
6.25% senior notes due June 2027	372	372
1.3% senior notes due August 2027	2,250	—
4.3% senior notes due March 2028	7,050	9,000
3.25% senior notes due August 2029	1,750	1,750
3.75% senior notes due April 2030	1,500	—
1.75% senior notes due August 2030	1,250	—
1.875% senior notes due February 2031	1,250	—
4.875% senior notes due July 2035	652	652
6.625% senior notes due June 2036	771	771
6.75% senior notes due December 2037	533	533
4.78% senior notes due March 2038	5,000	5,000
6.125% senior notes due September 2039	447	447
4.125% senior notes due April 2040	1,000	—
2.7% senior notes due August 2040	1,250	—
5.75% senior notes due May 2041	133	133
4.5% senior notes due May 2042	500	500
4.125% senior notes due November 2042	500	500
5.3% senior notes due December 2043	750	750
4.75% senior notes due March 2044	375	375
5.125% senior notes due July 2045	3,500	3,500
3.875% senior notes due August 2047	1,000	1,000
5.05% senior notes due March 2048	8,000	8,000
4.25% senior notes due April 2050	750	—
Finance lease liabilities	1,083	808
Other	326	279
Total debt principal	65,318	69,246
Debt premiums	238	262
Debt discounts and deferred financing costs	(909)	(1,028)
	64,647	68,480
Less:		
Current portion of long-term debt	(5,440)	(3,781)
Long-term debt	$ 59,207	$ 64,699

The following is a summary of the Company's required repayments of debt principal due during each of the next five years and thereafter, as of December 31, 2020:

In millions		
2021	$	5,405
2022		4,154
2023		4,055
2024		2,706
2025		3,785
Thereafter		44,130
Total		64,235
Finance lease liabilities [(1)]		1,083
Total debt principal	$	65,318

(1) See Note 6 ''Leases'' for a summary of maturities of the Company's finance lease liabilities.

Short-term Borrowings

Commercial Paper and Back-up Credit Facilities
The Company did not have any commercial paper outstanding as of December 31, 2020 or 2019. In connection with its commercial paper program, the Company maintains a $1.0 billion 364-day unsecured back-up revolving credit facility, which expires on May 12, 2021, a $1.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 18, 2022, a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 17, 2023 and a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 16, 2024. The credit facilities allow for borrowings at various rates that are dependent, in part, on the Company's public debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately 0.03%, regardless of usage. As of December 31, 2020 and 2019, there were no borrowings outstanding under any of the Company's back-up credit facilities.

Federal Home Loan Bank of Boston ("FHLBB")
Since the Aetna Acquisition Date, a subsidiary of the Company is a member of the FHLBB. As a member, the subsidiary has the ability to obtain cash advances, subject to certain minimum collateral requirements. The maximum borrowing capacity available from the FHLBB as of December 31, 2020 was approximately $925 million. At both December 31, 2020 and 2019, there were no outstanding advances from the FHLBB.

Long-term Borrowings

2020 Notes
On December 16, 2020, the Company issued $750 million aggregate principal amount of 1.3% unsecured senior notes due August 21, 2027 and $1.25 billion aggregate principal amount of 1.875% unsecured senior notes due February 28, 2031 for total proceeds of approximately $1.99 billion, net of discounts and underwriting fees. The $750 million aggregate principal amount of 1.3% unsecured senior notes represent a further issuance of the Company's 1.3% unsecured senior notes due August 21, 2027 initially issued in an aggregate principal amount of $1.5 billion on August 21, 2020.

On August 21, 2020, the Company issued $1.5 billion aggregate principal amount of 1.3% unsecured senior notes due August 21, 2027, $1.25 billion aggregate principal amount of 1.75% unsecured senior notes due August 21, 2030 and $1.25 billion aggregate principal amount of 2.7% unsecured senior notes due August 21, 2040 (collectively, the "August 2020 Notes") for total proceeds of approximately $3.97 billion, net of discounts and underwriting fees.

On March 31, 2020, the Company issued $750 million aggregate principal amount of 3.625% unsecured senior notes due April 1, 2027, $1.5 billion aggregate principal amount of 3.75% unsecured senior notes due April 1, 2030, $1.0 billion aggregate principal amount of 4.125% unsecured senior notes due April 1, 2040 and $750 million aggregate principal amount of 4.25% unsecured senior notes due April 1, 2050 (collectively, the "March 2020 Notes") for total proceeds of approximately $3.95 billion, net of discounts and underwriting fees.

The net proceeds of these offerings were used for general corporate purposes, which may include working capital, capital expenditures, as well as the repurchase and/or repayment of indebtedness.

During March 2020, the Company entered into several interest rate swap transactions to manage interest rate risk. These agreements were designated as cash flow hedges and were used to hedge the exposure to variability in future cash flows resulting from changes in interest rates related to the anticipated issuance of the March 2020 Notes. In connection with the issuance of the March 2020 Notes, the Company terminated all outstanding cash flow hedges. The Company paid a net amount of $7 million to the hedge counterparties upon termination, which was recorded as a loss, net of tax, of $5 million in accumulated other comprehensive income and will be reclassified as interest expense over the life of the March 2020 Notes. See Note 13 ‘‘Other Comprehensive Income’’ for additional information.

2019 Notes
On August 15, 2019, the Company issued $1.0 billion aggregate principal amount of 2.625% unsecured senior notes due August 15, 2024, $750 million aggregate principal amount of 3% unsecured senior notes due August 15, 2026 and $1.75 billion aggregate principal amount of 3.25% unsecured senior notes due August 15, 2029 (collectively, the “2019 Notes”) for total proceeds of approximately $3.46 billion, net of discounts and underwriting fees. The net proceeds of the 2019 Notes were used to repay certain of the Company’s outstanding debt.

Beginning in July 2019, the Company entered into several interest rate swap and treasury lock transactions to manage interest rate risk. These agreements were designated as cash flow hedges and were used to hedge the exposure to variability in future cash flows resulting from changes in interest rates related to the anticipated issuance of the 2019 Notes. In connection with the issuance of the 2019 Notes, the Company terminated all outstanding cash flow hedges. The Company paid a net amount of $25 million to the hedge counterparties upon termination, which was recorded as a loss, net of tax, of $18 million in accumulated other comprehensive income and will be reclassified as interest expense over the life of the 2019 Notes. See Note 13 ‘‘Other Comprehensive Income’’ for additional information.

Early Extinguishments of Debt
In December 2020, the Company purchased $4.5 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $113 million of its 4.0% senior notes due 2023, $1.4 billion of its 3.7% senior notes due 2023, $1.0 billion of its 4.1% senior notes due 2025 and $2.0 billion of its 4.3% senior notes due 2028. In connection with the purchase of such senior notes, the Company paid a premium of $619 million in excess of the aggregate principal amount of the senior notes that were purchased, wrote-off $45 million of unamortized deferred financing costs and incurred $10 million in fees, for a total loss on early extinguishment of debt of $674 million.

In August 2020, the Company purchased $6.0 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $723 million of its 4.0% senior notes due 2023, $2.3 billion of its 3.7% senior notes due 2023 and $3.0 billion of its 4.1% senior notes due 2025. In connection with the purchase of such senior notes, the Company paid a premium of $706 million in excess of the aggregate principal amount of the senior notes that were purchased, wrote-off $47 million of unamortized deferred financing costs and incurred $13 million in fees, for a total loss on early extinguishment of debt of $766 million.

In August 2019, the Company purchased $4.0 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $1.3 billion of its 3.125% senior notes due 2020, $723 million of its floating rate notes due 2020, $328 million of its 4.125% senior notes due 2021, $297 million of 4.125% senior notes due 2021 issued by Aetna, $413 million of 5.45% senior notes due 2021 issued by Coventry Health Care, Inc., a wholly-owned subsidiary of Aetna, and $962 million of its 3.35% senior notes due 2021. In connection with the purchase of such senior notes, the Company paid a premium of $76 million in excess of the aggregate principal amount of the senior notes that were purchased, incurred $8 million in fees and recognized a net gain of $5 million on the write-off of net unamortized deferred financing premiums, for a net loss on early extinguishment of debt of $79 million.

Debt Covenants

The Company’s back-up revolving credit facilities, unsecured senior notes and unsecured floating rate notes contain customary restrictive financial and operating covenants. These covenants do not include an acceleration of the Company’s debt maturities in the event of a downgrade in the Company’s credit ratings. The Company does not believe the restrictions contained in these covenants materially affect its financial or operating flexibility. As of December 31, 2020, the Company was in compliance with all of its debt covenants.

9. Pension Plans and Other Postretirement Benefits

Defined Contribution Plans

As of December 31, 2020, the Company sponsors several active 401(k) savings plans that cover all employees who meet plan eligibility requirements.

The Company makes matching contributions consistent with the provisions of the respective plans. At the participant's option, account balances, including the Company's matching contribution, can be invested among various investment options under each plan. The CVS Health Future Fund 401(k) Plan offers the Company's common stock fund as an investment option. The Company also maintains nonqualified, unfunded deferred compensation plans for certain key employees. The plans provide participants the opportunity to defer portions of their eligible compensation and for certain nonqualified plans, participants receive matching contributions equivalent to what they could have received under the CVS Health Future Fund 401(k) Plan absent certain restrictions and limitations under the Internal Revenue Code. The Company's contributions under its defined contribution plans were $520 million, $550 million and $334 million in the years ended December 31, 2020, 2019 and 2018, respectively. The Company's contributions for the years ended December 31, 2019 and 2018 include contributions to the Aetna 401(k) Plan subsequent to the Aetna Acquisition Date. On January 1, 2020, the Aetna 401(k) Plan was merged into the CVS Health Future Fund 401(k) Plan.

Defined Benefit Pension Plans

On November 28, 2018, the Company completed the Aetna Acquisition. Aetna sponsors a tax-qualified defined benefit pension plan that was frozen in 2010. Aetna also sponsors a nonqualified supplemental pension plan that was frozen in 2007. Aetna's pension plan benefit obligations and the fair value of plan assets were remeasured as of the Aetna Acquisition Date. The Company also sponsors several other defined benefit pension plans that are unfunded nonqualified supplemental retirement plans.

Pension Benefit Obligation and Plan Assets
The following tables outline the change in pension benefit obligation and plan assets over the specified periods:

In millions	2020	2019
Change in benefit obligation:		
Benefit obligation, beginning of year	$ 6,239	$ 5,841
Interest cost	168	225
Actuarial loss	413	530
Benefit payments	(358)	(357)
Benefit obligation, end of year	6,462	6,239
Change in plan assets:		
Fair value of plan assets, beginning of year	6,395	5,663
Actual return on plan assets	783	1,064
Employer contributions	25	25
Benefit payments	(358)	(357)
Fair value of plan assets, end of year	6,845	6,395
Funded status	$ 383	$ 156

The change in the pension benefit obligation during the years ended December 31, 2020 and 2019 was primarily driven by the change in the discount rate during each respective period.

The assets (liabilities) recognized on the consolidated balance sheets at December 31, 2020 and 2019 for the pension plans consisted of the following:

In millions	**2020**	**2019**
Non-current assets reflected in other assets	$ 744	$ 494
Current liabilities reflected in accrued expenses	(76)	(25)
Non-current liabilities reflected in other long-term liabilities	(285)	(313)
Net assets	$ 383	$ 156

Net Periodic Benefit Cost (Income)
The components of net periodic benefit cost (income) for the years ended December 31, 2020, 2019 and 2018 are shown below:

In millions	**2020**	**2019**	**2018**
Components of net periodic benefit cost (income):			
Interest cost	$ 168	$ 225	$ 25
Expected return on plan assets	(388)	(357)	(33)
Amortization of net actuarial loss	2	1	2
Net periodic benefit cost (income)	$ (218)	$ (131)	$ (6)

Pension Plan Assumptions
The Company uses a series of actuarial assumptions to determine its benefit obligation and net periodic benefit cost (income), the most significant of which include discount rates and expected return on plan assets assumptions.

Discount Rates - The discount rate is determined using a yield curve as of the annual measurement date. The yield curve consists of a series of individual discount rates, with each discount rate corresponding to a single point in time, based on high-quality bonds. Projected benefit payments are discounted to the measurement date using the corresponding rate from the yield curve that is consistent with the maturity profile of the expected liability cash flows.

Expected Return on Plan Assets - The expected long-term rate of return on plan assets is determined by using the plan's target allocation and return expectations based on many factors including forecasted long-term capital market real returns and the inflationary outlook on a plan by plan basis. See "Pension Plan Assets" below for additional details regarding the pension plan assets as of December 31, 2020 and 2019.

The Company also considers other assumptions including mortality, interest crediting rate, termination and retirement rates and cost of living adjustments.

The Company determined its benefit obligation based on the following weighted average assumptions as of December 31, 2020 and 2019:

	2020	**2019**
Discount rate	2.5 %	3.2 %

The Company determined its net periodic benefit cost (income) based on the following weighted average assumptions for the years ended December 31, 2020, 2019 and 2018:

	2020	**2019**	**2018**
Discount rate	2.9 %	4.0 %	4.0 %
Expected long-term rate of return on plan assets	6.3 %	6.5 %	6.6 %

Pension Plan Assets

Subsequent to the Aetna Acquisition Date, the Company's pension plan assets primarily include debt and equity securities held in separate accounts, common/collective trusts and real estate investments. The valuation methodologies used to value these debt and equity securities and common/collective trusts are similar to the methodologies described in Note 4 "Fair Value." Pension plan assets also include investments in other assets that are carried at fair value. The following is a description of the valuation methodologies used to value real estate investments and these additional investments, including the general classification pursuant to the fair value hierarchy.

Real Estate - Real estate investments are valued by independent third party appraisers. The appraisals comply with the Uniform Standards of Professional Appraisal Practice, which include, among other things, the income, cost, and sales comparison approaches to estimating property value. Therefore, these investments are classified in Level 3.

Private equity and hedge fund limited partnerships - Private equity and hedge fund limited partnerships are carried at fair value which is estimated using the NAV per unit as reported by the administrator of the underlying investment fund as a practical expedient to fair value. Therefore, these investments have been excluded from the fair value table below.

Pension plan assets with changes in fair value measured on a recurring basis at December 31, 2020 were as follows:

In millions	**Level 1**	**Level 2**	**Level 3**	**Total**
Cash and cash equivalents	$ 118	$ 81	$ —	$ 199
Debt securities:				
U.S. government securities	575	36	—	611
States, municipalities and political subdivisions	—	170	—	170
U.S. corporate securities	—	2,006	—	2,006
Foreign securities	—	167	—	167
Residential mortgage-backed securities	—	287	—	287
Commercial mortgage-backed securities	—	83	—	83
Other asset-backed securities	—	133	—	133
Redeemable preferred securities	—	5	—	5
Total debt securities	575	2,887	—	3,462
Equity securities:				
U.S. domestic	1,046	—	—	1,046
International	537	—	—	537
Domestic real estate	15	—	—	15
Total equity securities	1,598	—	—	1,598
Other investments:				
Real estate	—	—	343	343
Common/collective trusts [1]	—	266	—	266
Derivatives	—	(3)	—	(3)
Total other investments	—	263	343	606
Total pension investments [2]	$ 2,291	$ 3,231	$ 343	$ 5,865

(1) The assets in the underlying funds of common/collective trusts consist of $84 million of equity securities and $182 million of debt securities.

(2) Excludes $142 million of other receivables as well as $624 million of private equity limited partnership investments and $214 million of hedge fund limited partnership investments as these amounts are measured at NAV per share or an equivalent and are not subject to leveling within the fair value hierarchy.

Pension plan assets with changes in fair value measured on a recurring basis at December 31, 2019 were as follows:

In millions	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 92	$ 65	$ —	$ 157
Debt securities:				
U.S. government securities	592	31	—	623
States, municipalities and political subdivisions	—	157	—	157
U.S. corporate securities	—	1,849	1	1,850
Foreign securities	—	178	—	178
Residential mortgage-backed securities	—	385	—	385
Commercial mortgage-backed securities	—	89	—	89
Other asset-backed securities	—	150	—	150
Redeemable preferred securities	—	5	—	5
Total debt securities	592	2,844	1	3,437
Equity securities:				
U.S. domestic	931	1	—	932
International	481	—	—	481
Domestic real estate	25	—	—	25
Total equity securities	1,437	1	—	1,438
Other investments:				
Real estate	—	—	353	353
Common/collective trusts [1]	—	288	—	288
Derivatives	—	(2)	—	(2)
Total other investments	—	286	353	639
Total pension investments [2]	$ 2,121	$ 3,196	$ 354	$ 5,671

(1) The assets in the underlying funds of common/collective trusts consist of $137 million of equity securities and $151 million of debt securities.
(2) Excludes $540 million of private equity limited partnership investments and $184 million of hedge fund limited partnership investments as these amounts are measured at NAV per share or an equivalent and are not subject to leveling within the fair value hierarchy.

The changes in the balance of Level 3 pension plan assets during 2020 were as follows:

	2020		
In millions	Real estate	U.S. corporate securities	Total
Beginning balance	$ 353	$ 1	$ 354
Actual return on plan assets	(2)	—	(2)
Purchases, sales and settlements	(8)	—	(8)
Transfers out of Level 3	—	(1)	(1)
Ending balance	$ 343	$ —	$ 343

The changes in the balance of Level 3 pension plan assets during 2019 were as follows:

	2019		
In millions	**Real estate**	**U.S. corporate securities**	**Total**
Beginning balance	$ 425	$ 5	$ 430
Actual return on plan assets	5	—	5
Purchases, sales and settlements	(77)	(5)	(82)
Transfers into Level 3	—	1	1
Ending balance	$ 353	$ 1	$ 354

The Company's pension plan invests in a diversified mix of assets designed to generate returns that will enable the plan to meet its future benefit obligations. The risk of unexpected investment and actuarial outcomes is regularly evaluated. This evaluation is performed through forecasting and assessing ranges of investment outcomes over short- and long-term horizons and by assessing the pension plan's liability characteristics. Complementary investment styles and strategies are utilized by professional investment management firms to further improve portfolio and operational risk characteristics. Public and private equity investments are used primarily to increase overall plan returns. Real estate investments are viewed favorably for their diversification benefits and above-average dividend generation. Fixed income investments provide diversification benefits and liability hedging attributes that are desirable, especially in falling interest rate environments.

At December 31, 2020, target investment allocations for the Company's pension plan were: 20% in equity securities, 68% in fixed income and debt securities, 6% in real estate, 3% in private equity limited partnerships and 3% in hedge funds. Actual asset allocations may differ from target allocations due to tactical decisions to overweight or underweight certain assets or as a result of normal fluctuations in asset values. Asset allocations are consistent with stated investment policies and, as a general rule, periodically rebalanced back to target asset allocations. Asset allocations and investment performance are formally reviewed periodically throughout the year by the pension plan's Investment Subcommittee. Forecasting of asset and liability growth is performed at least annually.

Cash Flows
The Company generally contributes to its tax-qualified pension plan based on minimum funding requirements determined under applicable federal laws and regulations. Employer contributions related to the nonqualified supplemental pension plans generally represent payments to retirees for current benefits. The Company contributed $25 million, $25 million and $12 million to its pension plans during 2020, 2019 and 2018, respectively. No contributions are required for the tax-qualified pension plan in 2021. The Company expects to make an immaterial amount of contributions for all other pension plans in 2021. The Company estimates the following future benefit payments, which are calculated using the same actuarial assumptions used to measure the pension benefit obligation as of December 31, 2020:

In millions	
2021	$ 423
2022	376
2023	375
2024	375
2025	375
2026-2030	1,807

Multiemployer Pension Plans
The Company also contributes to a number of multiemployer pension plans under the terms of collective-bargaining agreements that cover its union-represented employees. The risks of participating in these multiemployer plans are different from single-employer pension plans in the following respects: (i) assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers, (ii) if a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers, and (iii) if the Company chooses to stop participating in some of its multiemployer plans, the Company may be required to pay those plans an amount based on the underfunded status of the applicable plan, which is referred to as a withdrawal liability.

None of the multiemployer pension plans in which the Company participates are individually significant to the Company. The Company's contributions to multiemployer pension plans were $19 million, $18 million and $18 million in 2020, 2019 and 2018, respectively.

Other Postretirement Benefits

The Company provides postretirement health care and life insurance benefits to certain retirees who meet eligibility requirements. During 2018, the Company acquired additional OPEB plans in connection with the Aetna Acquisition. The Company's funding policy is generally to pay covered expenses as they are incurred. For retiree medical plan accounting, the Company reviews external data and its own historical trends for health care costs to determine the health care cost trend rates. As of December 31, 2020 and 2019, the Company's other postretirement benefits had an accumulated postretirement benefit obligation of $226 million and $246 million, respectively. Net periodic benefit costs related to these other postretirement benefits were $12 million, $7 million and $2 million in 2020, 2019 and 2018, respectively.

The Company estimates the following future benefit payments, which are calculated using the same actuarial assumptions used to measure the accumulated other postretirement benefit obligation as of December 31, 2020:

In millions	
2021	$ 13
2022	13
2023	13
2024	13
2025	13
2026-2030	61

Pursuant to various collective bargaining agreements, the Company also contributes to multiemployer health and welfare plans that cover certain union-represented employees. The plans provide postretirement health care and life insurance benefits to certain employees who meet eligibility requirements. The Company's contributions to multiemployer health and welfare plans totaled $54 million, $57 million and $58 million in 2020, 2019 and 2018, respectively.

10. Income Taxes

The income tax provision for continuing operations consisted of the following for the years ended December 31, 2020, 2019 and 2018:

In millions	**2020**	**2019**	**2018**
Current:			
Federal	$ 2,615	$ 2,450	$ 1,480
State	518	565	499
	3,133	3,015	1,979
Deferred:			
Federal	(450)	(535)	22
State	(114)	(114)	1
	(564)	(649)	23
Total	$ 2,569	$ 2,366	$ 2,002

The TCJA was enacted on December 22, 2017. Among numerous changes to existing tax laws, the TCJA permanently reduced the federal corporate income tax rate from 35% to 21% effective on January 1, 2018. The effects of changes in tax rates on deferred tax balances are required to be taken into consideration in the period in which the changes are enacted, regardless of when they are effective. As a result of the reduction of the corporate income tax rate under the TCJA, the Company estimated the revaluation of its net deferred tax liabilities and recorded a provisional income tax benefit of approximately $1.5 billion for

year ended December 31, 2017. In 2018, the Company completed its process of determining the TCJA's final impact and recorded an additional income tax benefit of $100 million.

The following table is a reconciliation of the statutory income tax rate to the Company's effective income tax rate for continuing operations for the years ended December 31, 2020, 2019 and 2018:

	2020	2019	2018
Statutory income tax rate	21.0 %	21.0 %	21.0 %
State income taxes, net of federal tax benefit	3.2	4.0	27.7
Effect of the Tax Cuts and Jobs Act	—	—	(7.1)
Health insurer fee	2.2	—	2.2
Goodwill impairments	—	—	89.5
Basis difference upon disposition of subsidiary	(1.2)	—	5.0
Other	1.1	1.3	4.1
Effective income tax rate	26.3 %	26.3 %	142.4 %

The following table is a summary of the components of the Company's deferred income tax assets and liabilities as of December 31, 2020 and 2019:

In millions	2020	2019
Deferred income tax assets:		
Lease and rents	$ 5,742	$ 5,731
Inventory	80	23
Employee benefits	238	191
Bad debts and other allowances	395	294
Retirement benefits	—	47
Net operating loss and capital loss carryforwards	568	480
Deferred income	43	36
Insurance reserves	489	430
Payroll tax deferral	173	—
Other	500	451
Valuation allowance	(454)	(374)
Total deferred income tax assets	7,774	7,309
Deferred income tax liabilities:		
Retirement benefits	(29)	—
Investments	(421)	(289)
Lease and rents	(5,368)	(5,464)
Depreciation and amortization	(8,750)	(8,850)
Total deferred income tax liabilities	(14,568)	(14,603)
Net deferred income tax liabilities	$ (6,794)	$ (7,294)

As of December 31, 2020, the Company had net operating and capital loss carryovers of $568 million, which expire between 2021 and 2040. The Company considers all available positive and negative evidence, including future reversals of existing taxable temporary differences, projected future taxable income, tax planning strategies and the Company's recent operating results. The Company established a valuation allowance of $454 million because it does not consider it more likely than not that these deferred tax assets will be recovered.

A reconciliation of the beginning and ending balance of unrecognized tax benefits in 2020, 2019 and 2018 is as follows:

In millions	**2020**	**2019**	**2018**
Beginning balance	$ 655	$ 661	$ 344
Additions based on tax positions related to the current year	3	4	1
Additions based on tax positions related to prior years	182	115	324
Reductions for tax positions of prior years	(56)	(111)	(5)
Expiration of statutes of limitation	(2)	(7)	(2)
Settlements	(14)	(7)	(1)
Ending balance	$ 768	$ 655	$ 661

The increase in the balance of unrecognized tax benefits during 2018 was mainly due to the Aetna Acquisition.

The Company and most of its subsidiaries are subject to U.S. federal income tax as well as income tax of numerous state and local jurisdictions. The Company participated in the Compliance Assurance Process through 2019, which is a program made available by the U.S. Internal Revenue Service ("IRS") to certain qualifying large taxpayers, under which participants work collaboratively with the IRS to identify and resolve potential tax issues through open, cooperative and transparent interaction prior to the annual filing of their federal income tax returns. The IRS has completed its examinations of the Company's consolidated U.S. federal income tax returns for tax years 2013 and 2018. The IRS has substantially completed its examinations of the Company's consolidated U.S. federal income tax returns for tax years 2014 through 2017 and 2019.

The Company and its subsidiaries are also currently under income tax examinations by a number of state and local tax authorities. As of December 31, 2020, no examination has resulted in any proposed adjustments that would result in a material change to the Company's operating results, financial condition or liquidity.

Substantially all material state and local income tax matters have been concluded for fiscal years through 2014. Certain state exams are likely to be concluded and certain state statutes of limitations will lapse in 2021, but the change in the balance of the Company's uncertain tax positions is projected to be immaterial. In addition, it is reasonably possible that the Company's unrecognized tax benefits could change within the next twelve months due to the anticipated conclusion of various examinations with the IRS for various years. An estimate of the range of the possible change cannot be made at this time.

The Company records interest expense related to unrecognized tax benefits and penalties in the income tax provision. The Company accrued interest expense of approximately $34 million, $49 million and $19 million in 2020, 2019 and 2018, respectively. The Company had approximately $121 million and $173 million accrued for interest and penalties as of December 31, 2020 and 2019, respectively.

As of December 31, 2020, the total amount of unrecognized tax benefits that, if recognized, would affect the Company's effective income tax rate is approximately $651 million, after considering the federal benefit of state income taxes.

11. Stock Incentive Plans

The terms of the CVS Health 2017 Incentive Compensation Plan ("ICP") provide for grants of annual incentive and long-term performance awards to executive officers and other officers and employees of the Company or any subsidiary of the Company, as well as equity compensation to outside directors of CVS Health. Payment of such annual incentive and long-term performance awards will be in cash, stock, other awards or other property, at the discretion of the Management Planning and Development Committee (the "MP&D Committee") of CVS Health's Board of Directors (the "Board"). The ICP allows for a maximum of 58 million shares of CVS Health common stock to be reserved and available for grants. As of December 31, 2020, there were approximately 38 million shares of CVS Health common stock available for future grants under the ICP.

As of the Aetna Acquisition Date, approximately 22 million shares of Aetna common stock subject to awards outstanding under the Amended Aetna Inc. 2010 Stock Incentive Plan ("SIP") were assumed by CVS Health. In addition, in accordance with the merger agreement, shares which were available for future issuance under the SIP were converted into approximately 32 million shares of CVS Health common stock reserved and available for issuance pursuant to future awards. Subsequent to the

expiration of the SIP on May 21, 2020, the ICP is the only compensation plan under which the Company grants stock options, restricted stock and other stock-based awards to its employees.

Stock-Based Compensation Expense

Stock-based compensation is measured at the grant date based on the fair value of the award and is recognized as expense over the requisite service period of the stock award (generally three to five years) using the straight-line method. The following table is a summary of stock-based compensation for the years ended December 31, 2020, 2019 and 2018:

In millions	2020	2019	2018
Stock options and stock appreciation rights ("SARs") [1] [2]	$ 71	$ 76	$ 70
Restricted stock units and performance stock units [2]	329	377	210
Total stock-based compensation	$ 400	$ 453	$ 280

(1) Includes the ESPP.
(2) Stock-based compensation for the year ended December 31, 2018 includes $14 million and $27 million associated with accelerated vesting of SARs and restricted stock replacement awards, respectively, issued to Aetna employees who were terminated subsequent to the Aetna Acquisition.

ESPP

The Company's Employee Stock Purchase Plan ("ESPP") provides for the purchase of up to 60 million shares of CVS Health common stock. Under the ESPP, eligible employees may purchase common stock at the end of each six month offering period at a purchase price equal to 90% of the lower of the fair market value on the first day or the last day of the offering period. During 2020, approximately 3 million shares of common stock were purchased under the provisions of the ESPP at an average price of $53.85 per share. As of December 31, 2020, approximately 34 million shares of common stock were available for issuance under the ESPP.

The fair value of stock-based compensation associated with the ESPP is estimated on the date of grant (the first day of the six month offering period) using the Black-Scholes option pricing model.

The following table is a summary of the assumptions used to value the ESPP awards for the years ended December 31, 2020, 2019 and 2018:

	2020	2019	2018
Dividend yield [1]	1.46 %	1.70 %	1.45 %
Expected volatility [2]	37.21 %	27.96 %	28.02 %
Risk-free interest rate [3]	0.81 %	2.27 %	1.87 %
Expected life (in years) [4]	0.5	0.5	0.5
Weighted-average grant date fair value	$ 13.85	$ 10.51	$ 12.26

(1) The dividend yield is calculated based on semi-annual dividends paid and the fair market value of CVS Health stock at the grant date.
(2) The expected volatility is estimated based on the historical volatility of CVS Health's daily stock price over the previous six month period.
(3) The risk-free interest rate is selected based on the Treasury constant maturity interest rate whose term is consistent with the expected term of ESPP purchases (i.e., six months).
(4) The expected life is based on the semi-annual purchase period.

Restricted Stock Units and Performance Stock Units

The Company's restricted stock units and performance stock units are considered nonvested share awards and require no payment from the employee. The fair value of the restricted stock units is based on the market price of CVS Health common stock on the grant date and is recognized on a straight-line basis over the vesting period. For each restricted stock unit granted, employees receive one share of common stock, net of taxes, at the end of the vesting period.

The Company's performance stock units contain performance vesting conditions in addition to a service vesting condition. Vesting of the Company's performance stock units is dependent upon the degree to which the Company achieves its performance goals, which are generally set for a three-year performance period and are approved at the time of grant by the MP&D Committee.

The fair value of performance stock units granted with service and performance vesting conditions is based on the market price of CVS Health common stock on the grant date and is recognized over the vesting period. Certain of the performance stock units also contain a market vesting condition based on the performance of CVS Health common stock relative to a comparator group. The fair value of these performance stock units is determined using a Monte Carlo simulation as of the grant date and is recognized over the vesting period.

On November 28, 2018, the Company completed the Aetna Acquisition. All unvested Aetna performance stock unit and restricted stock unit awards as of the Aetna Acquisition Date were converted into replacement CVS Health restricted stock awards.

As of December 31, 2020, there was $493 million of total unrecognized compensation cost related to the Company's restricted stock units and performance stock units that are expected to vest. These costs are expected to be recognized over a weighted-average period of 2.3 years. The total fair value of restricted stock units vested during 2020, 2019 and 2018 was $229 million, $265 million and $262 million, respectively.

The following table is a summary of the restricted stock unit and performance stock unit activity for the year ended December 31, 2020:

In thousands, except weighted average grant date fair value	**Units**	**Weighted Average Grant Date Fair Value**
Outstanding at beginning of year, nonvested	13,125	$ 61.57
Granted	6,849	$ 58.38
Vested	(3,793)	$ 60.40
Forfeited	(1,357)	$ 59.10
Outstanding at end of year, nonvested	14,824	$ 58.12

Stock Options and SARs

All stock option grants are awarded at fair value on the date of grant. The fair value of stock options is estimated using the Black-Scholes option pricing model, and stock-based compensation is recognized on a straight-line basis over the requisite service period. Stock options granted generally become exercisable over a four-year period from the grant date. Stock options granted through 2018 generally expire seven years after the grant date. Stock options granted subsequent to 2018 generally expire ten years after the grant date.

On November 28, 2018, the Company completed the Aetna Acquisition. All unvested Aetna SARs outstanding as of the Aetna Acquisition Date were converted into replacement CVS Health SARs. The replacement SARs granted will be settled in CVS Health common stock, net of taxes, based on the appreciation of the stock price on the exercise date over the market price on the date of grant. The fair value of SARs is estimated using the Black-Scholes option pricing model, and stock-based compensation is recognized on a straight-line basis over the requisite service period. SARs generally become exercisable over a three-year period from the grant date. SARs generally expire ten years after the grant date.

The following table is a summary of stock option and SAR activity that occurred for the years ended December 31, 2020, 2019 and 2018:

In millions	**2020**	**2019**	**2018**
Cash received from stock options exercised (including ESPP)	$ 264	$ 210	$ 242
Payments for taxes for net share settlement of equity awards	88	112	97
Intrinsic value of stock options and SARs exercised	24	30	79
Fair value of stock options and SARs vested	252	467	324

The fair value of each stock option and SAR is estimated using the Black-Scholes option pricing model based on the following assumptions at the time of grant:

	2020	2019	2018
Dividend yield [1]	3.42 %	3.68 %	2.76 %
Expected volatility [2]	25.22 %	21.76 %	21.27 %
Risk-free interest rate [3]	0.61 %	0.56 %	2.77 %
Expected life (in years) [4]	6.3	6.3	4.8
Weighted-average grant date fair value	$ 8.78	$ 6.27	$ 24.55

(1) The dividend yield is based on annual dividends paid and the fair market value of CVS Health stock at the grant date.
(2) The expected volatility is estimated based on the historical volatility of CVS Health's daily stock price over a period equal to the expected life of each option or SAR grant after adjustments for infrequent events such as stock splits.
(3) The risk-free interest rate is selected based on yields from U.S. Treasury zero-coupon issues with a remaining term equal to the expected term of the options or SARs being valued.
(4) The expected life represents the number of years the options or SARs are expected to be outstanding from grant date based on historical option or SAR holder exercise experience.

The increase in the weighted-average grant date fair value in 2018 was due to the issuance of the replacement SARs in connection with the Aetna Acquisition in the year ended December 31, 2018.

As of December 31, 2020, unrecognized compensation expense related to unvested stock options and SARs totaled $45 million, which the Company expects to be recognized over a weighted-average period of 1.8 years. After considering anticipated forfeitures, the Company expects approximately 10 million of the unvested stock options and SARs to vest over the requisite service period.

The following table is a summary of the Company's stock option and SAR activity for the year ended December 31, 2020:

In thousands, except weighted average exercise price and remaining contractual term	Shares	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term	Aggregate Intrinsic Value
Outstanding at beginning of year	23,902	$ 69.98		
Granted	4,759	$ 58.50		
Exercised	(2,601)	$ 52.95		
Forfeited	(1,164)	$ 57.61		
Expired	(941)	$ 83.34		
Outstanding at end of year	23,955	$ 69.62	4.86	$ 185,487
Exercisable at end of year	13,545	$ 78.05	2.79	78,289
Vested at end of year and expected to vest in the future	23,448	$ 69.87	4.78	180,102

12. Shareholders' Equity

Share Repurchases

The following share repurchase program has been authorized by the Board:

In billions Authorization Date	Authorized	Remaining as of December 31, 2020
November 2, 2016 ("2016 Repurchase Program")	$ 15.0	$ 13.9

The 2016 Repurchase Program permits the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase transactions, and/or other derivative transactions. The 2016 Repurchase Program can be modified or terminated by the Board at any time.

During the years ended December 31, 2020, 2019 and 2018, the Company did not repurchase any shares of common stock pursuant to the 2016 Repurchase Program.

Dividends

The quarterly cash dividend declared by the Board was $0.50 per share in 2020 and 2019. CVS Health has paid cash dividends every quarter since becoming a public company. Future dividend payments will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

Regulatory Requirements

On November 28, 2018, the Company completed the Aetna Acquisition. Aetna's insurance business operations are conducted through subsidiaries that principally consist of HMOs and insurance companies. The Company's HMO and insurance subsidiaries report their financial statements in accordance with accounting practices prescribed by state regulatory authorities which may differ from GAAP. The combined statutory net income for the years ended and estimated combined statutory and capital surplus at December 31, 2020, 2019 and 2018 for the Company's insurance and HMO subsidiaries were as follows:

In millions	**2020**	**2019**	**2018**
Statutory net income [1]	$ 3,667	$ 2,842	NM
Estimated statutory capital and surplus	13,238	10,975	10,084

(1) Statutory net income of the Company's insurance and HMO subsidiaries for the year ended December 31, 2018 (which includes Aetna and its subsidiaries from November 28, 2018 to December 31, 2018) is not material ("NM").

The Company's insurance and HMO subsidiaries paid $3.1 billion of gross dividends to the Company for the year ended December 31, 2020.

In addition to general state law restrictions on payments of dividends and other distributions to stockholders applicable to all corporations, HMOs and insurance companies are subject to further regulations that, among other things, may require those companies to maintain certain levels of equity and restrict the amount of dividends and other distributions that may be paid to their equity holders. In addition, in connection with the Aetna Acquisition, the Company made certain undertakings that require prior regulatory approval of dividends by certain of its HMOs and insurance companies. At December 31, 2020, these amounts were as follows:

In millions	
Estimated minimum statutory surplus required by regulators	$ 5,395
Investments on deposit with regulatory bodies	712
Estimated maximum dividend distributions permitted in 2021 without prior regulatory approval	2,900

Noncontrolling Interests

At December 31, 2020 and 2019, noncontrolling interests were $312 million and $306 million, respectively, primarily related to third party interests in the Company's operating entities. The noncontrolling entities' share is included in total shareholders' equity on the consolidated balance sheets.

13. Other Comprehensive Income

Shareholders' equity included the following activity in accumulated other comprehensive income in 2020, 2019 and 2018:

	At December 31,		
In millions	**2020**	**2019**	**2018**
Net unrealized investment gains:			
Beginning of year balance	$ 774	$ 97	$ —
Other comprehensive income before reclassifications *($497, $927 and $132 pretax)*	415	763	97
Amounts reclassified from accumulated other comprehensive income *($31, $(105) and $1 pretax)* [1]	25	(86)	—
Other comprehensive income	440	677	97
End of year balance	1,214	774	97
Foreign currency translation adjustments:			
Beginning of year balance	4	(158)	(129)
Other comprehensive income (loss) before reclassifications	3	8	(29)
Amounts reclassified from accumulated other comprehensive income (loss) [2]	—	154	—
Other comprehensive income (loss)	3	162	(29)
End of year balance	7	4	(158)
Net cash flow hedges:			
Beginning of year balance	279	312	(15)
Adoption of new accounting standard [3]	—	—	(3)
Other comprehensive income (loss) before reclassifications *($(7), $(25) and $465 pretax)*	(5)	(18)	344
Amounts reclassified from accumulated other comprehensive income (loss) *($(35), $(20) and $(19) pretax)* [4]	(26)	(15)	(14)
Other comprehensive income (loss)	(31)	(33)	330
End of year balance	248	279	312
Pension and other postretirement benefits:			
Beginning of year balance	(38)	(149)	(21)
Adoption of new accounting standard [3]	—	—	(4)
Other comprehensive income (loss) before reclassifications *($(30), $162 and $(178) pretax)*	(22)	120	(132)
Amounts reclassified from accumulated other comprehensive loss *($7, $(12) and $11 pretax)* [5]	5	(9)	8
Other comprehensive income (loss)	(17)	111	(124)
End of year balance	(55)	(38)	(149)
Total beginning of year accumulated other comprehensive income (loss)	1,019	102	(165)
Adoption of new accounting standard [3]	—	—	(7)
Total other comprehensive income	395	917	274
Total end of year accumulated other comprehensive income	$ 1,414	$ 1,019	$ 102

(1) Amounts reclassified from accumulated other comprehensive income for specifically identified debt securities are included in net investment income in the consolidated statements of operations.

(2) Amounts reclassified from accumulated other comprehensive loss represent the elimination of the cumulative translation adjustment associated with the sale of Onofre, which was sold on July 1, 2019. The loss on the divestiture of Onofre is reflected in operating expenses in the consolidated statements of operations.

(3) Reflects the adoption of ASU 2018-02, *Income Statement Reporting Comprehensive Income (Topic 220); Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income* during the year ended December 31, 2018.

(4) Amounts reclassified from accumulated other comprehensive income (loss) for specifically identified cash flow hedges are included within interest expense in the consolidated statements of operations. The Company expects to reclassify approximately $13 million, net of tax, in net gains associated with its cash flow hedges into net income within the next 12 months.
(5) Amounts reclassified from accumulated other comprehensive loss for specifically identified pension and other postretirement benefits are included in other income in the consolidated statements of operations.

14. Earnings (Loss) Per Share

Earnings (loss) per share is computed using the two-class method. For periods in which the Company reports net income, diluted earnings per share is determined by using the weighted average number of common and dilutive common equivalent shares outstanding during the period, unless the effect is antidilutive. SARs and options to purchase 15 million and 17 million shares of common stock were outstanding, but were excluded from the calculation of diluted earnings per share for the years ended December 31, 2020 and 2019, respectively, because their exercise prices were greater than the average market price of the common shares and, therefore, the effect would be antidilutive. For the same reason, options to purchase 13 million shares of common stock were outstanding, but were excluded from the calculation of diluted earnings per share, for the year ended December 31, 2018. In addition, due to the loss from continuing operations attributable to CVS Health in the year ended December 31, 2018, 3 million potentially dilutive common equivalent shares were excluded from the calculation of diluted earnings per share, as the impact of these shares was antidilutive for that period.

The following is a reconciliation of basic and diluted earnings (loss) per share from continuing operations for the years ended December 31, 2020, 2019 and 2018:

In millions, except per share amounts	**2020**	**2019**	**2018**
Numerator for earnings (loss) per share calculation:			
Income (loss) from continuing operations	$ 7,201	$ 6,631	$ (596)
Income allocated to participating securities	—	(5)	(3)
Net (income) loss attributable to noncontrolling interests	(13)	3	2
Income (loss) from continuing operations attributable to CVS Health	$ 7,188	$ 6,629	$ (597)
Denominator for earnings (loss) per share calculation:			
Weighted average shares, basic	1,309	1,301	1,044
Effect of dilutive securities	5	4	—
Weighted average shares, diluted	1,314	1,305	1,044
Earnings (loss) per share from continuing operations:			
Basic	$ 5.49	$ 5.10	$ (0.57)
Diluted	$ 5.47	$ 5.08	$ (0.57)

15. Reinsurance

The Company utilizes reinsurance agreements primarily to: (a) reduce required capital and (b) facilitate the acquisition or disposition of certain insurance contracts. Ceded reinsurance agreements permit the Company to recover a portion of its losses from reinsurers, although they do not discharge the Company's primary liability as the direct insurer of the risks reinsured.

On November 30, 2018, the Company completed the sale of Aetna's standalone Medicare Part D prescription drug plans to a subsidiary of WellCare Health Plans, Inc. ("WellCare"), effective December 31, 2018. In connection with that sale, subsidiaries of WellCare and Aetna entered into reinsurance agreements under which WellCare ceded to Aetna 100% of the insurance risk related to the divested standalone Medicare Part D prescription drug plans for the 2019 PDP plan year.

In February 2021, the Company entered into two four-year reinsurance agreements with an unrelated reinsurer that allow it to reduce required capital and provide collateralized excess of loss reinsurance coverage on a portion of the Health Care Benefits segment's group Commercial Insured business.

Reinsurance recoverables (recorded as other current assets or other assets on the consolidated balance sheets) at December 31, 2020 and 2019 were as follows:

In millions	2020	2019
Reinsurer		
Hartford Life and Accident Insurance Company	$ 2,364	$ 3,085
Lincoln Life & Annuity Company of New York	406	413
WellCare Health Plans	13	355
VOYA Retirement Insurance and Annuity Company	170	175
All Other	102	103
Total	$ 3,055	$ 4,131

Direct, assumed and ceded premiums earned for the years ended December 31, 2020, 2019 and 2018 were as follows:

In millions	2020	2019	2018
Direct	$ 69,711	$ 62,968	$ 8,365
Assumed	478	2,108	38
Ceded	(825)	(1,954)	(219)
Net premiums	$ 69,364	$ 63,122	$ 8,184

The impact of reinsurance on benefit costs for the years ended December 31, 2020, 2019 and 2018 were as follows:

In millions	2020	2019	2018
Direct	$ 56,077	$ 52,592	$ 6,773
Assumed	329	1,562	32
Ceded	(727)	(1,625)	(211)
Net benefit costs	$ 55,679	$ 52,529	$ 6,594

There is not a material difference between premiums on a written basis versus an earned basis.

The Company also has various agreements with unrelated reinsurers that do not qualify for reinsurance accounting under GAAP, and consequently are accounted for using deposit accounting. The Company entered into these contracts to reduce the risk of catastrophic loss which in turn reduces the Company's capital and surplus requirements. Total deposit assets and liabilities related to reinsurance agreements that do not qualify for reinsurance accounting under GAAP were not material as of December 31, 2020 or 2019.

16. Commitments and Contingencies

COVID-19

The COVID-19 pandemic continues to evolve. We believe COVID-19's impact on our businesses, operating results, cash flows and/or financial condition primarily will be driven by the geographies impacted and the severity and duration of the pandemic; the pandemic's impact on the U.S. and global economies and consumer behavior and health care utilization patterns; and the timing, scope and impact of stimulus legislation as well as other federal, state and local governmental responses to the pandemic. Those primary drivers are beyond our knowledge and control. As a result, the impact COVID-19 will have on our businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be adverse and material. COVID-19 also may result in legal and regulatory proceedings, investigations and claims against us.

Guarantees

The Company has the following significant guarantee arrangements at December 31, 2020:

- ASC Claim Funding Accounts - The Company has arrangements with certain banks for the processing of claim payments for its ASC customers. The banks maintain accounts to fund claims of the Company's ASC customers. The customer is

responsible for funding the amount paid by the bank each day. In these arrangements, the Company guarantees that the banks will not sustain losses if the responsible ASC customer does not properly fund its account. The aggregate maximum exposure under these arrangements is generally limited to $250 million. The Company can limit its exposure to these guarantees by suspending the payment of claims for ASC customers that have not adequately funded the amount paid by the bank.

- Separate Accounts Assets - Certain Separate Accounts assets associated with the large case pensions business in the Corporate/Other segment represent funds maintained as a contractual requirement to fund specific pension annuities that the Company has guaranteed. Minimum contractual obligations underlying the guaranteed benefits in these Separate Accounts were approximately $1.4 billion at both December 31, 2020 and 2019. See Note 1 ‘‘Significant Accounting Policies’’ for additional information on Separate Accounts. Contract holders assume all investment and mortality risk and are required to maintain Separate Accounts balances at or above a specified level. The level of required funds is a function of the risk underlying the Separate Account’s investment strategy. If contract holders do not maintain the required level of Separate Accounts assets to meet the annuity guarantees, the Company would establish an additional liability. Contract holders’ balances in the Separate Accounts at December 31, 2020 exceeded the value of the guaranteed benefit obligation. As a result, the Company was not required to maintain any additional liability for its related guarantees at December 31, 2020.

Lease Guarantees

Between 1995 and 1997, the Company sold or spun off a number of subsidiaries, including Bob’s Stores and Linens ‘n Things, each of which subsequently filed for bankruptcy, and Marshalls. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the former subsidiary’s lease obligations for the initial lease term and any extension thereof pursuant to a renewal option provided for in the lease prior to the time of the disposition. When the subsidiaries were disposed of and accounted for as discontinued operations, the Company’s guarantees remained in place, although each initial purchaser agreed to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries fail to make the required payments under a store lease, the Company could be required to satisfy those obligations, and any significant adverse impact of COVID-19 on such purchasers and/or former subsidiaries increases the risk that the Company will be required to satisfy those obligations. As of December 31, 2020, the Company guaranteed 76 such store leases (excluding the lease guarantees related to Linens ‘n Things, which have been recorded as a liability on the consolidated balance sheets), with the maximum remaining lease term extending through 2030.

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers and life insurers as well as health insurers. The Company’s assessments generally are based on a formula relating to the Company’s health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

In 2009, the Pennsylvania Insurance Commissioner placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, “Penn Treaty”) in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. Penn Treaty was placed in liquidation in March 2017. The Company has recorded a liability for its estimated share of future assessments by applicable life and health insurance guaranty associations. It is reasonably possible that in the future the Company may record a liability and expense relating to other insolvencies which could have a material adverse effect on the Company’s operating results, financial condition and cash flows, and the risk is heightened by any significant adverse impact of the COVID-19 pandemic on the solvency of other insurers, including long-term care and life insurers. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that limit future offsets.

HMOs in certain states in which the Company does business are subject to assessments, including market stabilization and other risk-sharing pools, for which the Company is assessed charges based on incurred claims, demographic membership mix and other factors. The Company establishes liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments the Company pays are dependent upon the Company’s experience relative to other entities subject to the assessment, and the ultimate liability is not known at the financial statement date. While the ultimate amount of

the assessment is dependent upon the experience of all pool participants, the Company believes it has adequate reserves to cover such assessments.

The Company's total guaranty fund assessments liability was $78 million and $84 million at December 31, 2020 and 2019, respectively, and was recorded in accrued expenses on the consolidated balance sheets.

Litigation and Regulatory Proceedings

The Company has been involved or is currently involved in numerous legal proceedings, including litigation, arbitration, government investigations, audits, reviews and claims. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, state attorneys general, the U.S. Drug Enforcement Administration (the "DEA") and other governmental authorities.

Legal proceedings, in general, and securities, class action and multi-district litigation, in particular, and governmental special investigations, audits and reviews can be expensive and disruptive. Some of the litigation matters may purport or be determined to be class actions and/or involve parties seeking large and/or indeterminate amounts, including punitive or exemplary damages, and may remain unresolved for several years. The Company also may be named from time to time in *qui tam* actions initiated by private third parties that could also be separately pursued by a governmental body. The results of legal proceedings, including government investigations, are often uncertain and difficult to predict, and the costs incurred in these matters can be substantial, regardless of the outcome.

The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and reasonably estimable, the Company does not establish an accrued liability. None of the Company's accruals for outstanding legal matters are material individually or in the aggregate to the Company's financial condition.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and the Company is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters. The Company believes that its defenses and assertions in pending legal proceedings have merit and does not believe that any of these pending matters, after consideration of applicable reserves and rights to indemnification, will have a material adverse effect on the Company's financial position. Substantial unanticipated verdicts, fines and rulings, however, do sometimes occur, which could result in judgments against the Company, entry into settlements or a revision to its expectations regarding the outcome of certain matters, and such developments could have a material adverse effect on its results of operations. In addition, as a result of governmental investigations or proceedings, the Company may be subject to damages, civil or criminal fines or penalties, or other sanctions including possible suspension or loss of licensure and/or exclusion from participating in government programs. The outcome of such governmental investigations of proceedings could be material to the Company.

Usual and Customary Pricing Litigation

The Company and certain current and former directors and officers are named as a defendant in a number of lawsuits that allege that the Company's retail pharmacies overcharged for prescription drugs by not submitting the correct usual and customary price during the claims adjudication process. These actions are brought by a number of different types of plaintiffs, including plan members, private payors, government payors, and shareholders based on different legal theories. Some of these cases are brought as putative class actions, and in some instances, classes have been certified. The Company is defending itself against these claims.

PBM Litigation and Investigations

The Company is named as a defendant in a number of lawsuits and is subject to a number of investigations concerning its PBM practices.

The Company is facing multiple lawsuits, including several putative class actions, regarding drug pricing and its rebate arrangements with drug manufacturers. These complaints, brought under a variety of legal theories, generally allege that rebate agreements between the drug manufacturers and PBMs caused inflated prices for certain drug products. The Company is defending itself against these claims. The Company has also received subpoenas, civil investigative demands ("CIDs") and

other requests for documents and information from, and is being investigated by, Attorneys General of several states and the District of Columbia regarding its PBM practices, including pricing and rebates. The Company has been providing documents and information in response to these subpoenas, CIDs and requests for information.

United States ex rel. Behnke v. CVS Caremark Corporation, et al. (U.S. District Court for the Eastern District of Pennsylvania). In April 2018, the Court unsealed a complaint filed in February 2014. The government has declined to intervene in this case. The relator alleges that the Company submitted, or caused to be submitted, to Part D of the Medicare program Prescription Drug Event data and/or Direct and Indirect Remuneration reports that misrepresented true prices paid by the Company's PBM to pharmacies for drugs dispensed to Part D beneficiaries with prescription benefits administered by the Company's PBM. The Company is defending itself against these claims.

Controlled Substances Litigation, Audits and Subpoenas

In December 2017, the U.S. Judicial Panel on Multidistrict Litigation consolidated numerous cases filed against various defendants by plaintiffs such as counties, cities, hospitals, Indian tribes and third-party payors, alleging claims generally concerning the impacts of widespread prescription opioid abuse. The consolidated multidistrict litigation captioned *In re National Prescription Opiate Litigation* (MDL No. 2804) is pending in the U.S. District Court for the Northern District of Ohio. This multidistrict litigation presumptively includes hundreds of relevant federal court cases that name the Company as a defendant. A significant number of similar cases that name the Company as a defendant in some capacity are pending in state courts. In addition, the Company has been named as a defendant in similar cases brought by certain state Attorneys General. The Company is defending itself against all such claims. Additionally, the Company has received subpoenas, CIDs and/or other requests for information regarding opioids from state Attorneys General and insurance and other regulators of several U.S. jurisdictions. The Company has been cooperating with the government with respect to these subpoenas, CIDs and other requests for information.

In January 2020, the U.S. Department of Justice (the "DOJ") served the Company with a DEA administrative subpoena. The subpoena seeks documents relating to practices with respect to prescription opioids and other controlled substances at CVS Pharmacy locations in connection with an investigation concerning potential violations of the federal Controlled Substances Act and the federal False Claims Act. The Company has been cooperating with the government with respect to this subpoena.

Prescription Processing Litigation and Investigations

U.S. ex rel. *Bassan* et al. *v. Omnicare, Inc. and CVS Health Corp.* and *U.S.* ex rel. *Mohajer* et al. *v. Omnicare, Inc. and CVS Health Corp.* (U.S. District Court for the Southern District of New York). In December 2019, the U.S. Attorney's Office for the Southern District of New York (the "SDNY") filed complaints-in-intervention in these two previously sealed *qui tam* cases. With respect to the *Bassan* complaint, all states and Washington, D.C. have declined to intervene at this time. The government's investigation related to these complaints included the previously disclosed CID that the Company received in October 2015 from the SDNY concerning the Company's Omnicare pharmacies' cycle fill process for assisted living facilities. The complaints allege that for certain non-skilled nursing facilities, Omnicare improperly filled prescriptions beyond one year where a valid prescription did not exist and that these dispensing events violated the federal False Claims Act. The *Mohajer* relators have amended their complaint to include claims based on similar theories related to certain skilled nursing facilities. The Company is defending itself against these claims.

In July 2017, the Company also received a subpoena from the California Department of Insurance requesting documents concerning the Company's Omnicare pharmacies' cycle fill process for assisted living facilities. The Company has been cooperating with the California Department of Insurance and providing documents and information in response to this subpoena..

In December 2016, the Company received a CID from the U.S. Attorney's Office for the Northern District of New York requesting documents and information in connection with a federal False Claims Act investigation concerning whether the Company's retail pharmacies improperly submitted certain insulin claims to Part D of the Medicare program rather than Part B of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to this CID.

Provider Proceedings

The Company is named as a defendant in purported class actions and individual lawsuits arising out of its practices related to the payment of claims for services rendered to its members by providers with whom the Company has a contract and with

whom the Company does not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that the Company paid too little to its health plan members and/or providers for out-of-network services and/or otherwise allege that the Company failed to timely or appropriately pay or administer out-of-network claims and benefits (including the Company's post-payment audit and collection practices and reductions in payments to providers due to sequestration). Other major health insurers are the subject of similar litigation or have settled similar litigation.

The Company also has received subpoenas and/or requests for documents and other information from, and been investigated by, state Attorneys General and other state and/or federal regulators, legislators and agencies relating to, and the Company is involved in other litigation regarding, its out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against the Company with respect to its out-of-network benefit payment and/or administration practices.

CMS Actions

CMS regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to the Company's and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by providers. The Company collects claim and encounter data from providers and generally relies on providers to appropriately code their submissions to the Company and document their medical records, including the diagnosis data submitted to the Company with claims. CMS pays increased premiums to Medicare Advantage plans and Medicare PDP plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to the Company. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by providers and the resulting risk adjusted premium payments to the plans. CMS may require the Company to refund premium payments if the Company's risk adjusted premiums are not properly supported by medical record data. The Office of the Inspector General of the U.S. Department of Health and Human Services ("HHS-OIG") also is auditing the Company's risk adjustment-related data and that of other companies. The Company expects CMS and the OIG to continue these types of audits.

In 2012, CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will extrapolate the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. For contract years prior to 2011, CMS did not extrapolate sample error rates to the entire contract. As a result, the revised methodology may increase the Company's exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various contract years for RADV audit, and the number of RADV audits continues to increase. The Company is currently unable to predict which of its Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to the Company, the effect of any such refunds or adjustments on the actuarial soundness of the Company's Medicare Advantage bids, or whether any RADV audit findings would require the Company to change its method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in the Company's bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange-related or other audits by CMS, HHS-OIG or otherwise, including audits of the Company's MLR rebates, methodology and/or reports, could be material and could adversely affect the Company's operating results, cash flows and/or financial condition.

Medicare and Medicaid CIDs

The Company has received CIDs from the Civil Division of the DOJ in connection with a current investigation of the Company's patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to these CIDs.

In May 2017, the Company received a CID from the SDNY requesting documents and information concerning possible false claims submitted to Medicare in connection with reimbursements for prescription drugs under the Medicare Part D program. The Company has been cooperating with the government and providing documents and information in response to this CID.

In April 2020, the Company received a CID from the Office of the Washington Attorney General, Medicaid Fraud Control Division, on behalf of the State of Washington and all other states, as well as the District of Columbia, Puerto Rico and the U.S. Virgin Islands. The investigation involves, among other things, possible retention of overpayments and possible submission of false claims for Medicaid reimbursement relating to drugs prescribed by providers who were excluded by the applicable federal and/or state Medicaid programs. The Company is cooperating with the government with respect to this investigation.

Stockholder Matters

Beginning in February 2019, multiple class action complaints, as well as a derivative complaint were filed by putative plaintiffs against the Company and certain current and former officers and directors. The plaintiffs in these cases assert a variety of causes of action under federal securities laws that are premised on allegations that the defendants made certain omissions and misrepresentations relating to the performance of the Company's LTC business unit. Since filing, several of the cases have been consolidated, and the first-filed federal case, *City of Miami Fire Fighters' and Police Officers' Retirement Trust,* et al. (formerly known as *Anarkat*), was recently dismissed with prejudice. The Company and its current and former officers and directors are defending themselves against these claims.

In August and September 2020, two ERISA class actions were filed in the U.S. District Court for the District of Connecticut against CVS Health, Aetna, and several current and former executives, directors and/or members of Aetna's Compensation and Talent Management Committee: *Radcliffe v. Aetna Inc.,* et al. and *Flaim v. Aetna Inc.,* et al. The plaintiffs in these cases assert a variety of causes of action premised on allegations that the defendants breached fiduciary duties and engaged in prohibited transactions relating to participants in the Aetna 401(k) Plan's investment in company stock between December 3, 2017 and February 20, 2019, claiming losses related to the performance of the Company's LTC business unit. The district court consolidated the actions and the Company has moved to dismiss the amended and consolidated class action complaint. The Company also received a related document request pursuant to ERISA § 104(b), to which the Company has responded.

Other Legal and Regulatory Proceedings.

The Company is also a party to other legal proceedings and is subject to government investigations, inquiries and audits and has received and is cooperating with the government in response to CIDs, subpoenas or similar process from various governmental agencies requesting information. These other legal proceedings and government actions include claims of or relating to bad faith, medical or professional malpractice, claims processing, dispensing of medications, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits, provider network structure (including the use of performance-based networks and termination of provider contracts), rescission of insurance coverage, improper disclosure or use of personal information, anticompetitive practices, general contractual matters, product liability, intellectual property litigation and employment litigation. Some of these other legal proceedings are or are purported to be class actions or derivative claims. The Company is defending itself against the claims brought in these matters.

Awards to the Company and others of certain government contracts, particularly Medicaid contracts and other contracts with government customers in the Company's Health Care Benefits segment, frequently are subject to protests by unsuccessful bidders. These protests may result in awards to the Company being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect the Company's operating results. The Company will continue to defend contract awards it receives.

There also continues to be a heightened level of review and/or audit by regulatory authorities and legislators of, and increased litigation regarding, the Company's and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including manufacturers' rebates, pricing, the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers).

As a leading national health care company, the Company regularly is the subject of government actions of the types described above. These government actions may prevent or delay the Company from implementing planned premium rate increases and may result, and have resulted, in restrictions on the Company's businesses, changes to or clarifications of the Company's business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the

federal government, withholding of premium payments to the Company by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

The Company can give no assurance that its businesses, financial condition, operating results and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iii) pending or future federal or state government investigations of one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting one or more of the industries in which the Company competes and/or the health care industry generally.

17. Segment Reporting

The Company has three operating segments, Pharmacy Services, Retail/LTC and Health Care Benefits, as well as a Corporate/Other segment. The Company's segments maintain separate financial information, and the CODM evaluates the segments' operating results on a regular basis in deciding how to allocate resources among the segments and in assessing segment performance. The CODM evaluates the performance of the Company's segments based on adjusted operating income which is defined as operating income (GAAP measure) excluding the impact of amortization of intangible assets and other items, if any, that neither relate to the ordinary course of the Company's business nor reflect the Company's underlying business performance. See the reconciliation of consolidated operating income (GAAP measure) to adjusted operating income below for further context regarding the items excluded from operating income in determining adjusted operating income. The Company uses adjusted operating income as its principal measure of segment performance as it enhances the Company's ability to compare past financial performance with current performance and analyze underlying business performance and trends. Non-GAAP financial measures the Company discloses, such as consolidated adjusted operating income, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

In 2020 and 2019, revenues from the federal government accounted for 14% and 13%, respectively, of the Company's consolidated total revenues, primarily related to contracts with CMS for coverage of Medicare-eligible individuals within the Health Care Benefits segment. Revenues from the federal government were less than 10% of the Company's consolidated revenues in 2018. In 2018, approximately 9.8% of the Company's consolidated revenues were from Aetna, which was a Pharmacy Services segment client. On the Aetna Acquisition Date, Aetna became a wholly-owned subsidiary of CVS Health. Subsequent to the Aetna Acquisition Date, transactions with Aetna continue to be reported within the Pharmacy Services segment, but are eliminated in the Company's consolidated financial statements.

The following is a reconciliation of financial measures of the Company's segments to the consolidated totals:

In millions	Pharmacy Services [1]	Retail/ LTC	Health Care Benefits	Corporate/ Other	Intersegment Eliminations	Consolidated Totals
2020:						
Revenues from external customers	$ 132,663	$ 60,208	$ 74,926	$ 111	$ —	$ 267,908
Intersegment revenues	9,275	30,990	58	—	(40,323)	—
Net investment income	—	—	483	315	—	798
Total revenues	141,938	91,198	75,467	426	(40,323)	268,706
Adjusted operating income (loss)	5,688	6,146	6,188	(1,306)	(708)	16,008
Depreciation and amortization	612	1,801	1,832	196	—	4,441
2019:						
Revenues from external customers	130,428	56,258	68,979	100	—	255,765
Intersegment revenues	11,063	30,350	26	—	(41,439)	—
Net investment income	—	—	599	412	—	1,011
Total revenues	141,491	86,608	69,604	512	(41,439)	256,776
Adjusted operating income (loss)	5,129	6,705	5,202	(1,000)	(697)	15,339
Depreciation and amortization	766	1,723	1,721	161	—	4,371
2018:						
Revenues from external customers	130,012	54,999	8,904	4	—	193,919
Intersegment revenues	4,724	28,990	—	—	(33,714)	—
Net investment income	—	—	58	602	—	660
Total revenues	134,736	83,989	8,962	606	(33,714)	194,579
Adjusted operating income (loss)	4,955	7,403	528	(856)	(769)	11,261
Depreciation and amortization	710	1,698	172	138	—	2,718

(1) Total revenues of the Pharmacy Services segment include approximately $10.9 billion, $11.5 billion and $11.4 billion of retail co-payments for 2020, 2019 and 2018, respectively. See Note 1 ''Significant Accounting Policies'' for additional information about retail co-payments.

The following is a reconciliation of consolidated operating income to adjusted operating income for the years ended December 31, 2020, 2019 and 2018:

In millions	**2020**	**2019**	**2018**
Operating income (GAAP measure)	$ 13,911	$ 11,987	$ 4,021
Amortization of intangible assets [1]	2,341	2,436	1,006
Acquisition-related transaction and integration costs [2]	332	480	492
(Gain) loss on divestiture of subsidiary [3]	(269)	205	86
Receipt of fully reserved ACA risk corridor receivable [4]	(307)	—	—
Store rationalization charges [5]	—	231	—
Goodwill impairments [6]	—	—	6,149
Impairment of long-lived assets [7]	—	—	43
Interest income on financing for the Aetna Acquisition [8]	—	—	(536)
Adjusted operating income	$ 16,008	$ 15,339	$ 11,261

(1) The Company's acquisition activities have resulted in the recognition of intangible assets as required under the acquisition method of accounting which consist primarily of trademarks, customer contracts/relationships, covenants not to compete, technology, provider networks and value of business acquired. Definite-lived intangible assets are amortized over their estimated useful lives and are tested for impairment when events indicate that the carrying value may not be recoverable. The amortization of intangible assets is reflected in the Company's GAAP consolidated statements of operations in operating expenses within each segment. Although intangible assets contribute to the Company's revenue generation, the amortization of intangible assets does not directly relate to the underwriting of the Company's insurance products, the services performed for the Company's customers or the sale of the Company's products or services. Additionally, intangible asset amortization expense typically fluctuates based on the size and timing of the Company's acquisition activity. Accordingly, the Company believes excluding the amortization of intangible assets enhances the Company's and investors' ability to compare the Company's past financial performance with its current performance and to analyze underlying business performance and trends. Intangible asset amortization excluded from the related non-GAAP financial measure represents the entire amount recorded within the Company's GAAP financial statements, and the revenue generated by the associated intangible assets has not been excluded from the related non-GAAP financial measure. Intangible asset amortization is excluded from the related non-GAAP financial measure because the amortization, unlike the related revenue, is not affected by operations of any particular period unless an intangible asset becomes impaired or the estimated useful life of an intangible asset is revised.

(2) In 2020, 2019 and 2018, acquisition-related transaction and integration costs relate to the Aetna Acquisition. In 2018, acquisition-related integration costs also relate to the acquisition of Omnicare. The acquisition-related transaction and integration costs are reflected in the Company's consolidated statements of operations in operating expenses within the Corporate/Other segment and the Retail/LTC segment.

(3) In 2020, the gain on divestiture of subsidiary represents the pre-tax gain on the sale of the Workers' Compensation business, which the Company sold on July 31, 2020 for approximately $850 million. The gain on divestiture is reflected as a reduction in operating expenses in the Company's consolidated statement of operations within the Health Care Benefits segment. In 2019, the loss on divestiture of subsidiary represents the pre-tax loss on the sale of Onofre, which occurred on July 1, 2019. The loss on divestiture primarily relates to the elimination of the cumulative translation adjustment from accumulated other comprehensive income. In 2018, the loss on divestiture of subsidiary represents the pre-tax loss on the sale of the Company's RxCrossroads subsidiary for $725 million on January 2, 2018. The losses on divestiture of subsidiary are reflected in the Company's consolidated statements of operations in operating expenses within the Retail/LTC segment.

(4) In 2020, the Company received $313 million owed to it under the ACA's risk corridor program that was previously fully reserved for as payment was uncertain. After considering offsetting items such as the ACA's minimum MLR rebate requirements and premium taxes, the Company recognized pre-tax income of $307 million in the Company's consolidated statement of operations within the Health Care Benefits segment.

(5) In 2019, the store rationalization charges relate to the planned closure of 46 underperforming retail pharmacy stores in the second quarter of 2019 and the planned closure of 22 underperforming retail pharmacy stores in the first quarter of 2020. The store rationalization charges primarily relate to operating lease right-of-use asset impairment charges and are reflected in the Company's consolidated statement of operations in operating expenses within the Retail/LTC segment.

(6) In 2018, the goodwill impairments relate to the LTC reporting unit within the Retail/LTC segment.

(7) In 2018, impairment of long-lived assets primarily relates to the impairment of property and equipment within the Retail/LTC segment and is reflected in operating expenses in the Company's consolidated statement of operations.

(8) In 2018, the Company recorded interest income of $536 million on the proceeds of the $40 billion of unsecured senior notes it issued in March 2018 to partially fund the Aetna Acquisition. All amounts are for the periods prior to the close of the Aetna Acquisition, which occurred on November 28, 2018, and were recorded within the Corporate/Other segment.

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of CVS Health Corporation

Opinion on Internal Control over Financial Reporting

We have audited CVS Health Corporation's internal control over financial reporting as of December 31, 2020, 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, CVS Health Corporation (the Company) maintained, in all material respects, effective internal control over financial reporting as of December 31, 2020, 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 2020 consolidated financial statements of the Company and our report dated February 16, 2021, 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

Boston, Massachusetts
February 16, 2021

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of CVS Health Corporation

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of CVS Health Corporation (the Company) as of December 31, 2020 and 2019, the related consolidated statements of operations, comprehensive income (loss), shareholders' equity and cash flows for each of the three years in the period ended December 31, 2020, and the related notes (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, 2020 and 2019, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2020, 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, 2020, 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 16, 2021, 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 Matters

The critical audit matters communicated below are matters arising from the current period audit of the financial statements that were communicated or required to be communicated to the audit committee and that: (1) relate to accounts or disclosures that are material to the financial statements and (2) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters 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 matters below, providing separate opinions on the critical audit matters or on the accounts or disclosures to which they relate.

Impairment of goodwill of the Commercial Business reporting unit

Description of the Matter

At December 31, 2020, the Company's goodwill related to the Commercial Business reporting unit was $26.5 billion. As discussed in Note 1 to the consolidated financial statements, goodwill is not amortized, but rather is subject to an annual impairment review, or more frequent reviews, if events and circumstances indicate an impairment exists.

Auditing management's annual goodwill impairment test related to the Commercial Business reporting unit was complex and highly judgmental due to the significant estimation required to determine the fair value of the reporting unit. In particular, the fair value estimate was sensitive to changes in significant assumptions, such as the discount rate, projected revenue and projected operating income that are forward-looking and affected by future economic and market conditions.

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 annual goodwill impairment review process, including controls over management's review of the significant assumptions described above.

To test the estimated fair value of the Commercial Business reporting unit, we performed audit procedures that included, among others, assessing methodologies and testing the significant assumptions discussed above and the underlying data used by the Company in its analysis. We compared the significant assumptions to the reporting unit's historical results and third-party industry data. We performed sensitivity analyses of significant assumptions to evaluate the changes in the fair value of the reporting unit that would result from changes in the key assumptions. We involved valuation specialists to assist in our assessment of the methodology and significant assumptions (such as the discount rate), used by the Company. In addition, we tested management's reconciliation of the fair value of all reporting units to the market capitalization of the Company.

Valuation of health care costs payable

Description of the Matter

At December 31, 2020, the incurred but not reported ("IBNR") liabilities represented $6.1 billion of $7.9 billion of health care costs payable. As discussed in Note 1 to the financial statements, the Company's liability for health care costs payable includes estimated payments for (1) services rendered to members but not yet reported and (2) claims that have been reported but not yet paid, each as of the financial statement date (collectively, "IBNR"). The estimated IBNR liability is developed utilizing actuarial principles and assumptions that include historical and projected claim submission and processing patterns, historical and assumed medical cost trends, historical utilization of medical services, claim inventory levels, changes in membership and product mix, seasonality and other relevant factors to record the actuarial best estimate of health care costs payable. There is significant uncertainty inherent in determining management's actuarial best estimate of health care costs payable. In particular, the estimate is sensitive to the assumed completion factors and the assumed health care cost trend rates.

Auditing management's actuarial best estimate of IBNR reserves for health care costs payable for its products and services involved a high degree of subjectivity in evaluating management's assumptions used in the valuation process.

How We Addressed the Matter in Our Audit

We obtained an understanding, evaluated the design and tested the operating effectiveness of controls over the process for estimating IBNR reserves. This included, among others, controls over the completeness and accuracy of data used in the actuarial projections, the transfer of data between underlying source systems, and the review and approval processes that management has in place for the actuarial principles and assumptions used in estimating the health care costs payable.

To test IBNR reserves, our audit procedures included, among others, testing the completeness and accuracy of the underlying claim and membership data used in the calculation of IBNR reserves. We involved actuarial specialists to assist with our audit procedures, which included, among others, evaluating the methodologies applied by the Company in determining the actuarially determined liability, evaluating management's actuarial principles and assumptions used in their analysis based on historical claim experience, and independently calculating a range of reserve estimates for comparison to management's actuarial best estimate of the liability for health care costs payable. 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 2007.

Boston, Massachusetts
February 16, 2021

Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure.

None.

Item 9A. Controls and Procedures.

Evaluation of disclosure controls and procedures

The Company's Chief Executive Officer and Chief Financial Officer, after evaluating the effectiveness of the design and operation of the Company's disclosure controls and procedures (as defined in Rules 13a-15 (f) and 15d-15(f) under the Securities Exchange Act of 1934) as of December 31, 2020, have concluded that as of such date the Company's disclosure controls and procedures were adequate and effective at a reasonable assurance level and designed to ensure that material information relating to the Company and its consolidated subsidiaries would be made known to such officers on a timely basis.

Management's report on internal control over financial reporting

Management is responsible for establishing and maintaining adequate internal control over financial reporting. The 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 the Company's consolidated 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 Company's consolidated financial statements. In order to ensure the Company's internal control over financial reporting is effective, management regularly assesses such control and did so most recently for its financial reporting as of December 31, 2020.

Management conducted an assessment of the effectiveness of the Company's internal control over financial reporting based on the criteria established in *Internal Control-Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 Framework). This evaluation included review of the documentation, evaluation of the design effectiveness and testing of the operating effectiveness of controls. The Company's system of internal control over financial reporting is enhanced by periodic reviews by the Company's internal auditors, written policies and procedures and a written Code of Conduct adopted by CVS Health's Board of Directors, applicable to all employees of the Company. In addition, the Company has an internal Disclosure Committee, comprised of management from each functional area within the Company, which performs a separate review of disclosure controls and procedures. There are inherent limitations in the effectiveness of any system of internal control over financial reporting.

Based on management's assessment, management concluded that the Company's internal control over financial reporting is effective and provides reasonable assurance that assets are safeguarded and that the financial records are reliable for preparing financial statements as of December 31, 2020.

Ernst & Young LLP, the Company's independent registered public accounting firm, is appointed by CVS Health's Board of Directors and ratified by CVS Health's stockholders. They were engaged to render an opinion regarding the fair presentation of the Company's consolidated financial statements as well as conducting an audit of internal control over financial reporting. Their reports included in Item 8 of this Form 10-K are based upon audits conducted in accordance with the standards of the Public Company Accounting Oversight Board (United States).

Changes in internal control over financial reporting

There has been no change in the Company's internal control over financial reporting identified in connection with the evaluation required by paragraph (d) of Rule 13a-15 or Rule 15d-15 that occurred during the fourth quarter ended December 31, 2020 that has materially affected, or is reasonably likely to materially affect, the Company's internal control over financial reporting.

Item 9B. Other Information.

No events have occurred during the fourth quarter ended December 31, 2020 that would require disclosure under this item.

PART III

Item 10. Directors, Executive Officers and Corporate Governance.

Information concerning the Executive Officers of CVS Health Corporation is included in Part I of this 10-K pursuant to General Instruction G to Form 10-K.

The sections of the Proxy Statement under the captions "Committees of the Board as of the Annual Meeting," "Code of Conduct," "Audit Committee Report," and "Biographies of our Incumbent Board Nominees" are incorporated herein by reference.

Item 11. Executive Compensation.

The sections of the Proxy Statement under the captions "Non-Employee Director Compensation" and "Executive Compensation and Related Matters," including "Letter from the Management Planning and Development Committee," "Compensation Committee Report," "Compensation Discussion and Analysis" and "Compensation of Named Executive Officers" are incorporated herein by reference.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.

The sections of the Proxy Statement under the captions "Share Ownership of Directors and Certain Executive Officers" and "Share Ownership of Principal Stockholders" are incorporated herein by reference. Those sections contain information concerning security ownership of certain beneficial owners and management and related stockholder matters.

The following table summarizes information about the registrant's common stock that may be issued upon the exercise of options, warrants and rights under all of the Company's equity compensation plans as of December 31, 2020:

	Number of securities to be issued upon exercise of outstanding options, warrants and rights [1] [2] (a)	Weighted average exercise price of outstanding options, warrants and rights (b)	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in first column) [1] (c)
Equity compensation plans approved by stockholders [3]	33,944	$ 72.18	37,856
Equity compensation plans not approved by stockholders [4]	4,812	43.27	—
Total	38,756	$ 71.18	37,856

(1) Shares in thousands.
(2) Consists of: (i) 21,796 shares of common stock underlying outstanding options, (ii) 779 shares of common stock issuable upon the exercise of outstanding stock appreciation rights ("SARs") and (iii) 16,181 shares of common stock issuable on the vesting of outstanding restricted stock units, deferred stock units and performance stock units, assuming target level performance in the case of performance stock units. The number of shares included with respect to outstanding SARs is the number of shares of CVS Health common stock that would have been issued had the SARs been exercised based on the closing price per share of CVS Health common stock on December 31, 2020, as reported on the NYSE, which was $68.30.
(3) Consists of the CVS Health 2017 Incentive Compensation Plan.
(4) Consists of the Amended Aetna Inc. 2010 Stock Incentive Plan (the "Aetna Stock Plan"). The Aetna Stock Plan expired on May 21, 2020, therefore there are no securities available for future issuance under this plan.

The Aetna Stock Plan was last approved by Aetna's shareholders at Aetna's 2017 Annual Meeting on May 19, 2017. The Company elected to continue to grant awards under the Aetna Stock Plan to employees of Aetna and its subsidiaries following the completion of the Aetna Acquisition. The Aetna Stock Plan was designed to promote the Company's interests and those of its stockholders and to further align the interests of stockholders and employees by tying awards to total return to stockholders, enabling plan participants to acquire additional equity interests in the Company and providing compensation opportunities dependent upon the Company's performance. The Aetna Stock Plan was not submitted to the Company's stockholders and expired on May 21, 2020. Under the Aetna Stock Plan, eligible participants could be granted stock options to purchase shares of

CVS Health common stock, SARs, time-vesting and/or performance-vesting incentive stock or incentive units and other stock-based awards.

Item 13. Certain Relationships and Related Transactions, and Director Independence.

The sections of the Proxy Statement under the captions “Independence Determinations for Directors” and “Related Person Transaction Policy” are incorporated herein by reference.

Item 14. Principal Accountant Fees and Services.

The section of the Proxy Statement under the caption “Item 2: Ratification of Appointment of Independent Registered Public Accounting Firm for 2021” is incorporated herein by reference.

PART IV

Item 15. Exhibits, Financial Statement Schedules.

The following documents are filed as part of this 10-K:

1. Financial Statements. See "Index to Consolidated Financial Statements" in Item 8 of this 10-K.

2. Financial Statement Schedules. All financial statement schedules are omitted because they are not applicable, not required under the instructions, or the information is included in the consolidated financial statements or related notes.

3. Exhibits. The exhibits listed in the "Index to Exhibits" in this Item 15 are filed or incorporated by reference as part of this 10-K. Exhibits marked with an asterisk (*) are management contracts or compensatory plans or arrangements. Exhibits other than those listed are omitted because they are not required to be listed or are not applicable. Pursuant to Item 601(b)(4)(iii) of Regulation S-K, the Registrant hereby agrees to furnish to the Securities and Exchange Commission a copy of any omitted instrument that is not required to be listed.

INDEX TO EXHIBITS

Exhibit	Description
2	**Plan of acquisition, reorganization, arrangement, liquidation or succession**
2.1	Agreement and Plan of Merger, dated as of May 20, 2015, among CVS Pharmacy, Inc., Tree Merger Sub, Inc. and Omnicare, Inc. (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K filed May 21, 2015).
2.2	Master Transaction Agreement dated as of October 22, 2017, by and between Aetna Inc. and Hartford Life and Accident Insurance Company (incorporated by reference to Exhibit 2.3 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
2.3	Agreement and Plan of Merger, dated as of December 3, 2017, among CVS Health Corporation, Hudson Merger Sub Corp. and Aetna Inc. (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K filed December 5, 2017).
3	**Articles of Incorporation and Bylaws**
3.1	Restated Certificate of Incorporation of the Registrant dated June 4, 2018 (incorporated by reference to Exhibit 3.1C of Registrant's Current Report on Form 8-K filed June 5, 2018).
3.2	By-Laws of the Registrant, as amended and restated July 8, 2020 (incorporated by reference to Exhibit 3.1 to the Registrant's Current Report on Form 8-K filed July 10, 2020).
4	**Instruments defining the rights of security holders, including indentures**
4.1	Specimen common stock certificate (incorporated by reference to Exhibit 4.1 to the Registration Statement of the Registrant ((then known as CVS Corporation) as successor to Melville Corporation) on Form 8-B filed November 4, 1996).
4.2	Senior Indenture dated August 15, 2006, between the Registrant and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed August 15, 2006).
4.3	Form of the Registrant's 2021 Floating Rate Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.4	Form of the Registrant's 2021 Note (incorporated by reference to Exhibit 4.4 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.5	Form of the Registrant's 2023 Note (incorporated by reference to Exhibit 4.5 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.6	Form of the Registrant's 2025 Note (incorporated by reference to Exhibit 4.6 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.7	Form of the Registrant's 2028 Note (incorporated by reference to Exhibit 4.7 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.8	Form of the Registrant's 2038 Note (incorporated by reference to Exhibit 4.8 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.9	Form of the Registrant's 2048 Note (incorporated by reference to Exhibit 4.9 to the Registrant's Current Report on Form 8-K filed March 12, 2018).

4.10	Form of the Registrant's 2024 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed August 15, 2019).
4.11	Form of the Registrant's 2026 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed August 15, 2019).
4.12	Form of the Registrant's 2029 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed August 15, 2019).
4.13	Form of the Registrant's 2027 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed on March 31, 2020).
4.14	Form of the Registrant's 2030 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed on March 31, 2020).
4.15	Form of the Registrant's 2040 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed on March 31, 2020).
4.16	Form of the Registrant's 2050 Note (incorporated by reference to Exhibit 4.4 to the Registrant's Current Report on Form 8-K filed on March 31, 2020).
4.17	Form of the Registrant's 2027 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed on August 21, 2020).
4.18	Form of the Registrant's 2030 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed on August 21, 2020).
4.19	Form of the Registrant's 2040 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed on August 21, 2020).
4.20	Form of the Registrant's 2027 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed on December 16, 2020).
4.21	Form of the Registrant's 2031 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed on December 16, 2020).
4.22	Material terms of outstanding securities that are registered under Section 12 of the 1934 Act as required by Item 202(a)-(d) and (f) of Regulation S-K.
10	**Material Contracts**
10.1	Five Year Credit Agreement, dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017).
10.2	Amendment No. 1 to Five Year Credit Agreement dated as of December 15, 2017, to the Five Year Credit Agreement dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.3 to the Registrant's Current Report on Form 8-K filed December 19, 2017).
10.3	Amendment No. 2 to Five Year Credit Agreement dated as of May 17, 2018, to the Five Year Credit Agreement dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.4 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018).
10.4	Amendment No. 3, dated as of May 16, 2019, to the Five Year Credit Agreement dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.4 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).
10.5	Five Year Credit Agreement dated as of May 17, 2018, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018).
10.6	Amendment No. 1, dated as of May 16, 2019, to the Five Year Credit Agreement dated as of May 17, 2018, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.3 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).
10.7	364-Day Credit Agreement dated as of May 13, 2020 by and among the Registrant, the lenders party thereto, Barclays Bank PLC and JPMorgan Chase Bank, N.A., as Co-Syndication Agents, Goldman Sachs Bank USA, and Wells Fargo Bank, National Association, as Co-Documentation Agents, and Bank of America, N.A., as Administrative Agent (incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2020).
10.8	Five Year Credit Agreement dated as of May 16, 2019 by and among the Registrant, the lenders party thereto and Bank of America, N.A., as Administrative Agent (incorporated by reference to Exhibit 10.2 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).

10.9*	The Registrant's Supplemental Retirement Plan I for Select Senior Management, as amended and restated as of December 31, 2008 (incorporated by reference to Exhibit 10.6 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2009).
10.10*	Form of Enterprise Non-Competition, Non-Disclosure and Developments Agreement between the Registrant and certain of the Registrant's executive officers (incorporated by reference to Exhibit 10.25 of the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2013).
10.11*	The Registrant's Deferred Stock Compensation Plan, as amended and restated (incorporated by reference to Exhibit 10.11 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2019).
10.12*	The Registrant's 2007 Employee Stock Purchase Plan, as amended (incorporated by reference to Exhibit 99.2 to the Registrant's Registration Statement on Form S-8 filed May 19, 2020).
10.13*	Universal 409A Definition Document, as amended (incorporated by reference to Exhibit 10.28 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
10.14*	The Registrant's Deferred Compensation Plan, as amended and restated (incorporated by reference to Exhibit 10.14 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2019).
10.15*	The Registrant's Partnership Equity Program, as amended (incorporated by reference to Exhibit 10.25 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.16*	The Registrant's Performance-Based Restricted Stock Unit Plan, as amended (incorporated by reference to Exhibit 10.27 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.17*	The Registrant's 2017 Incentive Compensation Plan, as amended (incorporated by reference to Exhibit 99.1 to the Registrant's Registration Statement on Form S-8 filed May 19, 2020).
10.18*	The Registrant's Executive Incentive Plan, as amended (incorporated by reference to Exhibit 10.4 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017).
10.19*	The Registrant's Long-Term Incentive Plan, as amended (incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017).
10.20*	Form of Non-Qualified Stock Option Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.29 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.21*	Form of Restricted Stock Unit Agreement - Annual Grant - between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.30 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.22*	Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.23*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Pre-Tax) (incorporated by reference to Exhibit 10.32 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.24*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Post-Tax) (incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.25*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2018).
10.26*	Form of Performance Stock Unit Agreement (LTIP) - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2018).
10.27*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended September 30, 2020).
10.28*	The Registrant's Management Incentive Plan (incorporated by reference to Exhibit 10.27 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2019).
10.29*	The Registrant's Severance Plan for Non-Store Employees amended as of November 28, 2018 (incorporated by reference to Exhibit 10.37 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.30*	The Registrant's Performance-Based Restricted Stock Unit Program, as amended (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.31*	Form of Non-Qualified Stock Option Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.39 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).

10.32*	Form of Restricted Stock Unit Agreement - Annual Grant - between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.40 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.33*	Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.41 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.34*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Pre-Tax) (incorporated by reference to Exhibit 10.42 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.35*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Post-Tax) (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2013).
10.36*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.5 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).
10.37*	Amended and Restated Employment Agreement between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2008).
10.38*	Amendment dated as of December 21, 2012 to the Amended and Restated Employment Agreement between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012).
10.39*	Form of Non-Qualified Stock Option Agreement - Annual Grant between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.37 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.40*	Form of Restricted Stock Unit Agreement - Annual Grant between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.41*	Amendment dated January 22, 2015 to Nonqualified Stock Option Agreements between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K filed January 23, 2015).
10.42*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).
10.43*	Change in Control Agreement effective as of July 19, 2010 between the Registrant and Eva Boratto (incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2019).
10.44*	Restrictive Covenant Agreement dated June 21, 2019 between the Registrant and Eva Boratto (incorporated by reference to Exhibit 10.48 to the registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2019).
10.45*	Change in Control Agreement dated December 22, 2008 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012).
10.46*	Amendment dated as of December 31, 2012 to the Change in Control Agreement dated December 22, 2008 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.34 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012).
10.47*	Restricted Stock Unit Agreement - Annual Grant dated April 1, 2016 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.44 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.48*	Restrictive Covenant Agreement dated May 20, 2016 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.45 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.49*	Change in Control Agreement dated October 1, 2012 between the Registrant and Thomas Moriarty (incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2015).
10.50*	Restrictive Covenant Agreement dated July 8, 2019 between the Registrant and Thomas Moriarty (incorporated by reference to Exhibit 10.56 of the Registrant's Annual Report on form 10-K for the fiscal year ended December 31, 2019).
10.51*	Amended and Restated Employment Agreement dated November 5, 2020 between the Registrant and Karen S. Lynch.

10.52*	Restrictive Covenant Agreement dated November 6, 2020 between the Registrant and Karen S. Lynch.
10.53*	Descriptions of certain arrangements not embodied in formal documents as described under the heading "Non-Employee Director Compensation" are incorporated herein by reference to the Proxy Statement (when filed).
21	**Subsidiaries of the registrant**
21.1	Subsidiaries of CVS Health Corporation.
23	**Consents of experts and counsel**
23.1	Consent of Ernst & Young LLP.
31	**Rule 13a-14(a)/15d-14(a) Certifications**
31.1	Certification by the Chief Executive Officer.
31.2	Certification by the Chief Financial Officer.
32	**Section 1350 Certifications**
32.1	Certification by the Chief Executive Officer.
32.2	Certification by the Chief Financial Officer.
101	**Interactive Data File**
101	The following materials from the CVS Health Corporation Annual Report on Form 10-K for the fiscal year ended December 31, 2020 formatted in Inline XBRL: (i) the Consolidated Statements of Operations, (ii) the Consolidated Statements of Comprehensive Income (Loss), (iii) the Consolidated Balance Sheets, (iv) the Consolidated Statements of Cash Flows, (v) the Consolidated Statements of Shareholders' Equity and (vi) the related Notes to Consolidated Financial Statements. The instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
104	
104	Cover Page Interactive Data File - The cover page from the Company's Annual Report on Form 10-K for the year ended December 31, 2020, formatted in Inline XBRL (included as Exhibit 101).

Item 16. Form 10-K Summary.

None.

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SIGNATURES

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

CVS HEALTH CORPORATION

Date: February 16, 2021

By: /s/ EVA C. BORATTO

Eva C. Boratto

Executive Vice President and Chief Financial Officer

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

Signature	Title(s)	Date
/s/ FERNANDO AGUIRRE **Fernando Aguirre**	Director	February 16, 2021
/s/ C. DAVID BROWN II **C. David Brown II**	Director	February 16, 2021
/s/ EVA C. BORATTO **Eva C. Boratto**	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 16, 2021
/s/ JAMES D. CLARK **James D. Clark**	Senior Vice President - Controller and Chief Accounting Officer (Principal Accounting Officer)	February 16, 2021
/s/ ALECIA A. DECOUDREAUX **Alecia A. DeCoudreaux**	Director	February 16, 2021
/s/ NANCY-ANN M. DEPARLE **Nancy-Ann M. DeParle**	Director	February 16, 2021
/s/ DAVID W. DORMAN **David W. Dorman**	Chair of the Board and Director	February 16, 2021
/s/ ROGER N. FARAH **Roger N. Farah**	Director	February 16, 2021
/s/ ANNE M. FINUCANE **Anne M. Finucane**	Director	February 16, 2021
/s/ EDWARD J. LUDWIG **Edward J. Ludwig**	Director	February 16, 2021
/s/ KAREN S. LYNCH **Karen S. Lynch**	President and Chief Executive Officer (Principal Executive Officer) and Director	February 16, 2021
/s/ LARRY J. MERLO **Larry J. Merlo**	Director	February 16, 2021
/s/ JEAN-PIERRE MILLON **Jean-Pierre Millon**	Director	February 16, 2021
/s/ MARY L. SCHAPIRO **Mary L. Schapiro**	Director	February 16, 2021
/s/ WILLIAM C. WELDON **William C. Weldon**	Director	February 16, 2021
/s/ TONY L. WHITE **Tony L. White**	Director	February 16, 2021

Exhibit 4.22

DESCRIPTION OF COMMON STOCK REGISTERED UNDER SECTION 12 OF THE SECURITIES EXCHANGE ACT OF 1934

The following description (this "Description") of the terms of the common stock of CVS Health Corporation ("CVS Health") is a summary only and is qualified by reference to the relevant provisions of Delaware law and the Restated Certificate of Incorporation (the "Charter") and the By-Laws (the "By-Laws") of CVS Health. Copies of the Charter and the By-Laws are incorporated by reference as exhibits to the Annual Report on Form 10-K to which this Description is an exhibit.

Authorized Capital Stock

Under the Charter as of February 16, 2021, the authorized capital stock of CVS Health consisted of (i) 3,200,000,000 shares of common stock, par value of $0.01 per share ("common stock"), (ii) 120,619 shares of cumulative preferred stock, par value $0.01 per share ("preferred stock"), and (iii) 50,000,000 shares of preference stock, par value $1.00 per share ("preference stock").

Common Stock

The holders of shares of common stock are entitled to one vote per share on all matters voted on by CVS Health stockholders, including elections of directors. Except as otherwise required by law, or by the provisions of the preferred stock or the preference stock, or provided in any resolution adopted by the CVS Health board of directors (the "board") with respect to any subsequently created class or series of shares of CVS Health, the holders of the shares of common stock exclusively possess all voting power. The Charter precludes cumulative voting in the election of directors. The Charter provides for a majority vote standard for uncontested elections of directors, and a plurality of votes standard for contested elections of directors. Subject to any rights of any outstanding series of preferred stock or preference stock, (i) the holders of shares of common stock are entitled to such dividends as may be declared from time to time by the board from funds available therefor, (ii) no dividends may be declared, paid, or set aside for payment on shares of common stock unless full cumulative dividends are paid on any outstanding preference stock and any other preferred stock issued and outstanding at such time that is designated to have such dividend preference and (iii) upon dissolution the holders of shares of common stock are entitled to receive pro rata all assets of CVS Health available for distribution to such holders, subject to any liquidation preferences designated to any preferred stock or preference stock that may be issued and outstanding at such time of liquidation.

No Preemptive Rights

The Charter provides that no holder of any shares of CVS Health of any class or series may have any preemptive right to purchase or subscribe to any shares of CVS Health or any security convertible into shares of CVS Health of any class or series.

Provisions Relating to Amendments to CVS Health's Charter and By-Laws

Under Delaware law, stockholders have the right to adopt, amend or repeal the certificate of incorporation and by-laws of a corporation. However, Delaware law requires that any amendment to the Charter also be approved by the board. Under Delaware law, unless a higher vote is required in a corporation's certificate of incorporation, amendments to the corporation's certificate of incorporation will be adopted upon receiving at a properly convened meeting the affirmative vote of a majority of the votes cast by all stockholders entitled to vote thereon, and if any class or series is entitled to vote thereon as a class, the affirmative vote of a majority of the votes cast in each class vote.

In addition, the By-Laws may be amended by the board with respect to all matters not exclusively reserved by law to the stockholders. Amendments to the By-Laws may be adopted and approved by the affirmative vote of the holders of record of a majority of the outstanding shares of stock of CVS Health entitled to vote at any annual or special meeting, or by the affirmative vote of a majority of the directors cast at any regular or special meeting, at which a quorum is present.

Certain Statutory and Charter Provisions

Certain provisions of the Charter and By-Laws summarized in the following paragraphs may be deemed to have an antitakeover effect and may delay, defer or prevent a tender offer or takeover attempt.

Potential Issuances of Preferred Stock and Preference Stock

As of February 16, 2021, the Charter authorized 120,619 shares of preferred stock, par value $0.01 per share and 50,000,000 shares of preference stock, par value $1.00 per share. The Charter also authorizes the board to issue shares of preferred stock or preference stock, from time to time, in such class or classes, and such series within any class, and with such designations, preferences and relative, participating, optional or other special rights, and qualifications, limitations or restrictions thereof as the board may determine, including, for example, (i) the designation of the class or series; (ii) the number of shares of the class or series, which number the board may thereafter (except where otherwise provided in the designation of any subsequently authorized class or series) increase or decrease (but not below the number of shares thereof then outstanding); (iii) whether dividends, if any, will be cumulative or noncumulative and the dividend rate of the class or series; (iv) the dates on which dividends, if any, will be payable; (v) the redemption rights and price or prices, if any, for shares of the class or series; (vi) the terms and amounts of any sinking fund provided for the purchase or redemption of shares of the class or series; (vii) the amounts payable on shares of the class or series in the event of any voluntary or involuntary liquidation, dissolution or winding up of the affairs of CVS Health; (viii) whether the shares of the class or series will be convertible into shares of any other class or series, or any other security, of CVS Health or any other corporation, and, if so, the specification of such other class or series or such other security, the conversion price or prices or rate or rates, any adjustments thereof, the date or dates as of which such shares will be convertible and all other terms and conditions upon which such conversion may be made; (ix) restrictions on the issuance of shares of the same class or series or of any other class or series; and (x) the voting rights, if any, of the holders of such class or series. The authorized capital stock of CVS Health, including preferred stock, preference stock and common stock, will be available for issuance without further action by CVS Health stockholders, unless such action is required by applicable law or the rules of any stock exchange or automated quotation system on which CVS Health's securities may be listed or traded. If the approval of CVS Health stockholders is not so required, the board does not intend to seek stockholder approval.

Although the board has no intention at the present time of doing so, it could issue a class or series of preferred stock or preference stock that could, depending on the terms of such class or series, impede completion of a merger, tender offer or other takeover attempt that the holders of some, or a majority, of CVS Health shares might believe to be in their best interests or in which CVS Health stockholders might receive a premium for their shares over the then-current market price of such shares.

Potential Issuances of Rights to Purchase Securities

CVS Health does not currently have a stockholder rights plan, although the board retains the right to adopt a new plan at a future date. The Charter grants the board exclusive authority to create and issue rights entitling the holders thereof to purchase from CVS Health shares of capital stock or other securities and to elect to repurchase, redeem, terminate or amend any such rights. The times at which and terms upon which such rights are to be issued, repurchased, redeemed, terminated or amended are to be determined exclusively by the board and set forth in the contracts or instruments that evidence any such rights. The authority of the board with respect to such rights includes determining, for example, (i) the purchase price of the capital stock or other securities or property to be purchased upon exercise of such rights; (ii) provisions relating to the times at which and the circumstances under which such rights may be exercised or sold or otherwise transferred, either together with or separately from any other shares or other securities of CVS Health; (iii) provisions which adjust the number or exercise price of such rights or the amount or nature of the shares, other securities or other property receivable upon exercise of such rights in the event of a combination, split or recapitalization of any shares of CVS Health, a change in ownership of CVS Health's shares or other securities or a reorganization, merger, consolidation, sale of assets or other occurrence relating to CVS Health or any shares of CVS Health, and provisions restricting the ability of CVS Health to enter into any such transaction absent an assumption by the other party or parties thereto of the obligations of CVS Health under such rights; (iv) provisions which deny the holder of a specified percentage of the outstanding securities of CVS Health the right to exercise such rights and/or cause such rights held by such holder to become void; (v) provisions which

permit CVS Health to redeem or exchange such rights; and (vi) the appointment of the rights agent with respect to such rights. This provision is intended to confirm the board's exclusive authority to issue, repurchase, redeem, terminate or amend share purchase rights or other rights to purchase shares or securities of CVS Health or any other corporation.

Stockholder Action by Written Consent

The Charter provides that stockholder action may be taken at an annual or special meeting of stockholders or by written consent in lieu of a meeting, but only if such action is taken in accordance with the provisions of the Charter and By-Laws. Any person other than CVS Health seeking to have the CVS Health stockholders authorize or take corporate action by written consent without a meeting is required to deliver a written notice signed by holders of record of at least twenty-five percent (25%) of the voting power of the outstanding capital stock of CVS Health entitled to express consent on the relevant action and request that a record date be fixed for such purpose.

Stockholder Vote on Fundamental or Extraordinary Corporate Transactions

Under Delaware law, a sale, lease or exchange of all or substantially all of CVS Health's assets, an amendment to the Charter, a merger or consolidation of CVS Health with another corporation or a dissolution of CVS Health generally requires the affirmative vote of the board and, with limited exceptions, the affirmative vote of a majority of the aggregate voting power of the outstanding stock entitled to vote on the transaction.

With respect to transactions with related persons (persons who own at least 10% of the outstanding capital stock of CVS Health), the Charter provides that a majority of outstanding shares (excluding those owned by the related person) voting as a single class is required to approve a business combination transaction with a related person, unless (i) such transaction is approved by a majority of continuing directors (directors who are not the related person, or an affiliate or associate thereof (or a representative or nominee of the related person or such affiliate or associate), that is involved in the relevant business combination and (a) who were members of the board immediately prior to the time that such related person became a related person or (b) whose initial election as a director was recommended by the affirmative vote of a least a majority of the continuing directors then in office, provided that, in either such case, such continuing director has continued in office after becoming a continuing director) or (ii) certain fair price requirements are met.

State Anti-Takeover Provisions

CVS Health has not opted out of Section 203 of the Delaware General Corporation Law, which provides that, if a person acquires 15% or more of the outstanding voting stock of a Delaware corporation, thereby becoming an "interested stockholder," that person may not engage in certain "business combinations" with the corporation, including mergers, purchases and sales of 10% or more of its assets, stock purchases and other transactions pursuant to which the percentage of the corporation's stock owned by the interested stockholder increases (other than on a pro rata basis) or pursuant to which the interested stockholder receives a financial benefit from the corporation, for a period of three years after becoming an interested stockholder unless one of the following exceptions applies: (i) the board approved the acquisition of stock pursuant to which the person became an interested stockholder or the transaction that resulted in the person becoming an interested stockholder prior to the time that the person became an interested stockholder; (ii) upon consummation of the transaction that resulted in the person becoming an interested stockholder such person owned at least 85% of the outstanding voting stock of CVS Health, excluding, for purposes of determining the voting stock outstanding, voting stock owned by directors who are also officers and certain employee stock plans; or (iii) the transaction is approved by the board and by the affirmative vote of two-thirds of the outstanding voting stock which is not owned by the interested stockholder. An "interested stockholder" also includes the affiliates and associates of a 15% or more owner and any affiliate or associate of CVS Health who was the owner of 15% or more of the outstanding voting stock within the three-year period prior to determine whether a person is an interested stockholder.

Exhibit 10.51

AMENDED AND RESTATED EMPLOYMENT AGREEMENT

AMENDED AND RESTATED EMPLOYMENT AGREEMENT (this "**Agreement**"), dated this 5th day of November 2020, by and between CVS Health Corporation, a Delaware corporation (the "**Company**" or "**CVS Health**"), and Karen S. Lynch ("**Executive**") (certain capitalized terms used herein being defined in Article 6).

WHEREAS, Executive is currently employed as Executive Vice President, CVS Health and President, Aetna, pursuant to an employment agreement dated, as of December 10, 2014, which was amended on November 28, 2018 (the "**Original Employment Agreement**");

WHEREAS, the Company and Executive desire for Executive to transition from Executive's position as Executive Vice President, CVS Health and President, Aetna to the position of President and Chief Executive Officer of the Company; and

WHEREAS, in connection with such transition, the Company and Executive desire to amend and restate the Original Employment Agreement in its entirety to reflect the prior amendment thereto and to set forth the revised terms of Executive's employment as President and Chief Executive Officer of the Company.

NOW THEREFORE, in consideration of the foregoing and of the mutual covenants and agreements of the parties set forth in this Agreement, and of other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto, intending to be legally bound, agree as follows:

ARTICLE 1

POSITION; AT-WILL EMPLOYMENT

SECTION 1.01. *Position.*

(a) Effective on the 1st day of February 2021 (the "**Effective Date**"), Executive shall commence her duties as President and Chief Executive Officer of CVS Health and shall provide services to CVS Health and its subsidiaries in accordance with the terms of this Agreement. Executive acknowledges that Executive's employment under this Agreement will be with CVS Pharmacy, Inc., a Delaware corporation and a subsidiary of CVS Health, and therefore references to the Company in this Agreement shall also refer to CVS Pharmacy, Inc., unless the context indicates otherwise. Executive shall be appointed to the Board of Directors of CVS Health Corporation effective February 1, 2021 and, thereafter, shall be subject to annual re-election by stockholders beginning with the 2021 Annual Meeting of Stockholders.

(b) In such position, Executive shall have such duties, responsibilities and authority, consistent with such position, as shall be determined from time to time by the Board and shall report to the Board.

(c) During Executive's employment with the Company, Executive will devote substantially all of her business time to the performance of her duties hereunder and will not engage in any other business, profession or occupation for compensation or otherwise which would conflict with the rendition of such services either directly or indirectly, without the prior written consent of

the Board; provided that nothing herein shall be deemed to preclude Executive, subject to the prior written consent of the Board, from serving on any business, civic or charitable board, managing personal investments or participating in CEO leadership events, as long as such activities do not materially interfere with the performance of Executive's duties hereunder. If the Company concludes that it is desirable, upon the Company's request, Executive will resign from any board of directors on which she serves as soon as reasonably practicable considering her fiduciary duty to such board's company or civic or charitable organization, as the case may be.

SECTION 1.02. *At-will Employment.* Executive's employment under this Agreement shall commence on the Effective Date and shall end on the date Executive's employment is terminated, as provided herein. For the avoidance of doubt, Executive's employment with the Company shall at all times be on an at-will basis and nothing in this Agreement shall provide Executive the right to employment for any specified period following the Effective Date.

ARTICLE 2

COMPENSATION AND BENEFITS

SECTION 2.01. *Base Salary.* Starting on the Effective Date, the Company shall pay Executive an annual base salary (the "**Base Salary**") at the initial annual rate of $1,450,000 payable in equal monthly installments or otherwise in accordance with the payroll and personnel practices of the Company from time to time. The Base Salary shall be reviewed annually by the Board or the Committee for possible increase in the sole discretion of the Board or the Committee, as the case may be. Executive's Base Salary, as in effect from time to time, may not be reduced by the Company without Executive's consent, except in the event of a ratable reduction affecting all senior officers of the Company.

SECTION 2.02. *Incentive Compensation.* Subject in each case to Executive's continued employment as contemplated hereby:

(a) Executive shall be eligible to participate in the Company's annual bonus plan for similarly situated executives (the "**Annual Bonus Plan**") with a target annual cash bonus opportunity of 200% of Base Salary (the "**Annual Bonus**"). Executive's eligibility and target annual cash bonus opportunity are subject to periodic review and adjustment by the Board or the Committee. The Annual Bonus shall be determined in accordance with the terms of the Annual Bonus Plan, and payment of the Annual Bonus shall be made at the same time that other senior-level executives of the Company receive their incentive awards, which is generally in March following the plan year.

(b) Executive shall be eligible to receive annual equity awards at a level commensurate with Executive's position beginning in calendar year 2021. For 2021, the cash value of Executive's target annual equity award is $11,000,000. The composition of annual equity awards is currently 75% Company performance stock units ("**PSUs**") and 25% stock options. As of the date hereof, PSUs have a three-year cliff vesting period and a two-year post-vesting holding period for net shares of Company common stock delivered upon settlement, and stock options vest in four equal installments on the first four anniversaries of the grant date and have a ten-year term. The Company's annual equity award program components, terms and weightings are reviewed annually by the Committee and are subject to change.

SECTION 2.03. *Employee Benefits; Perquisites*.

(a) Executive shall be eligible for employee benefits that are offered to similarly situated executives of the Company.

(b) Executive shall be entitled to use the Company aircraft in accordance with the Company's aircraft policy, as approved by the Committee and as in effect from time to time. Executive shall reimburse the Company for any costs of personal air travel that exceed $250,000 per calendar year.

SECTION 2.04. *Business Expenses.*

(a) Reasonable travel, entertainment and other business expenses incurred by Executive in the performance of her duties hereunder shall be reimbursed by the Company in accordance with the Company's policies as in effect from time to time.

(b) The Company shall provide Executive with appropriate office facilities and support at the Company's headquarters, which shall be Executive's principal job location.

ARTICLE 3

CERTAIN BENEFITS

SECTION 3.01. *Certain Events.* A "**Qualifying Event**" means any of the following events:

(a) The involuntary termination of Executive's employment by the Company, other than (y) for Cause, or (z) by reason of Executive's death or Disability; or

(b) Executive's voluntary termination of employment for Good Reason, provided that Executive shall have provided the Company with notice of any event constituting Good Reason no later than 30 days following the occurrence of such event and such termination occurs within 90 days after the occurrence of any event constituting Good Reason (that has not otherwise been cured by the Company prior to the end of such 90-day period).

SECTION 3.02. *Separation Payments*. Except to the extent provided in Section 5.09 and Section 5.18, Executive shall be entitled to the benefits set forth below (the "**Separation Benefits**") upon a termination of employment:

(a) Upon any termination of employment including by reason of death or Disability, Executive's voluntary termination of employment (with or without Good Reason) or upon involuntary termination of Executive's employment by the Company, Executive shall be entitled to:

(i) Executive's earned but unpaid Base Salary and other vested but unpaid cash entitlements (including any earned but unpaid cash Annual Bonus for the performance year prior to the year in which Executive terminates employment) for the period through and including the date of termination of Executive's employment (other than entitlements referenced in Section 3.02(b) below) (the "**Accrued Compensation**"); and

(ii) Executive's other vested benefits earned by Executive for the period through and including the date of Executive's termination of employment, which shall be paid in accordance with the terms of the applicable plans, programs or arrangements (the "**Accrued Benefits**").

(b) Upon a Qualifying Event, the Company shall pay Executive in addition to the amounts set forth in Section 3.02(a) above:

(i) Cash compensation through the second anniversary of such Qualifying Event (the "**Payment Period**") in equal installments during the Payment Period in accordance with the applicable Company payroll, in an aggregate amount equal to two times the sum of (y) the highest Base Salary in effect during the six-month period immediately prior to the time of such termination of employment and (z) the Executive's target Annual Bonus opportunity for the year of termination of employment (such payment, the "**Cash Severance Payment**"), on the condition that Executive has delivered to the Company a release substantially in the form as attached hereto as Exhibit A (with such changes as may be required under applicable law) of any employment-related claims, provided that this release must be signed within 30 days after the Executive's separation from service and any payment that otherwise would be made within such 30-day period shall by paid at the expiration of such 30-day period, subject to Executive's execution of such release; provided, however, that if Executive experiences a Qualifying Event within two years following a Change in Control, the Cash Severance Payment shall instead be an aggregate amount equal to two-and-a-half times the sum of (y) the highest Base Salary in effect during the six-month period immediately prior to the time of such termination of employment and (z) the Executive's target Annual Bonus opportunity for the year of termination of employment.

(ii) A "**Pro-Rata Bonus Amount**" for the year of Executive's termination of employment calculated as Executive's Annual Bonus opportunity multiplied by a fraction, the numerator of which is the number of days in the year through the date of Executive's termination of employment and the denominator of which is 365. The Pro-Rata Bonus Amount shall be based on the greater of Executive's Annual Bonus opportunity at target and the actual funding percentage for the Annual Bonus Plan for such performance period, as determined by the Committee in its sole discretion. Payment of this pro-rata bonus amount, if any, shall be made to Executive at the same time as annual bonuses are paid to senior executives of the Company;

(iii) With respect to equity awards made prior to the Effective Date, Executive shall be treated as eligible for 'retirement' under the vesting and exercise terms of any such equity award. For the avoidance of doubt, 'retirement' treatment for equity awards made prior to the Effective Date shall mean: (1) with respect to restricted stock units (excluding the Closing Sign-On Equity Award), performance stock units and any LTIP awards, pro-rated vesting as of Executive's termination of employment date (with any performance criteria deemed achieved based on actual performance as of the end of the applicable performance period) and settlement on the originally scheduled settlement date; and (2) with respect to stock options and stock appreciation rights, immediate vesting in that portion of the stock option and/or stock appreciation right that would have otherwise vested within one year following Executive's termination of employment date and the ability to exercise such stock option and/or stock appreciation right for five years following Executive's termination of employment date; provided, however, that Executive shall not be permitted to exercise any stock option or stock appreciation right beyond the original term of such award. Notwithstanding the foregoing, this Section 3.02(b)(iii) shall not apply to the Closing Sign-On Equity Award or equity awards granted following the Effective Date;

(iv) With respect to Company equity awards granted following the Effective Date, Executive shall be treated as 'retirement' eligible under the vesting and exercise terms of the applicable award agreements relating to Company awards generally applicable to senior-level executives of the Company; and

(v) Continued participation in all medical, health and life insurance plans at the same benefit and cost sharing level at which Executive and Executive's eligible dependents were participating on the date of termination of Executive's employment until the earlier of: (1) the 18- month anniversary of Executive's termination of employment date; or (2) the date, or dates, Executive receives equivalent coverage and benefits under the plans and programs of a subsequent employer (such coverage and benefits to be determined on a coverage-bycoverage, or benefit-by- benefit, basis); provided, however, that (A) if Executive is precluded from continuing Executive's participation in any employee benefit plan or program as provided in this clause (v), Executive shall receive cash payments equal on an aftertax basis to the cost to Executive of obtaining the benefits provided under the plan or program in which Executive is unable to participate for the period specified in this clause (v), (B) such cost shall be deemed to be the lowest reasonable cost that would be incurred by Executive in obtaining such benefit on an individual basis, and (C) payment of such amounts shall be made quarterly in advance. For the avoidance of doubt, Executive acknowledges and agrees that Executive shall be responsible for Executive's portion of any premiums due in connection with Executive's continued participation in any medical, health and life insurance plans pursuant to this Section 3.02(b)(v).

To the extent that Executive is a "Specified Employee" within the meaning of Section 409A of the Code at the time of her separation from service, to the extent required by Section 409A and the regulations issued thereunder, the payments to which Executive would otherwise be entitled during the first six months following her separation of service shall be deferred and accumulated for a period of six months and paid in a lump sum on the first day of the seventh month with the seventh month's payment, with interest on such deferred compensation at the rate paid pursuant to the stable value fund of the Company's 401(k) plan or, if such fund no longer exists, the fund with the investment criteria most clearly comparable to that of such fund.

(c) For the avoidance of doubt and consistent with the applicable award agreements, equity awards made by Aetna before the Closing Effective Date, the Closing Sign-On Equity Award, 2018-2020 LTIP and any supplemental LTIP with respect to the 2018-2020 performance period shall be treated as follows: (1) upon an involuntary termination of Executive's employment by reason of death, unvested awards shall become immediately vested (with any performance criteria deemed achieved based on target performance as of Executive's death); and (2) upon an involuntary termination of Executive's employment by reason of Disability, pro-rated vesting as of Executive's termination of employment date (with any performance criteria deemed achieved based on actual performance as of the end of the applicable performance period); provided that in each case stock options shall remain exercisable for one year following Executive's termination of employment date, except that Executive shall not be permitted to exercise any stock option beyond the original term of such award.

(d) If Executive experiences a Qualifying Event within two years following a Change in Control, any outstanding equity awards held by Executive at such time shall be treated in accordance with the terms of the applicable award agreement governing such equity awards.

ARTICLE 4

SUCCESSORS AND ASSIGNMENTS

SECTION 4.01. *Successors.* The Company will require any successor (whether by reason of a change in control, direct or indirect, by purchase, merger, consolidation, or otherwise) to all or substantially all of the business and/or assets of the Company to expressly assume and agree to perform the obligations under this Agreement in the same manner and to the same extent that the Company would be required to perform it if no such succession had taken place. The Company's rights hereunder shall not otherwise be assignable without Executive's consent.

SECTION 4.02. *Assignment by Executive.* This Agreement shall inure to the benefit of and be enforceable by Executive's personal or legal representatives, executors, administrators, successors, heirs, distributees, devisees, and legatees. If Executive should die or become disabled while any amount is owed but unpaid to Executive hereunder, all such amounts, unless otherwise provided herein, shall be paid to Executive's devisee, legatee, legal guardian or other designee, or if there is no such designee, to Executive's estate. Executive's rights hereunder shall not otherwise be assignable.

ARTICLE 5

MISCELLANEOUS

SECTION 5.01. *Notices.* Any notice required to be delivered hereunder shall be in writing and shall be addressed

if to the Company, to:

CVS Health Corporation
One CVS Drive
MC 1160
Woonsocket, RI 02895
Attn: General Counsel

if to Executive, to Executive's last known address as reflected on the books and records of the Company or such other address as such party may hereafter specify for the purpose by written notice to the other party hereto. With a copy to Thomas A. Hickey, Esq., Gunster, Yoakley & Stuart, P.A., 777 South Flagler Drive, Suite 500 East, West Palm Beach, FL 33401.

Any such notice shall be deemed received on the date of receipt by the recipient thereof if received prior to 5:00 p.m. in the place of receipt and such day is a business day in the place of receipt. Otherwise, any such notice shall be deemed not to have been received until the next succeeding business day in the place of receipt.

SECTION 5.02. *Legal Fees and Expenses*. The Company shall pay all legal fees, costs of litigation, arbitration (*i.e.*, American Arbitration Association and arbitrator fees), prejudgment interest, and other expenses which are reasonably incurred by Executive as a result of any conflict between the parties pertaining to this Agreement or in connection with the termination of Executive's employment if Executive is the prevailing party as determined by the arbitrator. In addition, the

Company shall pay Executive's reasonable legal fees and expenses associated with entering this Agreement.

SECTION 5.03. *Arbitration.* Except as provided in any agreement referenced in Section 5.15, any dispute or controversy arising under or in connection with this Agreement shall be settled by arbitration, conducted before a panel of three arbitrators sitting in a location selected by Executive within 50 miles from the location of Executive's principal place of employment with the Company, in accordance with the rules of the American Arbitration Association then in effect. The decision of the arbitrators in that proceeding, shall be binding on the Company and Executive. Judgment may be entered on the award of the arbitrator in any court having jurisdiction. Notwithstanding the foregoing of this Section 5.03, each of the parties agrees that, prior to submitting a dispute under this Agreement to arbitration, the parties agree to submit, for a period of sixty (60) days, to voluntary mediation before a jointly selected neutral third party mediator under the Employment Mediation Rules of the American Arbitration Association to take place in Woonsocket, RI (however, such mediation or obligation to mediate shall not suspend or otherwise delay any termination of employment or other action of the Company or affect the Company's other rights under this Agreement). Except as provided in Section 5.02, each party shall pay its own expenses of such mediation and/or arbitration and all common expenses of such mediation and/or arbitration shall be borne equally by Executive and the Company.

SECTION 5.04. *Unfunded Agreement.* The obligations of the Company under this Agreement represent an unsecured, unfunded promise to pay benefits to Executive and/or Executive's beneficiaries, and shall not entitle Executive or such beneficiaries to a preferential claim to any asset of the Company.

SECTION 5.05. *Non-Exclusivity of Benefits.* Unless specifically provided herein, neither the provisions of this Agreement nor the benefits provided hereunder shall reduce any amounts otherwise payable, or in any way diminish Executive's rights as an employee of the Company, whether existing now or hereafter, under any compensation and/or benefit plans (qualified or nonqualified), programs, policies, or practices provided by the Company, for which Executive may qualify; provided, however, that the Separation Benefits shall be in lieu of any severance benefits under any such plans, programs, policies or practices. Vested benefits or other amounts which Executive is otherwise entitled to receive under any plan, policy, practice, or program of the Company (i.e., including, but not limited to, vested benefits under any qualified or nonqualified retirement plan), at or subsequent to the date of termination of Executive's employment shall be payable in accordance with such plan, policy, practice, or program except as expressly modified by this Agreement.

SECTION 5.06. *Employment Status*. Nothing herein contained shall interfere with the Company's right to terminate Executive's employment with the Company at any time, with or without Cause, subject to the Company's obligation to provide Separation Benefits and other benefits provided hereunder, if any. Executive shall also have the right to terminate her employment with the Company at any time without liability, subject only to her obligations under the employee covenants or obligations contained in any equity or other awards granted to Executive or any other obligation agreed to by Executive before or after the Effective Date.

SECTION 5.07. *Mitigation*. In no event shall Executive be obligated to seek other employment or take any other action by way of mitigation of the amounts payable to Executive under any of the provisions of this Agreement nor shall the amount of any payment or benefit hereunder be

reduced by any compensation earned by Executive as a result of employment by another employer, including, but not limited to, Executive's eligibility for any retiree health benefits.

SECTION 5.08. *Entire Agreement.* This Agreement represents the entire agreement between Executive and the Company and its affiliates with respect to Executive's employment and/or severance rights, and, as of the Effective Date, supersedes all prior discussions, negotiations, and agreements concerning such rights (including the Original Employment Agreement, as amended).

SECTION 5.09. *Tax Withholding*. Notwithstanding anything in this Agreement to the contrary, the Company shall withhold from any amounts payable under this Agreement all federal, state, city, or other taxes as are legally required to be withheld.

SECTION 5.10. *Waiver of Rights.* The waiver by either party of a breach of any provision of this Agreement shall not operate or be construed as a continuing waiver or as a consent to or waiver of any subsequent breach hereof.

SECTION 5.11. *Severability.* In the event any provision of the Agreement shall be held illegal or invalid for any reason, the illegality or invalidity shall not affect the remaining parts of the Agreement, and the Agreement shall be construed and enforced as if the illegal or invalid provision had not been included.

SECTION 5.12. *Governing Law.* This Agreement shall be governed by, construed and enforced in accordance with the laws of the State of Rhode Island without reference to principles of conflicts of laws.

SECTION 5.13. *Counterparts.* This Agreement may be signed in several counterparts, each of which shall be an original, with the same effect as if the signatures thereto and hereto were on the same instrument.

SECTION 5.14. *Indemnification.* During Executive's employment with the Company and for so long thereafter as Executive may have any liability as a result of her service: (a) the Company shall indemnify Executive (and Executive's legal representatives or other successors) to the fullest extent permitted by the Certificate of Incorporation and By-Laws of the Company, as in effect at such time or on the Effective Date; and (b) Executive shall be entitled to the protection of any insurance policies that the Company may elect to maintain generally for the benefit of its directors and officers (and to the extent the Company maintains such an insurance policy or policies, Executive shall be covered by such policy or policies, in accordance with its or their terms, to the maximum extent of the coverage available for any officer or director of the Company), against all costs, charges and expenses whatsoever incurred or sustained by Executive or Executive's legal representatives at the time such costs, charges and expenses are incurred or sustained, in connection with any action, suit or proceeding to which Executive (or Executive's legal representatives or other successors) may be made a party by reason of Executive's serving or having served as a director, officer or employee of the Company, or any subsidiary or Executive's serving or having served any other enterprise as a director, officer, employee or fiduciary at the request of the Company. For purposes of this Section 5.14, it is understood and agreed that the Company's Certificate of Incorporation provide, and shall continue to provide the maximum indemnification permitted by the Company's State of Incorporation.

SECTION 5.15. *Restrictive Covenant Agreement.* Concurrently with the execution of this Agreement, Executive shall execute the Company's Restrictive Covenant Agreement (the "**Restrictive Covenant Agreement**"), attached hereto as Exhibit B, which shall become effective upon the Effective Date and shall supersede Executive's current Restrictive Covenant Agreement, dated as of December 8, 2018, which shall remain in full force and effect until such time. Executive acknowledges that the Company may modify such Restrictive Covenant Agreement in the future in connection with the granting of equity awards and Executive agrees to execute a modified agreement to the extent the modification is applicable to senior officers of the Company and not in anticipation of a Change in Control. Upon request by the Company, Executive agrees to execute a new Restrictive Covenant Agreement, with substantially similar post-employment non-competition and non-solicitation periods and limitations as those set forth in the Restrictive Covenant Agreement then applicable to Executive, upon Executive's termination of employment in exchange for a one-time cash payment equal to $10,000, which shall be paid within 30 days of Executive's execution of such Restrictive Covenant Agreement.

SECTION 5.16. *Stock Ownership Requirements*. Executive acknowledges and understands that the Company has adopted certain stock ownership guidelines for executives and that the Company expects Executive to own shares of stock in the Company consistent with Executive's position in accordance with such stock ownership guidelines, as approved by the Committee and as in effect from time to time.

SECTION 5.17. *Section 409A.* If any provision of this Agreement (or any award of compensation or benefits provided under this Agreement) would cause Executive to incur any additional tax or interest under Section 409A of the Code, the Company shall reform such provision to comply with Section 409A and agrees to maintain, to the maximum extent practicable without violating Section 409A of the Code, the original intent and economic benefit to Executive of the applicable provision. The Company shall not accelerate the payment of any deferred compensation in violation of Section 409A of the Code and to the extent required under Section 409A, the Company shall delay the payment of any deferred compensation for six months following Executive's termination of employment. When used in connection with any payments subject to Section 409A required to be made hereunder, the phrase "termination of employment" and correlative terms shall mean separation from service as defined in Section 409A. Unless such payments are otherwise exempt from Section 409A, any reimbursements or in-kind benefits provided under Sections 2.03, 2.04, 3.02 or 5.02 of this Agreement shall be administered in accordance with Section 409A, such that: (a) the amount of expenses eligible for reimbursement, or in-kind benefits provided, during one year shall not affect the expenses eligible for reimbursement or the in-kind benefits provided in any other year; (b) reimbursement of eligible expenses shall be made on or before December 31 of the year following the year in which the expense was incurred; and (c) Executive's right to reimbursement or in-kind benefits shall not be subject to liquidation or to exchange for another benefit. For purposes of Section 409A, Executive's right to receive any installment payments pursuant to this Agreement shall be treated as a right to receive a series of separate and distinct payments.

SECTION 5.18. *Section 280G.* Notwithstanding anything in this Agreement to the contrary, in the event the Separation Benefits described in this Agreement either alone or together with any other payments and benefits which Executive has the right receive from the Company or any affiliated company (together with the Separation Benefits, the "**Total Benefits**") would subject Executive to an excise tax under Section 4999 of the Code (the "**Excise Tax**"), then the Company shall reduce the Separation Benefits (the "**Benefit Reduction**") by the amount necessary to result in

Executive not being subject to the Excise Tax, if such reduction would result in Executive's "Net After-Tax Amount" attributable to the Total Benefits being greater than it would be if no Benefit Reduction was effected. For this purpose "Net After-Tax Amount" shall mean the net amount of the Total Benefits that Executive is entitled to receive under this Agreement or any other agreement, plan or arrangement of the Company or otherwise after giving effect to all federal, state and local taxes that would be applicable to such payments, including, but not limited to, the Excise Tax. The determination of whether any such Benefit Reduction shall be effected shall be made by a nationally recognized public accounting firm selected by the Company that is reasonably acceptable to Executive and is not the audit firm of the potential acquirer in any transaction that would constitute a Change in Control (the "**Accounting Firm**") and such determination shall be binding on both Executive and the Company. In the event it is determined that a Benefit Reduction is required, the parties shall cooperate in all material respects to mitigate the amount of any such reduction. To the extent that any Benefit Reduction is required following mitigation, then such reduction shall be done first by reducing cash severance; then any accelerated vesting of any equity awards shall be reduced or eliminated or waived, in reverse order of date of grant; and finally any other benefits to which Executive is or may be entitled shall be reduced or eliminated, all as determined by the Accounting Firm.

SECTION 5.19. No provision of this Agreement may be altered, modified, or amended unless such alteration, modification or amendment is agreed to in writing and signed by each of the parties hereto.

ARTICLE 6

DEFINITIONS

SECTION 6.01. *Definitions*. For purposes of this Agreement, the following terms shall have the meanings set forth below.

"*Accounting Firm*" has the meaning accorded such term in Section 5.18.

"*Accrued Benefits*" has the meaning accorded such term in Section 3.02.

"*Accrued Compensation*" has the meaning accorded such term in Section 3.02.

"*Aetna*" means Aetna Inc., a Pennsylvania corporation.

"*Agreement*" has the meaning accorded such term in the introductory paragraph of this Agreement.

"*Annual Bonus*" has the meaning accorded such term in Section 2.02(a).

"*Annual Bonus Plan*" has the meaning accorded such term in Section 2.02(a).

"*Base Salary*" has the meaning accorded such term in Section 2.01.

"*Beneficial Owner*" has the meaning ascribed to such term in Rule 13d-3 under the Exchange Act (including any successor to such rule).

"*Benefit Reduction*" has the meaning accorded such term in Section 5.18.

"*Board*" means the Board of Directors of the Company.

"*Cash Severance Payment*" has the meaning accorded such term in Section 3.02(b)(i).

"*Cause*" means the occurrence of any one or more of the following:

(a) Executive's willful and material breach of Sections 2, 3, 4 or 7 of the Restrictive Covenant Agreement;

(b) Executive is convicted of a felony involving moral turpitude; or

(c) Executive engages in conduct that constitutes willful gross neglect or willful gross misconduct in carrying out Executive's duties under this Agreement, resulting, in either case, in material harm to the financial condition or reputation of the Company.

For purposes of this Agreement, an act or failure to act on Executive's part shall be considered "willful" if it was done or omitted to be done by Executive not in good faith and shall not include any act or failure to act resulting from any incapacity of Executive. For purposes of this definition, wherever the term "Cause" is used in plans or other agreements governing Executive's rights, the term used in such plans or other agreements shall be no less favorable to Executive than the term Cause herein.

A termination for Cause shall not take effect unless the provisions of this paragraph are complied with. Executive shall be given written notice by the Company of its intention to terminate Executive for Cause, such notice (i) to state in detail the particular act or acts or failure or failures to act that constitute the grounds on which the proposed termination for Cause is based; and (ii) to be given within 90 days of the Company's learning of such act or acts or failure or failures to act. Executive shall have 20 days after the date that such written notice has been given to Executive in which to cure such conduct, to the extent such cure is possible. If Executive fails to cure such conduct, Executive shall then be entitled to a hearing before the Committee at which Executive is entitled to appear. Such hearing shall be held within 25 days of such notice to Executive, provided Executive requests such hearing within 10 days of the written notice from the Company of the intention to terminate Executive for Cause. If, within five days following such hearing, Executive is furnished written notice by the Board confirming that, in its judgment, grounds for Cause on the basis of the original notice exist, Executive shall thereupon be terminated for Cause.

"*Change in Control*" means the occurrence of:

(a) any Person (other than (i) the Company, (ii) any trustee or other fiduciary holding securities under any employee benefit plan of the Company, (iii) any company owned, directly or indirectly, by the stockholders of the Company immediately after the occurrence with respect to which the evaluation is being made in substantially the same proportions as their ownership of the common stock of the Company immediately prior to such occurrence or (iv) any surviving or resulting entity from a merger or consolidation referred to in clause (c) below that does not constitute a Change in Control under clause (c) below) becomes the Beneficial Owner (except that a Person shall be deemed to be the Beneficial Owner of all shares that any such Person has the right to acquire pursuant to any agreement or arrangement or upon exercise of conversion rights, warrants or options or otherwise, without regard to the 60 day period referred to in Rule 13d-3 under the Exchange Act),

directly or indirectly, of securities of the Company or of any subsidiary owning directly or indirectly all or substantially all of the consolidated assets of the Company (a "**Significant Subsidiary**"), representing 30% or more of the combined voting power of the Company's or such Significant Subsidiary's then outstanding securities;

(b) during any period of 12 consecutive months, individuals who at the beginning of such period constitute the Board, and any new director whose election by the Board or nomination for election by the Company's stockholders was approved by a vote of at least a majority of the directors then still in office who either were directors at the beginning of the 12 month period or whose election or nomination for election was previously so approved, cease for any reason to constitute at least a majority of the Board;

(c) the consummation of a merger or consolidation of the Company or any Significant Subsidiary with any other entity, other than a merger or consolidation which would result in the voting securities of the Company or a Significant Subsidiary outstanding immediately prior thereto continuing to represent (either by remaining outstanding or by being converted into voting securities of the surviving or resulting entity) more than 50% of the combined voting power of the surviving or resulting entity outstanding immediately after such merger or consolidation; or

(d) the consummation of a transaction (or series of transactions within a 12 month period) which constitutes the sale or disposition of all or substantially all of the consolidated assets of the Company but in no event assets having a gross fair market value of less than 40% of the total gross fair market value of all of the consolidated assets of the Company (other than such a sale or disposition immediately after which such assets will be owned directly or indirectly by the stockholders of the Company in substantially the same proportions as their ownership of the common stock of the Company immediately prior to such sale or disposition).

For purposes of this definition of Change in Control, the term "Person" shall have the meaning ascribed to such term in Section 3(a)(9) of the Exchange Act and used in Sections 13(d) and 14(d) thereof, including "group" as defined in Section 13(d) thereof.

"*Closing Effective Date*" means November 28, 2018.

"*Closing Sign-On Equity Award*" means the sign-on equity award granted to Executive on the Closing Effective Date.

"*Code*" means the Internal Revenue Code of 1986, as amended.

"*Committee*" shall mean the Management Planning and Development Committee of the Board.

"*Company*" means CVS Health Corporation, a Delaware corporation.

"*Disability*" means Long-Term Disability, as such term is defined in the Disability Plan.

"*Disability Plan*" means the long-term disability plan (or any successor disability and/or survivorship plan adopted by the Company) in which Executive participates, as in effect immediately prior to the relevant event (subject to changes in coverage levels applicable to all employees generally covered by such Disability Plan).

"*Effective Date*" has the meaning accorded such term in Section 1.01.

"*Exchange Act*" means the Securities Exchange Act of 1934, as amended from time to time, or any successor act thereto.

"*Excise Tax*" has the meaning accorded such term in Section 5.18.

"*Executive*" has the meaning accorded such term in the introductory paragraph of this Agreement.

"*Good Reason*" means, without Executive's express written consent, the occurrence of any one or more of the following: (a) a reduction by the Company of Executive's Base Salary or Annual Bonus from the level in effect immediately prior thereto, except in the event of a ratable reduction affecting all senior officers of the Company; (b) an assignment of any duties to Executive that is materially inconsistent with Executive's duties and responsibilities or a material diminution of Executive's duties and responsibilities, in each case as such duties and responsibilities were in effect immediately following the Effective Date; (c) any failure of a successor of the Company to assume and agree to perform the Company's entire obligations under this Agreement, as required by Section 4.01 hereof, provided that such successor has received at least ten (10) days written notice from the Company or Executive of the requirements of such Section 4.01; (d) Executive reporting to any person other than the Board; (e) removal of Executive as President and Chief Executive Officer of the Company (other than in connection with a termination of Executive's employment for Cause); (f) any action or inaction by the Company that constitutes a material breach of the terms of this Agreement; or (g) the Company's failure to nominate and recommend Executive for re-election to the Board.

"*LTIP*" means the Company's long-term incentive program.

"*Original Employment Agreement*" has the meaning accorded such term in the recitals to this Agreement.

"*Payment Period*" has the meaning accorded such term in Section 3.02.

"*Pro-Rata Bonus Amount*" has the meaning accorded such term in Section 3.02.

"*PSUs*" has the meaning accorded such term in Section 2.02(c).

"*Qualifying Event*" has the meaning accorded such term in Section 3.01.

"*Restrictive Covenant Agreement*" has the meaning accorded such term in Section 5.15.

"*Separation Benefits*" has the meaning accorded such term in Section 3.02.

"*Total Benefits*" has the meaning accorded such term in Section 5.18.

[*Signature page follows*]

IN WITNESS WHEREOF, the Company and Executive have executed this Agreement on this 5th day of November 2020.

CVS HEALTH CORPORATION
By: /s/ Lisa Bisaccia
Name: Lisa Bisaccia
Title: Chief Human Resources Officer

Acknowledged and Accepted:

CVS PHARMACY, INC.
By: /s/ Lisa Bisaccia
Name: Lisa Bisaccia
Title: Chief Human Resources Officer

EXECUTIVE
/s/ Karen S. Lynch
Karen S. Lynch

Exhibit A: Form of Release Agreement
Exhibit B: Restrictive Covenant Agreement

Exhibit 10.52

CVS Health Corporation
Restrictive Covenant Agreement

I, Karen Lynch, enter into this Restrictive Covenant Agreement ("Agreement") with CVS Health Corporation, on its own behalf and on behalf of its subsidiaries and affiliates ("CVS" or "Corporation"), which is effective as of February 1, 2021 ("Effective Date") and shall supersede my current Restrictive Covenant Agreement, dated as of December 8, 2018 ("Current Restrictive Covenant Agreement"), which shall remain in full force and effect until such time. In consideration of the mutual promises in this Agreement, the parties agree as follows:

1. Consideration for Agreement. In connection with my duties and responsibilities at CVS Health Corporation or one of its subsidiaries or affiliates, including but not limited to CVS Pharmacy, Inc., Aetna, Inc., Caremark, LLC and Coram, LLC (collectively, the "Corporation"), the Corporation will provide me with Confidential Information and/or access to the Corporation's customers and clients and the opportunity to develop and maintain relationships and goodwill with them. In addition, the Corporation has awarded me additional financial compensation, pursuant to my Amended and Restated Employment Agreement, dated as of November 5, 2020 ("Employment Agreement"), which is contingent on the execution of this Agreement and compliance with its terms.

2. Non-Competition. During my employment by the Corporation and during the Non-Competition Period following the termination of my employment for any reason, I will not, directly or indirectly, engage in Competition or provide Consulting or Audit Services within the Restricted Area.

a. **Competition**. Engaging in "Competition" means providing services to a Competitor of the Corporation (whether as an employee, independent contractor, consultant, principal, agent, partner, officer, director, investor, or shareholder, except as a shareholder of less than one percent of a publicly traded company) that: (i) are the same or similar in function or purpose to the services I provided to the Corporation at any time during the last two years of my employment by the Corporation; or (ii) will likely result in the disclosure of Confidential Information to a Competitor or the use of Confidential Information on behalf of a Competitor. If a representative of the Corporation, during my employment or the Non-Competition Period, requests that I identify the company or business to which I will be or am providing services, or with which I will be or am employed, and requests that I provide information about the services that I am or will be providing to such entity, I shall provide the Corporation with a written statement detailing the identity of the entity and the nature of the services that I am or will be providing to such entity with sufficient detail to allow the Corporation to independently assess whether I am or will be in violation of this Agreement. Such statement shall be delivered to the Corporation's Chief Human Resources Officer or her authorized delegate via personal delivery or overnight delivery within five calendar days of my receipt of such request.

b. **Competitor**. A "Competitor" for purposes of this Agreement shall mean any person, corporation or other entity that competes with one or more of the business offerings of the Corporation As of the Effective Date, the Corporation's business offerings include: (i) pharmacy benefits management ("PBM"), including: (a) the administration of pharmacy benefits for businesses, government agencies and health plans; (b) mail order pharmacy; (c) specialty pharmacy; (d) the procurement of prescription drugs at a negotiated rate for dispensing; and (e) Medicare Part D

services; (ii) retail, which includes the sale of prescription drugs, over-the-counter medications, beauty products and cosmetics, digital and traditional photo finishing services, digital and other online offerings, seasonal and other general merchandise, greeting cards, convenience foods and other product lines and services which are sold by the Corporation's retail division ("Retail"); (iii) retail health clinics ("MinuteClinic"); (iv) the provision of pharmaceutical products and ancillary services, including specialty pharmaceutical products and support services and the provision of related pharmacy consulting, data management services and medical supplies to long-term care facilities, other healthcare service providers and recipients of services from such facilities ("Long- Term Care"); (v) the provision of prescription infusion drugs and related services ("Infusion"); (vi) the provision of insurance ("Insurance") including: (a) health insurance products and services; (b) managed health care products and services; (c) dental, vision, workers compensation and employee assistance program products and services; (d) wellness products and services to employers, government agencies, health plans, other businesses or third party payers; (e) other voluntary products that are excepted benefits under HIPAA; (vii) the creation and provision of population health management products and services ("Health Management"); (viii) the administration of (ii) – (vii) ("Administration"); and (ix) any other business in which Corporation is engaged or imminently will be engaged.

For the purpose of assessing whether I am engaging in "Competition" under Section 2(a)(i) above, a person, corporation or other entity shall not be considered a Retail Competitor if such entity derives annual gross revenues from its business in an amount which is less than 2% of the Corporation's gross revenues from Retail, during its most recently completed fiscal year. For avoidance of doubt, this exclusion does not apply to a determination of whether I am engaging in "Competition" as set forth in Section 2(a)(ii) above.

The parties acknowledge that both the Corporation's products and services and the entities which compete with the Corporation's products and services evolve and an entity will be considered a Competitor if it provides products or services competitive with the products and services provided by the Corporation within the last two years of my employment.

I agree to this enterprise-wide definition of Competition which may prevent me from providing services to any of the Corporation's PBM, Retail, Insurance, Health Management, MinuteClinic, Long-Term Care, Administration and/or Infusion Competitors or any combination thereof during the Non-Competition period.

c. **Consulting or Audit Services**. "Consulting or Audit Services" shall mean any activity which involves providing audit review or other consulting or advisory services with respect to any relationship or prospective relationship between the Corporation and any third party that is likely to result in the use or disclosure of Confidential Information.

d. **Non-Competition Period**. The "Non-Competition Period" shall be the period of 24 months following the termination of my employment with the Corporation for any reason.

e. **Restricted Area**. "Restricted Area" refers to those states within the United States in which the Corporation conducts its business, as well as the District of Columbia and Puerto Rico. To the extent I worked on international projects in Asia, Europe, Brazil or other countries where the Corporation may conduct business, the Restricted Area includes those countries and those countries where the Corporation is actively planning to conduct business.

3. Non-Solicitation. During the Non-Solicitation Period, which shall be during my employment by the Corporation and for 24 months following the termination of my employment with the Corporation for any reason, I will not, unless a duly authorized officer of the Corporation gives me written authorization to do so:

a. interfere with the Corporation's relationship with its Business Partners by soliciting or communicating (regardless of who initiates the communication) with a Business Partner to: (i) induce or encourage the Business Partner to stop doing business or reduce its business with the Corporation, or (ii) buy a product or service that competes with a product or service offered by the Corporation's business. "Business Partner" means: a customer (person or entity), prospective customer (person or entity), healthcare provider, supplier, agency, manufacturer, broker, hospital, hospital system, long-term care facility, and/or pharmaceutical manufacturer with whom the Corporation has a business relationship and with which I had business-related contact or dealings, or about which I received Confidential Information, in the two years prior to the termination of my employment with the Corporation. A Business Partner does not include a customer, supplier, manufacturer, broker, hospital, hospital system, long-term care facility and/or pharmaceutical manufacturer which has fully and finally ceased doing any business with the Corporation independent of any conduct or communications by me or breach of this Agreement and such full cessation of business has been in effect for at least 1 year prior to my separation from employment with the Corporation. Nothing in this Paragraph 3(a) shall prevent me from working as a staff pharmacist or in another retail position wherein I would be providing or selling prescriptions or other products directly to consumers.

b. work on a Corporation account on behalf of a Business Partner or serve as the representative of a Business Partner for the Corporation.

c. interfere with the Corporation's relationship with any employee or contractor of the Corporation by: (i) soliciting or communicating with the employee or contractor to induce or encourage him or her to leave the Corporation's employ or engagement (regardless of who first initiates the communication); (ii) helping another person or entity evaluate such employee or contractor as an employment or contractor candidate; or (iii) otherwise helping any person or entity hire an employee or contractor away from the Corporation.

4. Non-Disclosure of Confidential Information.

a. Subject to Sections 7 and 8 below, I will not at any time, whether during or after the termination of my employment, disclose to any person or entity any of the Corporation's Confidential Information, except as may be appropriately required in the ordinary course of performing my duties as an employee of the Corporation. The Corporation's Confidential Information includes but is not limited to the following non-public information: trade secrets; computer code generated or developed by the Corporation; software or programs and related documentation; strategic compilations and analysis; strategic processes; business or financial methods, practices and plans; non-public costs and prices; operating margins; marketing, merchandising and selling techniques and information; customer lists; provider lists; details of customer agreements; pricing arrangements with pharmaceutical manufacturers, distributors or suppliers including but not limited to any discounts and/or rebates; pharmacy reimbursement rates; premium information; payment rates; contractual forms; expansion strategies; real estate strategies; operating strategies; sources of supply; patient records; business plans; other financial, commercial, business or technical information related to the Corporation and confidential information of third

parties which is given to the Corporation pursuant to an obligation or agreement to keep such information confidential (collectively, "Confidential Information"). I shall not use or attempt to use any Confidential Information on behalf of any person or entity other than the Corporation, or in any manner which may injure or cause loss or may be calculated to injure or cause loss, whether directly or indirectly, to the Corporation. If, at any time over the last two years of my employment at CVS, my position included access to Confidential Information, as described above, specifically related to the Corporation's procurement of prescription drugs, I understand and agree my employment with a pharmaceutical manufacturer, distributor or supplier ("Pharmaceutical Entity")would place a substantial risk of use and/or disclosure of Confidential Information with which I have been or will be entrusted during my employment with the Corporation. In light of this risk of disclosure, I acknowledge and agree that the Corporation will be entitled to immediate injunctive relief to prevent me from disclosing any such Confidential Information in the course of my employment with any such Pharmaceutical Entity. I agree that the disclosure of such Confidential Information, to Corporation's PBM Competitors with which one may negotiate in the course of employment with such Pharmaceutical Entity, would cause immediate and irreparable harm to the Corporation. For employees residing in Connecticut, these restrictions on use or disclosure of Confidential Information will only apply for three (3) years after the end of my employment where information that does not qualify as a trade secret is concerned; however, the restrictions will continue apply to trade secret information for as long as the information at issue remains qualified as a trade secret.

b. During my employment, I shall not make, use, or permit to be used, any materials of any nature relating to any matter within the scope of the business of the Corporation or concerning any of its dealings or affairs other than for the benefit of the Corporation. I shall not, after the termination of my employment, use or permit to be used any such materials and shall return same in accordance with Section 5 below.

5. Ownership and Return of the Corporation's Property. On or before my final date of employment with the Corporation, I shall return to the Corporation all property of the Corporation in my possession, custody or control, including but not limited to the originals and copies of any information provided to or acquired by me in connection with the performance of my duties for the Corporation, such as files, correspondence, communications, memoranda, e-mails, slides, records, and all other documents, no matter how produced or reproduced, all computer equipment, communication devices (including but not limited to any mobile phone or other portable digital assistant or device), computer programs and/or files, and all office keys and access cards. I agree that all the items described in this Section are the sole property of the Corporation.

6. Rights to Inventions, Works.

a. **Assignment of Inventions.** All inventions, original works of authorship, developments, concepts, improvements, designs, discoveries, ideas, trademarks or trade secrets, whether patentable or otherwise protectable under similar law, made, conceived or developed by me, whether alone or jointly with others, from the date of my initial employment by the Corporation and continuing until the end of any period during which I am employed by the Corporation, relating or pertaining in any way to my employment with or the business of the Corporation (collectively referred to as "Inventions") shall be promptly disclosed in writing to the Corporation. I hereby assign to the Corporation, or its designee, all of my rights, title and interest to such Inventions. All original works of authorship which are made by me (solely or jointly with others) within the scope of and during the period of my employment with the Corporation and which are protectable by copyright are "works made for hire," as that term is defined in the United States Copyright Act and

as such are the sole property of the Corporation. The decision whether to commercialize or market any Invention developed by me solely or jointly with others is within the Corporation's sole discretion and for the Corporation's sole benefit and no royalty will be due to me as a result of the Corporation's efforts to commercialize or market any such Invention.

b. **Inventions Retained and Licensed.** I have attached hereto as Exhibit A, a list describing all inventions, original works of authorship, developments, improvements, and trade secrets which were made by me prior to my employment with the Corporation ("Prior Inventions"), which belong to me and are not assigned to the Corporation hereunder. If no such list is attached, I represent that there are no such Prior Inventions. I will not incorporate, or permit to be incorporated, any Prior Invention owned by me or in which I have an interest into a Corporation product, process or machine without the Corporation's prior written consent. Notwithstanding the foregoing sentence, if, in the course of my employment with the Corporation, I incorporate into a Corporation product, process or machine a Prior Invention owned by me or in which I have an interest, the Corporation is hereby granted and shall have a nonexclusive, royalty-free, irrevocable, perpetual, worldwide license to make, have made, modify, use and sell such Prior Invention as part of or in connection with such product, process or machine.

c. **Patent and Copyright Registrations.** I will assist the Corporation, or its designee, at the Corporation's expense, in every proper way to secure the Corporation's rights in the Inventions and any copyrights, patents, mask work rights or other intellectual property rights relating thereto, including, but not limited to, the disclosure to the Corporation of all pertinent information and data with respect thereto, the execution of all applications, specifications, oaths, assignments and all other instruments which the Corporation shall deem necessary in order to apply for and obtain such rights and in order to assign and convey to the Corporation, its successors, assigns, and nominees the sole and exclusive rights, title and interest in and to such Inventions, and any copyrights, patents, mask work rights or other intellectual property rights relating thereto. My obligation to execute or cause to be executed, when it is in my power to do so, any such instrument or papers shall continue after my employment ends for any reason and/or after the termination of this Agreement. If the Corporation is unable because of my mental or physical incapacity or for any other reason to secure my signature to apply for or to pursue any application for any United States or foreign patents or copyright registrations covering Inventions or original works of authorship assigned to the Corporation as above, then I hereby irrevocably designate and appoint the Corporation and its duly authorized officers and agents as my agent and attorney in fact, to act for and in my behalf and stead to execute and file any such applications and to do all other lawfully permitted acts to further the prosecution and issuance of letters patent or copyright registrations thereon with the same legal force and effect as if executed by me.

7. Cooperation.

a. In the event I receive a subpoena, deposition notice, interview request, or other process or order to testify or produce Confidential Information or any other information or property of the Corporation, I shall promptly: (a) notify the Corporation of the item, document, or information sought by such subpoena, deposition notice, interview request, or other process or order; (b) furnish the Corporation with a copy of said subpoena, deposition notice, interview request, or other process or order; and (c) provide reasonable cooperation with respect to any procedure that the Corporation may initiate to protect Confidential Information or other interests. If the Corporation objects to the subpoena, deposition notice, interview request, process, or order, I shall cooperate to ensure that there shall be no disclosure until the court or other applicable entity has ruled upon the objection, and

then only in accordance with the ruling so made. If no such objection is made despite a reasonable opportunity to do so, I shall be entitled to comply with the subpoena, deposition, notice, interview request, or other process or order provided that I have fulfilled the above obligations.

b. I will cooperate fully with the Corporation, its affiliates, and their legal counsel in connection with any action, proceeding, or dispute arising out of matters with which I was directly or indirectly involved while serving as an employee of the Corporation, its predecessors, subsidiaries or affiliates. This cooperation shall include, but shall not be limited to, meeting with, and providing information to, the Corporation and its legal counsel, maintaining the confidentiality of any past or future privileged communications with the Corporation's legal counsel (outside and in-house), and making myself available to testify truthfully by affidavit, in depositions, or in any other forum on behalf of the Corporation. The Corporation agrees to reimburse me for any reasonable and necessary out-of-pocket costs associated with my cooperation.

8. Limitation on Restrictions. Nothing in this Agreement is intended to or shall interfere with my right to file charges or participate in a proceeding with any appropriate federal, state or local government agency, including the Occupational Safety and Health Administration ("OSHA"), National Labor Relations Board ("NLRB") or the Securities and Exchange Commission ("SEC"), or to exercise rights under Section 7 of the National Labor Relations Act ("NLRA"), or interfere with my right to file a charge or complaint with or participate or cooperate in an investigation or proceeding with the US Equal Employment Opportunity Commission ("EEOC") or comparable state or local agencies; such agencies have authority to carry out their statutory duties by investigating a charge, issuing a determination, filing a lawsuit, or taking any other action authorized by law. I retain the right to participate in any such action and retain the right to communicate with, NLRB, SEC, EEOC, OSHA and comparable state or local agencies and such communication shall not be limited by any provision in this Agreement. Nothing in this Agreement limits my right to receive an award for information provided to a government agency such as the SEC and OSHA. In addition, nothing in this Agreement is intended to interfere with or restrain the immunity provided under 18 U.S.C. § 1833(b) for confidential disclosures of trade secrets to government officials, or lawyers, solely for the purpose of reporting or investigating a suspected violation of law; or in a sealed filing in court or other proceeding.

9. Injunctive Relief. Any breach of this Agreement by me will cause irreparable damage to the Corporation and, in the event of such breach, the Corporation shall have, in addition to any and all remedies of law, the right to an injunction, specific performance or other equitable relief to prevent the violation of my obligations hereunder, and without providing a bond to the extent permitted by the applicable rules of civil procedure.

10. No Right of Continued Employment. This Agreement does not create an obligation on the Corporation or any other person or entity to continue my employment.

11. No Conflicting Agreements. I represent that the performance of my job duties with the Corporation and my compliance with all of the terms of this Agreement does not and will not breach any agreement to keep in confidence proprietary information acquired by me in confidence or in trust prior to my employment by the Corporation.

12. Entire Agreement/No Reliance/No Modifications. Except as provided in this Section 12 and Section 13, this Agreement and any compensation, benefit or equity plan or agreement referred to herein or under which equity was granted, including my Employment Agreement, to the extent

those other agreements apply to me, set forth the entire agreement between the parties hereto and fully supersede any and all prior and/or supplemental understandings, whether written or oral, between the parties concerning the subject matter of this Agreement; provided, however, that my Current Restrictive Covenant Agreement shall continue to remain in full force and effect until the Effective Date. I agree and acknowledge that I have not relied on any representations, promises or agreements of any kind in connection with my decision to accept the terms of this Agreement, except for the representations, promises and agreements herein. This Agreement shall not have any effect on any prior existing agreements between Corporation and me regarding the arbitration of workplace legal disputes and any such agreements remain in full force and effect. Any modification to this Agreement must be made in writing and signed by me and the Corporation's Chief Human Resources Officer or her authorized representative.

13. Supplementation. The Restrictive Covenants set forth in this Agreement shall supplement and do not supersede the restrictions agreed to by me in any other agreement or contract I have entered into with the Corporation (including Aetna, Inc.).

14. No Waiver. Any waiver by the Corporation of a breach of any provision of this Agreement, or of any other similar agreement with any other current or former employee of the Corporation, shall not operate or be construed as a waiver of any subsequent breach of such provision or any other provision hereof.

15. Severability. The parties hereby agree that each provision herein shall be treated as a separate and independent clause, and the unenforceability of any one clause shall in no way impair the enforceability of any of the other clauses herein. Moreover, if one or more of the provisions of this Agreement are for any reason held to be excessively broad as to scope, activity, duration, subject or otherwise so as to be unenforceable at law, the parties consent to such provision or provisions being modified or limited by the appropriate judicial body (where allowed by applicable law), so as to be enforceable to the maximum extent compatible with the applicable law.

16. Survival of Employee's Obligations. My obligations under this Agreement shall survive the termination of my employment regardless of the manner of such termination and shall be binding upon my heirs, personal representatives, executors, administrators and legal representatives.

17. Eligibility for Severance Pay. If my employment with the Corporation terminates under circumstances in which I am eligible for severance under my Employment Agreement, the Corporation will offer me severance in accordance with my Employment Agreement and the length of the Non-Competition Period will match the length of the severance period. I acknowledge that my Employment Agreement sets forth pre-requisites I must meet in order to receive severance, including but not limited to execution and non-revocation of the form of release agreement attached as Exhibit A to my Employment Agreement. In the event that the Corporation fails to comply with its obligations to offer me severance according to my Employment Agreement, then Section 2 of this Agreement shall be of no further effect. I agree that if I decline the Corporation's offer of severance, I shall continue to be subject to the restrictions in Section 2.

18. Corporation's Right to Assign Agreement. The Corporation has the right to assign this Agreement to its successors and assigns without the need for further agreement or consent by me, and all covenants and agreements hereunder shall inure to the benefit of and be enforceable by said successors or assigns.

19. Non-Assignment. I shall not assign my rights and obligations under this Agreement, in whole or in part, whether by operation of law or otherwise, without the prior written consent of the Corporation, and any such assignment contrary to the terms hereof shall be null and void and of no force or effect.

20. Governing Law; Venue; Headings. This Agreement shall be governed by and construed in accordance with the laws of the state of Rhode Island. I agree that any claim or dispute I may have against the corporation must be resolved by a court located in the state of Rhode Island. The headings of the sections contained in this Agreement are for convenience only and shall not be deemed to control or affect the meaning or construction of any provision of this Agreement.

21. Tolling. In the event I violate one of the time-limited restrictions in this Agreement, I agree that the time period for such violated restriction shall be extended by one day for each day I have violated the restriction, up to a maximum extension equal to the length of the original period of the restricted covenant.

IN WITNESS WHEREOF, the undersigned has executed this Agreement as a sealed instrument as of the date set forth below.

/s/ Karen S. Lynch

Employee ID

Date: 11-6-2020

/s/ Lisa Bisaccia

Lisa Bisaccia
Chief Human Resources Officer
CVS Health Corporation

Exhibit 21.1

Subsidiaries of CVS Health Corporation

Listed below are subsidiaries under CVS Health Corporation at December 31, 2020 with their jurisdictions of organization shown in parentheses. Subsidiaries excluded from the list below are not insurance companies and would not, in the aggregate, constitute a "significant subsidiary" of CVS Health Corporation, as that term is defined in Rule 1-02(w) of Regulation S-X.

- **CVS Foreign, Inc. (New York)**
  - CVS Caremark Indemnity Ltd. (Bermuda)
  - CVS International, L.L.C. (Delaware)

- **CVS Pharmacy, Inc. (Rhode Island)**
  - Aetna Inc. (Pennsylvania)
    - Aetna Health Holdings, LLC (Delaware)
      - Aetna Health of California Inc. (California)
      - Aetna Health Inc. (Connecticut)
      - Aetna Health Inc. (Florida)
      - Aetna Health Inc. (Georgia)
      - Aetna Health Inc. (Maine)
      - Aetna Health of Michigan Inc. (Michigan)
      - Aetna Health Inc. (New Jersey)
      - Aetna Health Inc. (New York)
        - Aetna Better Health Inc. (New York)
      - Aetna Health Inc. (Pennsylvania)
      - Aetna Health Inc. (Texas)
      - Aetna Better Health of California Inc. (California)
      - Aetna Health of Ohio Inc. (Ohio)
      - Aetna Better Health of Texas Inc. (Texas)
      - Aetna Better Health of Washington, Inc. (Washington)
      - Aetna Better Health Inc. (Georgia)
      - Aetna HealthAssurance Pennsylvania, Inc. (Pennsylvania)
      - Aetna Dental of California Inc. (California)
      - Aetna Dental Inc. (New Jersey)
      - Aetna Dental Inc. (Texas)
      - Aetna Rx Home Delivery, LLC (Delaware)
      - Aetna Health Management, LLC (Delaware)
      - Aetna Ireland Inc. (Delaware)
      - Aetna Specialty Pharmacy, LLC (Delaware)
      - Cofinity, Inc. (Delaware)
      - @Credentials Inc. (Delaware)
      - Aetna Better Health Inc. (Pennsylvania)
      - Aetna Better Health Inc. (Connecticut)
      - Aetna Better Health of Illinois Inc. (Illinois)
      - Aetna Better Health Premier Plan MMAI Inc. (Illinois)
      - Aetna Better Health of Kansas Inc. (Kansas)
      - Aetna Better Health, Inc. (Louisiana)
      - Aetna Florida Inc. (Florida)
      - Aetna Better Health Inc. (Ohio)
      - Aetna Better Health of Oklahoma Inc. (Oklahoma)
      - Aetna Better Health of Nevada Inc. (Nevada)
      - Aetna Better Health Inc. (New Jersey)
      - Aetna Better Health of North Carolina Inc. (North Carolina)
      - Aetna Network Services LLC (Connecticut)
      - Aetna Risk Assurance Company of Connecticut Inc. (Connecticut)
      - Aetna Student Health Agency Inc. (Massachusetts)

- Delaware Physicians Care, Incorporated (Delaware)
- Schaller Anderson Medical Administrators, Incorporated (Delaware)
- Aetna Medicaid Administrators LLC (Arizona)
- iTriage, LLC (Delaware)
- Medical Examinations of New York, P.C. (New York)
- bswift LLC (Illinois)
- Prodigy Health Group, Inc. (Delaware)
  - Niagara Re, Inc. (New York)
  - Performax, Inc. (Delaware)
  - Scrip World, LLC (Utah)
  - Precision Benefit Services, Inc. (Delaware)
  - American Health Holding, Inc. (Ohio)
  - Meritain Health, Inc. (New York)
    - Administrative Enterprises, Inc. (Arizona)
    - U.S Healthcare Holdings, LLC (Ohio)
    - Prime Net, Inc. (Ohio)
    - Professional Risk Management, Inc. (Ohio)
- ADMINCO, Inc. (Arizona)
- Aetna ACO Holdings Inc. (Delaware)
- Aetna Pharmacy Management Services, LLC (Delaware)
- Coventry Transplant Network, Inc. (Delaware)
- Aetna Health of Iowa Inc. (Iowa)
- Coventry Health Care of Nebraska, Inc. (Nebraska)
- Aetna Health Inc. (Louisiana)
- HealthAssurance Pennsylvania, Inc. (Pennsylvania)
- Coventry Prescription Management Services Inc. (Nevada)
- Coventry Health and Life Insurance Company (Missouri)
  - Aetna Better Health of Kentucky Insurance Company (Kentucky)
- Coventry Health Care of Virginia, Inc. (Virginia)
- Coventry Health Care of Missouri, Inc. (Missouri)
- Aetna Better Health of Missouri LLC (Missouri)
- Coventry Health Care of Illinois, Inc. (Illinois)
- Coventry Health Care of West Virginia, Inc. (West Virginia)
- Coventry HealthCare Management Corporation (Delaware)
- Coventry Health Care of Kansas, Inc. (Kansas)
- Coventry Health Care National Accounts, Inc. (Delaware)
- Aetna Better Health of Michigan Inc. (Michigan)
- Aetna Health of Utah Inc. (Utah)
- Aetna Better Health of Tennessee Inc. (Tennessee)
- Coventry Health Care National Network, Inc. (Delaware)
- Coventry Consumer Advantage, Inc. (Delaware)
- MHNet Specialty Services, LLC (Maryland)
  - Mental Health Network of New York IPA, Inc. (New York)
  - Mental Health Associates, Inc. (Louisiana)
  - MHNet of Florida, Inc. (Florida)
- Group Dental Service, Inc. (Maryland)
  - Group Dental Service of Maryland, Inc. (Maryland)
- Florida Health Plan Administrators, LLC (Florida)
  - Aetna Better Health of Florida Inc. (Florida)
  - Carefree Insurance Services, Inc. (Florida)
  - Coventry Health Plan of Florida, Inc. (Florida)
- First Health Group Corp. (Delaware)
  - First Health Life & Health Insurance Company (Texas)
  - Claims Administration Corp. (Maryland)
- Continental Life Insurance Company of Brentwood, Tennessee (Tennessee)

- American Continental Insurance Company (Tennessee)
- Aetna Life Insurance Company (Connecticut)
  - AHP Holdings, Inc. (Connecticut)
    - Aetna Insurance Company of Connecticut (Connecticut)
    - AE Fourteen, Incorporated (Connecticut)
    - Aetna Life Assignment Company (Connecticut)
  - Aetna ACO Holdings Inc. (Delaware)
    - Innovation Health Holdings, LLC (Delaware)
      - Innovation Health Insurance Company (Virginia)
        - Innovation Health Plan, Inc. (Virginia)
    - Texas Health + Aetna Health Insurance Holding Company LLC (Texas)
      - Texas Health + Aetna Health Insurance Company (Texas)
        - Texas Health + Aetna Health Plan Inc. (Texas)
  - Banner Health and Aetna Health Insurance Holding Company LLC (Delaware)
    - Banner Health and Aetna Health Insurance Company (Arizona)
      - Banner Health and Aetna Health Plan Inc. (Arizona)
  - Sutter Health and Aetna Insurance Holding Company LLC (Delaware)
    - Sutter Health and Aetna Administrative Services LLC (Delaware)
    - Sutter Health and Aetna Insurance Company (California)
  - Allina Health and Aetna Insurance Holding Company LLC (Delaware)
    - Allina Health and Aetna Insurance Company (Minnesota)
- PE Holdings, LLC (Connecticut)
- Aetna Resources LLC (Delaware)
- Canal Place, LLC (Delaware)
- Aetna Ventures, LLC (Delaware)
- Phoenix Data Solutions LLC (Delaware)
- Aetna Financial Holdings, LLC (Delaware)
  - Aetna Asset Advisors, LLC (Delaware)
  - U.S. Healthcare Properties, Inc. (Pennsylvania)
  - Aetna Capital Management, LLC (Delaware)
    - Aetna Partners Diversified Fund, LLC (Delaware)
  - Aetna Workers' Comp Access, LLC (Delaware)
  - Aetna Behavioral Health, LLC (Delaware)
  - Managed Care Coordinators, Inc. (Delaware)
  - Horizon Behavioral Services, LLC (Delaware)
    - Employee Assistance Services, LLC (Kentucky)
    - Health and Human Resource Center, Inc. (California)
    - Resources for Living, LLC (Texas)
    - The Vasquez Group Inc. (Illinois)
    - Work and Family Benefits, Inc. (New Jersey)
  - Aetna Card Solutions, LLC (Connecticut)
  - PayFlex Holdings, Inc. (Delaware)
    - PayFlex Systems USA, Inc. (Nebraska)
- Aetna Health and Life Insurance Company (Connecticut)
- Aetna Health Insurance Company (Pennsylvania)
- Aetna Health Insurance Company of New York (New York)
- AUSHC Holdings, Inc. (Connecticut)
  - PHPSNE Parent Corporation (Delaware)
- Active Health Management, Inc. (Delaware)
  - Health Data & Management Solutions, Inc. (Delaware)
  - Aetna Integrated Informatics, Inc. (Pennsylvania)
- Health Re, Inc. (Vermont)
- ASI Wings, LLC (Delaware)
- CVS Health Clinical Trial Services LLC (Connecticut)
- Aetna Corporate Services LLC (Delaware)

- Echo Merger Sub, Inc. (Delaware)
- Aetna International Inc. (Connecticut)
  - Aetna Life & Casualty (Bermuda) Ltd. (Bermuda)
  - Aetna International Ex Pat LLC (Delaware)
  - Aetna Global Holdings Limited (England & Wales)
    - Aetna Insurance (Hong Kong) Limited (Hong Kong)
    - Virtual Home Healthcare LLC (Dubai)
    - Minor Health Enterprise Co, Ltd. (Thailand)
    - Health Care Management Co. Ltd. (Thailand)
      - Aetna Services (Thailand) Limited (Thailand)
      - Aetna Health Insurance (Thailand) Public Company Limited (Thailand)
    - Aetna Health Insurance (Thailand) Public Company Limited (Thailand)
    - Aetna Holdings (Thailand) Limited (Thailand)
      - Health Care Management Co. Ltd. (Thailand)
      - Minor Health Enterprise Co, Ltd. (Thailand)
        - Aetna Health Insurance (Thailand) Public Company Limited (Thailand)
  - Aetna Global Benefits (Bermuda) Limited (Bermuda)
    - Goodhealth Worldwide (Global) Limited (Bermuda)
    - Aetna Global Benefits (Europe) Limited (England & Wales)
    - Aetna Global Benefits (Asia Pacific) Limited (Hong Kong)
      - PT Aetna Management Consulting (Indonesia)
    - Goodhealth Worldwide (Asia) Limited (Hong Kong)
    - Aetna Global Benefits Limited (DIFC, UAE)
    - Aetna Global Benefits (Middle East) LLC (UAE)
    - Pt. Aetna Global Benefits Indonesia (Indonesia)
    - Spinnaker Topco Limited (Bermuda)
      - Spinnaker Bidco Limited (England and Wales)
        - Aetna Holdco (UK) Limited (England and Wales)
          - Aetna Global Benefits (UK) Limited (England and Wales)
          - Aetna Insurance Company Limited (England and Wales)
  - Aetna Insurance (Singapore) Pte. Ltd. (Singapore)
  - Aetna Health Insurance Company of Europe DAC (Ireland)
  - Aetna (Shanghai) Enterprise Services Co. Ltd. (China)
    - Aetna (Beijing) Enterprise Management Services Co., Ltd. (China)
  - Aetna Global Benefits (Singapore) PTE. LTD. (Singapore)
    - Indian Health Organisation Private Limited (India)
  - PT Aetna Management Consulting (Indonesia)

- CVS Pharmacy, Inc. (continued)

  - Alabama CVS Pharmacy, L.L.C. (Alabama)
  - Alaska CVS Pharmacy, L.L.C. (Alaska)
  - American Drug Stores Delaware, L.L.C. (Delaware)
  - Arkansas CVS Pharmacy, L.L.C. (Arkansas)
  - CareCenter Pharmacy, L.L.C. (Delaware)
  - Caremark Rx, L.L.C. (Delaware)
    - ACS ACQCO CORP. (Delaware)
      - Advanced Care Scripts, Inc. (Florida)
    - CaremarkPCS, L.L.C. (Delaware)
      - CaremarkPCS Health, L.L.C. (Delaware)
      - Caremark IPA, L.L.C. (New York)
    - Accordant Health Services, L.L.C. (Delaware)
    - AdvancePCS SpecialtyRx, LLC (Delaware)
    - AdvanceRx.com, L.L.C. (Delaware)
    - Caremark PhC, L.L.C. (Delaware)

- Caremark Ulysses Holding Corp. (New York)
  - MemberHealth LLC (Delaware)
  - UAC Holding, Inc. (Delaware)
- Caremark, L.L.C. (California)
  - Caremark Arizona Mail Pharmacy, LLC (Arizona)
  - Caremark Arizona Specialty Pharmacy, L.L.C. (Arizona)
  - Caremark California Specialty Pharmacy, L.L.C. (California)
  - Caremark Florida Mail Pharmacy, LLC (Florida)
  - Caremark Florida Specialty Pharmacy, LLC (Florida)
  - Caremark Hawaii Mail Pharmacy, L.L.C. (Hawaii)
  - Caremark Hawaii Specialty Pharmacy, LLC (Hawaii)
  - Caremark Illinois Mail Pharmacy, LLC (Illinois)
  - CVS Caremark Advanced Technology Pharmacy, L.L.C. (Illinois)
  - Caremark Illinois Specialty Pharmacy, LLC (Illinois)
  - Caremark Irving Resource Center, LLC (Texas)
  - Caremark Kansas Specialty Pharmacy, LLC (Kansas)
  - Caremark Logistics, LLC (Delaware)
  - Caremark Louisiana Specialty Pharmacy, LLC (Louisiana)
  - Caremark Maryland Specialty Pharmacy, LLC (Maryland)
  - Caremark Massachusetts Specialty Pharmacy, L.L.C. (Massachusetts)
  - Caremark Michigan Specialty Pharmacy, LLC (Michigan)
  - Caremark Minnesota Specialty Pharmacy, LLC (Minnesota)
  - Caremark New Jersey Specialty Pharmacy, LLC (New Jersey)
  - Caremark North Carolina Specialty Pharmacy, LLC (North Carolina)
  - Caremark Ohio Specialty Pharmacy, L.L.C. (Ohio)
  - Caremark Pennsylvania Specialty Pharmacy, LLC (Pennsylvania)
  - Caremark Redlands Pharmacy, L.L.C. (California)
  - Caremark Repack, LLC (Illinois)
  - Caremark Tennessee Specialty Pharmacy, LLC (Tennessee)
  - Caremark Texas Mail Pharmacy, LLC (Texas)
  - Caremark Texas Specialty Pharmacy, LLC (Texas)
  - Caremark Washington Specialty Pharmacy, LLC (Washington)
  - Central Rx Services, LLC (Nevada)
  - CVS Caremark TN SUTA, LLC (Delaware)
  - Generation Health, L.L.C. (Delaware)
  - NovoLogix, LLC (Delaware)
- CaremarkPCS Alabama Mail Pharmacy, LLC (Alabama)
- CVS Caremark Part D Services, L.L.C. (Delaware)
- Eckerd Corporation of Florida, Inc. (Florida)
- Express Pharmacy Services of PA, L.L.C. (Delaware)
- Ocean Acquisition Sub, L.L.C. (Delaware)
  - Coram LLC (Delaware)
  - T2 Medical, Inc. (Delaware)
    - Coram Healthcare Corporation of Alabama (Delaware)
    - Coram Healthcare Corporation of Florida (Delaware)
    - Coram Healthcare Corporation of Greater D.C. (Delaware)
    - Coram Healthcare Corporation of Greater New York (New York)
    - Coram Healthcare Corporation of Indiana (Delaware)
    - Coram Healthcare Corporation of Mississippi (Delaware)
    - Coram Healthcare Corporation of Nevada (Delaware)
    - Coram Healthcare Corporation of Northern California (Delaware)
    - Coram Healthcare Corporation of Southern California (Delaware)
    - Coram Healthcare Corporation of Southern Florida (Delaware)
    - Coram Specialty Infusion Services, L.L.C. (Delaware)
      - Coram Rx, LLC (Delaware)

        - Coram Healthcare Corporation of North Texas (Delaware)
        - Coram Healthcare Corporation of Utah (Delaware)
        - Coram Healthcare Corporation of Massachusetts (Delaware)
      - Coram Alternate Site Services, Inc. (Delaware)
        - Geneva Woods Management, LLC (Delaware)
    - Part D Holding Company, L.L.C. (Delaware)
      - Accendo Insurance Company (Utah)
      - Silverscript Insurance Company (Tennessee)
- Connecticut CVS Pharmacy, L.L.C. (Connecticut)
- Coram Clinical Trials, Inc. (Delaware)*
  - CVS Cabot Holdings Inc. (Delaware)*
  - CVS Shaw Holdings Inc. (Delaware)*
    - Omnicare, LLC (Delaware)*
      - Evergreen Pharmaceutical of California, LLC (California)
      - JHC Acquisition, LLC (Delaware)
        - Geneva Woods Pharmacy, LLC (Alaska)
          - Geneva Woods Health Services, LLC (Delaware)
            - Geneva Woods Retail Pharmacy LLC (Delaware)
            - Geneva Woods LTC Pharmacy, LLC
              - Geneva Woods Pharmacy Wyoming, LLC (Delaware)
              - Geneva Woods Pharmacy Washington, LLC (Delaware)
              - Geneva Woods Pharmacy Alaska, LLC (Delaware)
        - AMC - Tennessee, LLC (Delaware)
        - CHP Acquisition, LLC (Delaware)
          - Home Pharmacy Services, LLC (Missouri)
        - CP Acquisition, LLC (Oklahoma)
        - Managed Healthcare, LLC (Delaware)
        - Medical Arts Health Care, LLC (Georgia)
        - NIV Acquisition, LLC (Delaware)
        - OCR Services, LLC (Delaware)
          - Shore Pharmaceutical Providers, LLC (Delaware)
        - Omnicare of Nevada, LLC (Delaware)
        - Omnicare Pharmacies of the Great Plains Holding, LLC (Delaware)
          - Omnicare of Nebraska LLC (Delaware)
        - Pharmacy Associates of Glenn Falls, LLC (New York)
        - Sterling Healthcare Services, LLC (Delaware)
        - Superior Care Pharmacy, LLC (Delaware)
        - TCPI Acquisition, LLC (Delaware)
        - UC Acquisition, LLC (Delaware)
        - Weber Medical Systems LLC (Delaware)
        - Williamson Drug Company, LLC (Virginia)
      - Med World Acquisition Corp. (Delaware)
      - MHHP Acquisition Company, LLC (Delaware)

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*Coram Clinical Trials, Inc. – CVS Pharmacy, Inc. 75%/Aetna Life Insurance Company 25%

* CVS Cabot Holdings, Inc. – Coram Clinical Trials, Inc. 99.72%/Aetna Inc. 0.28%

*CVS Shaw Holdings, Inc. – Coram Clinical Trials, Inc. 99.72%/Aetna Inc. 0.28%

*Omnicare, LLC – Aetna Inc. 0.28%/CVS Cabot Holdings, Inc. 49.86%/CVS Shaw Holdings, Inc. 49.86%

- Omnicare, LLC (continued)
  - NeighborCare Pharmacy Services, LLC (Delaware)
    - APS Acquisition LLC (Delaware)
    - ASCO HealthCare, LLC (Maryland)
    - Badger Acquisition LLC (Delaware)
      - Badger Acquisition of Minnesota LLC (Delaware)
        - Merwin Long Term Care, LLC (Minnesota)
      - Badger Acquisition of Ohio LLC (Delaware)
      - Badger Acquisition of Kentucky LLC (Delaware)
    - Best Care LTC Acquisition Company, LLC (Delaware)
    - Care Pharmaceutical Services, LP (Delaware)
    - CCRx Holdings, LLC (Delaware)
      - Continuing Care Rx, LLC (Pennsylvania)
      - CCRx of North Carolina LLC (Delaware)
    - Compscript, LLC (Florida)
      - Campo's Medical Pharmacy, LLC (Louisiana)
    - D & R Pharmaceutical Services LLC (Kentucky)
    - Enloe Drugs, LLC (Delaware)
    - Evergreen Pharmaceutical, LLC (Washington)
    - Home Care Pharmacy, LLC (Delaware)
    - Interlock Pharmacy Systems, LLC (Missouri)
    - Langsam Health Services, LLC (Delaware)
      - LCPS Acquisition, LLC (Delaware)
        - Omnicare Pharmacy of Tennessee LLC (Delaware)
    - Lobos Acquisition, LLC (Delaware)
    - Lo-Med Prescription Services, LLC (Ohio)
      - ZS Acquisition Company, LLC (Delaware)
    - Main Street Pharmacy, L.L.C. (Maryland)
    - NCS Healthcare of Illinois, LLC (Ohio)
    - NCS Healthcare of Iowa, LLC (Ohio)
      - Martin Health Services, LLC (Delaware)
    - NCS Healthcare of Kansas, LLC (Ohio)
    - NCS Healthcare of Kentucky, LLC (Ohio)
    - NCS Healthcare of Montana, LLC (Ohio)
    - NCS Healthcare of New Mexico, LLC (Ohio)
    - NCS Healthcare of South Carolina, LLC (Ohio)
    - NCS Healthcare of Tennessee, LLC (Ohio)
    - NCS Healthcare of Ohio, LLC (Ohio)
    - NCS Healthcare of Wisconsin, LLC (Ohio)
    - North Shore Pharmacy Services LLC (Delaware)
    - Omnicare Indiana Partnership Holding Company LLC (Delaware)
    - Omnicare of New York, LLC (Delaware)
      - NeighborCare of Indiana, LLC (Indiana)
        - Grandview Pharmacy, LLC (Indiana)
      - NeighborCare of Virginia, LLC (Virginia)
    - Omnicare Pharmacies of Pennsylvania West LLC (Pennsylvania)
    - Omnicare Pharmacy and Supply Services LLC (South Dakota)
    - Omnicare Pharmacy of the Midwest, LLC (Delaware)
    - Omnicare Property Management, LLC (Delaware)
    - Pharmacy Consultants, LLC (South Carolina)
    - PRN Pharmaceutical Services, LP (Delaware)
    - Roeschen's Healthcare LLC (Wisconsin)
      - PP Acquisition Company LLC (Delaware)
    - Specialized Pharmacy Services, LLC (Michigan)

        - Value Health Care Services LLC (Delaware)
        - VAPS Acquisition Company, LLC (Delaware)
        - Westhaven Services Co, LLC (Ohio)
      - Three Forks Apothecary, LLC (Kentucky)
      - UNI-Care Health Services of Maine, LLC (New Hampshire)

- CVS Pharmacy, Inc. (continued)
  - CVS 2948 Henderson, L.L.C. (Nevada)
  - CVS AL Distribution, L.L.C. (Alabama)
  - CVS Albany, L.L.C. (New York)
  - CVS AOC Services, L.L.C. (Delaware)
    - CVS AOC Corporation (California)
  - CVS Care Concierge, LLC (Delaware)
  - CVS Health Clinical Trial Services LLC (Connecticut)
  - CVS Health Solutions LLC (Delaware)
  - CVS Indiana, L.L.C. (Indiana)
  - CVS International, L.L.C. (Delaware)
    - CCI Foreign, S.à R.L. (R.C.S. Luxembourg)
      - Beauty Holdings, L.L.C. (Delaware)
      - Pamplona Saúde e Beleza LTDA (Brazil)
  - CVS Kidney Care, LLC (Delaware)
    - CVS Kidney Care Health Services LLC (Delaware)
    - CVS Kidney Care Advanced Technologies LLC (Delaware)
    - CVS Kidney Care Home Dialysis LLC (Delaware)
      - CVS-SHC Kidney Care Home Dialysis of Austin LLC (Delaware)
      - CVS-SHC Kidney Care Home Dialysis of Los Angeles LLC (Delaware)
      - CVS-SHC Kidney Care Home Dialysis of Philadelphia LLC (Delaware)
  - CVS Manchester NH, L.L.C. (New Hampshire)
  - CVS Media Exchange LLC (Delaware)
  - CVS Michigan, L.L.C. (Michigan)
  - CVS Orlando FL Distribution, L.L.C. (Florida)
  - CVS PA Distribution, L.L.C. (Pennsylvania)
  - CVS Pharmacy Overseas Online, LLC
  - CVS PR Center, Inc. (Delaware)
    - Puerto Rico CVS Pharmacy, L.L.C. (Puerto Rico)
    - Caremark Puerto Rico, L.L.C. (Puerto Rico)
    - Caremark Puerto Rico Specialty Pharmacy, L.L.C. (Puerto Rico)
  - CVS RS Arizona, L.L.C. (Arizona)
    - Arizona CVS Stores, L.L.C. (Arizona)
    - CVS 3268 Gilbert, L.L.C. (Arizona)
    - CVS 3745 Peoria, L.L.C. (Arizona)
    - CVS Gilbert 3272, L.L.C. (Arizona)
  - CVS Rx Services, Inc. (New York)
    - Busse CVS, L.L.C. (Illinois)
    - Goodyear CVS, L.L.C. (Arizona)
    - Sheffield Avenue CVS, L.L.C. (Illinois)
    - South Wabash CVS, L.L.C. (Illinois)
    - Thomas Phoenix CVS, L.L.C. (Arizona)
    - Washington Lamb CVS, L.L.C. (Nevada)
  - CVS SC Distribution, L.L.C. (South Carolina)
  - CVS State Capital, L.L.C. (Maine)
  - CVS TN Distribution, L.L.C. (Tennessee)
  - CVS Transportation, L.L.C. (Indiana)

- CVS Vero FL Distribution, L.L.C. (Florida)
- D.A.W., LLC (Massachusetts)
- Delaware CVS Pharmacy, L.L.C. (Delaware)
- Digital eHealth, LLC (Rhode Island)
- District of Columbia CVS Pharmacy, L.L.C. (District of Columbia)
- Enterprise Patient Safety Organization, LLC (Rhode Island)
- E.T.B., Inc. (Texas)
- Garfield Beach CVS, L.L.C. (California)
- Georgia CVS Pharmacy, L.L.C. (Georgia)
- German Dobson CVS, L.L.C. (Arizona)
- Grand St. Paul CVS, L.L.C. (Minnesota)
- Highland Park CVS, L.L.C. (Illinois)
- Holiday CVS, L.L.C. (Florida)
- Hook-SupeRx, L.L.C. (Delaware)
- Idaho CVS Pharmacy, L.L.C. (Idaho)
- Iowa CVS Pharmacy, L.L.C. (Iowa)
- Kansas CVS Pharmacy, L.L.C. (Kansas)
- Kentucky CVS Pharmacy, L.L.C. (Kentucky)
- Longs Drug Stores California, L.L.C. (California)
- Louisiana CVS Pharmacy, L.L.C. (Louisiana)
- Maryland CVS Pharmacy, L.L.C. (Maryland)
- Melville Realty Company, Inc. (New York)
    - CVS Bellmore Avenue, L.L.C. (New York)
- MinuteClinic, L.L.C. (Delaware)
    - MinuteClinic Diagnostic of Alabama, L.L.C. (Alabama)
    - MinuteClinic Diagnostic of Arkansas, LLC (Arkansas)
    - MinuteClinic Diagnostic of Arizona, LLC (Minnesota)
    - MinuteClinic Diagnostic of Colorado LLC (Colorado)
    - MinuteClinic Diagnostic of Florida, LLC (Minnesota)
    - MinuteClinic Diagnostic of Georgia, LLC (Minnesota)
    - MinuteClinic Diagnostic of Hawaii, L.L.C. (Hawaii)
    - MinuteClinic Diagnostic of Illinois, LLC (Delaware)
    - MinuteClinic Diagnostic of Kentucky, L.L.C. (Kentucky)
    - MinuteClinic Diagnostic of Louisiana, L.L.C. (Louisiana)
    - MinuteClinic Diagnostic of Maine, L.L.C. (Maine)
    - MinuteClinic Diagnostic of Maryland, LLC (Minnesota)
    - MinuteClinic Diagnostic of Massachusetts, LLC (Massachusetts)
    - MinuteClinic Diagnostic of Nebraska, L.L.C. (Nebraska)
    - MinuteClinic Diagnostic of New Hampshire, L.L.C. (New Hampshire)
    - MinuteClinic Diagnostic of New Mexico, L.L.C. (New Mexico)
    - MinuteClinic Diagnostic of Ohio, LLC (Ohio)
    - MinuteClinic Diagnostic of Oklahoma, LLC (Oklahoma)
    - MinuteClinic Diagnostic of Oregon, LLC (Oregon)
    - MinuteClinic Diagnostic of Pennsylvania, LLC (Minnesota)
    - MinuteClinic Diagnostic of Rhode Island, LLC (Minnesota)
    - MinuteClinic Diagnostic of South Carolina, L.L.C. (South Carolina)
    - MinuteClinic Diagnostic of Texas, LLC (Minnesota)
    - MinuteClinic Diagnostic of Utah, L.L.C. (Utah)
    - MinuteClinic Diagnostic of Virginia, LLC (Virginia)
    - MinuteClinic Diagnostic of Washington, LLC (Oregon)
    - MinuteClinic Diagnostic of Wisconsin, L.L.C. (Wisconsin)
    - MinuteClinic Online Diagnostic Services, LLC (Delaware)
    - MinuteClinic Physician Practice of Texas (Texas)
    - MinuteClinic Telehealth Services, LLC (Delaware)
- Mississippi CVS Pharmacy, L.L.C. (Mississippi)

- Missouri CVS Pharmacy, L.L.C. (Missouri)
- Montana CVS Pharmacy, L.L.C. (Montana)
- Nebraska CVS Pharmacy, L.L.C. (Nebraska)
- New Jersey CVS Pharmacy, L.L.C. (New Jersey)
- North Carolina CVS Pharmacy, L.L.C. (North Carolina)
- Ohio CVS Stores, L.L.C. (Ohio)
- Oklahoma CVS Pharmacy, L.L.C. (Oklahoma)
- Oregon CVS Pharmacy, L.L.C. (Oregon)
- Pennsylvania CVS Pharmacy, L.L.C. (Pennsylvania)
- ProCare Pharmacy Direct, L.L.C. (Ohio)
- ProCare Pharmacy, L.L.C. (Rhode Island)
- Red Oak Sourcing, LLC (Delaware)
- Rhode Island CVS Pharmacy, L.L.C. (Rhode Island)
- South Carolina CVS Pharmacy, L.L.C. (South Carolina)
- Tennessee CVS Pharmacy, L.L.C. (Tennessee)
- Utah CVS Pharmacy, L.L.C. (Utah)
- Vermont CVS Pharmacy, L.L.C. (Vermont)
- Virginia CVS Pharmacy, L.L.C. (Virginia)
- Warm Springs Road CVS, L.L.C. (Nevada)
- Washington CVS Pharmacy, L.L.C. (Washington)
- Wellpartner, LLC (Delaware)
- West Virginia CVS Pharmacy, L.L.C. (West Virginia)
- Wisconsin CVS Pharmacy, L.L.C. (Wisconsin)
- Woodward Detroit CVS, L.L.C. (Michigan)
- Zinc Health Ventures, LLC
- Zinc Health Services, LLC

Exhibit 23.1

Consent of Independent Registered Public Accounting Firm

We consent to the incorporation by reference in the following Registration Statements:

(1) Registration Statement (Form S-3ASR No. 333-238506) of CVS Health Corporation, and
(2) Registration Statements (Form S-8 Nos. 333-238507, 333-230035, 333-228622, 333-167746, 333-217853, 333-208805, 333-141481, 333-139470, 333-63664, 333-91253, 333-49407, 333-34927, and 333-28043) of CVS Health Corporation;

of our reports dated February 16, 2021, with respect to the consolidated financial statements of CVS Health Corporation and the effectiveness of internal control over financial reporting of CVS Health Corporation included in this Annual Report (Form 10-K) of CVS Health Corporation for the year ended December 31, 2020.

/s/ Ernst & Young LLP

Boston, Massachusetts
February 16, 2021

Exhibit 31.1

Certification

I, Karen S. Lynch, President and Chief Executive Officer of CVS Health Corporation, certify that:

1. I have reviewed this annual report on Form 10-K of CVS Health Corporation;
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(s) 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(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 16, 2021

By: /s/ KAREN S. LYNCH

Karen S. Lynch
President and Chief Executive Officer

Exhibit 31.2

Certification

I, Eva C. Boratto, Executive Vice President and Chief Financial Officer of CVS Health Corporation, certify that:

1. I have reviewed this annual report on Form 10-K of CVS Health Corporation;
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(s) 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(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 16, 2021

By: /s/ EVA C. BORATTO

Eva C. Boratto
Executive Vice President and Chief Financial Officer

Exhibit 32.1

CERTIFICATION

The certification set forth below is being submitted in connection with the Annual Report of CVS Health Corporation (the "Company") on Form 10-K for the period ended December 31, 2020 (the "Report") solely for the purpose of complying with Rule 13a-14(b) or Rule 15d-14(b) of the Securities Exchange Act of 1934 (the "Exchange Act") and Section 1350 of Chapter 63 of Title 18 of the United States Code.

I, Karen S. Lynch, President and Chief Executive Officer of the Company, certify that, to the best of my knowledge:

1. the Report fully complies with the requirements of Section 13(a) or 15(d) of the Exchange Act; and
2. the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: February 16, 2021

/s/ KAREN S. LYNCH

Karen S. Lynch
President and Chief Executive Officer

Exhibit 32.2

CERTIFICATION

The certification set forth below is being submitted in connection with the Annual Report of CVS Health Corporation (the "Company") on Form 10-K for the period ended December 31, 2020 (the "Report") solely for the purpose of complying with Rule 13a-14(b) or Rule 15d-14(b) of the Securities Exchange Act of 1934 (the "Exchange Act") and Section 1350 of Chapter 63 of Title 18 of the United States Code.

I, Eva C. Boratto, Executive Vice President and Chief Financial Officer of the Company, certify that, to the best of my knowledge:

1. the Report fully complies with the requirements of Section 13(a) or 15(d) of the Exchange Act; and
2. the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: February 16, 2021

/s/ EVA C. BORATTO

Eva C. Boratto
Executive Vice President and Chief Financial Officer

aetna®

Responses to Technical Questions

Tab 7

Topic Area 1: Qualifications and Experience

Tab 7a

Topic Area 1: Experience and Qualifications

1. Describe the bidder's Medicaid Managed Care experience in the past five (5) years by completing a table that includes the information listed below for each contract.
   a. Name of state and program name.
   b. Start and end date.
   c. Services covered under the contract (e.g., physical health Behavioral Health, Long-Term Services and Supports, Pharmacy, Transportation).
   d. Covered population(s) (e.g., families and children, including pregnant women; aged, blind, and disabled without Medicare; aged, blind, and disabled with Medicare; CHIP; Members enrolled in Home- and Community-Based Services (HCBS) Waivers; and foster care children.
   e. Average number of total Member months for the most recent twelve (12) months of the contract (or most recent period if the contract has been in place less than twelve [12] months).
   f. Instances of non-compliance under the Medicaid Managed Care contract resulting in one (1) or more of the following actions: corrective action plan, directed corrective action plan, notice to cure, liquidated damage, withhold of all or part of a Capitation Payment, financial sanction, non-financial sanction, suspension of new enrollment, temporary management, termination, or non-renewal due to performance concerns. For each instance of non-compliance identified, provide a description of the non-compliance, the action taken by the state or contract holder, the actions taken by the bidder to correct the non-compliance, and the length of time for the bidder to correct the non-compliance.
   g. Instances of breach(es) of unsecured protected health information (PHI) under 45 CFR § 164.400 et seq. under the Medicaid Managed Care contract. For each instance of breach identified, provide a description of the breach and the actions taken by the state or contract holder to address the unsecured PHI under 45 CFR § 164.400 et seq.
   h. Subcontractors performing delegated Managed Care functions and the functions the Subcontractors performed.

Kansas

State of Kansas	
a.	State of Kansas, KanCare
b.	January 2019 - Present
c.	Medical, Pharmacy, Behavioral Health, Dental, Vision, Transportation, HCBS Services
d.	TANF, CHIP, LTSS, ABD, LTC, Foster Care and duals
e.	[redacted]

	State of Kansas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]	[redacted]	[redacted]	[redacted]	

	State of Kansas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		

	State of Kansas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		

	State of Kansas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		

	State of Kansas
g.	[redacted]
h.	[redacted]

	State of Kansas
	[redacted]

Arizona

State of Arizona	
a.	1. Arizona Department of Child Safety Comprehensive Health Plan (DCS CHP), Mercy Care 2. Arizona Division of Developmental Disabilities (DDD), a Division of the Department of Economic Security (DES), Mercy Care 3. Arizona Health Care Cost Containment System (AHCCCS), Mercy Care ACC/RBHA 4. Arizona Health Care Cost Containment System (AHCCCS), Mercy Care EPD/ALTC
b.	• DCS CHP: 2021 - Present • DDD & DES: 1991-Present

State of Arizona	
	• AHCCCS ACC/RBHA: Acute ACC: 1985- Present; Regional Behavioral Health Authority: 2014-Present • AHCCCS EPD/ALTC: 2000-Present
c.	• DCS CHP: Medical, Pharmacy, Behavioral Health, Dental, Vision, Transportation • DDD & DES: Medical, Pharmacy, Behavioral Health, Dental, Vision, Transportation, LTSS, HCBS • AHCCCS ACC/RBHA: Medical, Pharmacy, Behavioral Health, Dental, Vision, Transportation, LTSS, HCBS • AHCCCS EPD/ALTC: Medical, Pharmacy, Behavioral Health, Dental, Vision, Transportation, LTSS, HCBS
d.	• DCS CHP: Children and youth placed in out-of-home care • DDD & DES: Children and adults with disabilities • AHCCCS ACC/RBHA: Acute, General Mental Health/Substance Abuse Use (GMH/SU), Children • AHCCCS EPD/ALTC: Elderly, Physically Disabled/Long-Term Care (EPD/ALTC)
e.	DCS CHP: [redacted] DDD & DES: [redacted] AHCCCS ACC/RBHA: [redacted] AHCCCS EPD/ALTC: [redacted]

f.	State of Arizona				
	Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

f.

State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
[redacted]				

f.

State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
[redacted]				

f.

State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
[redacted]				

f.

State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
[redacted]				
[redacted]	[redacted]		[redacted]	[redacted]
[redacted]	[redacted]		[redacted]	[redacted]

f.

State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
[redacted]				
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

f.

State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
[redacted]				

f.

State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
[redacted]				

f.

State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
[redacted]				
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f.

State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
[redacted]				
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f.

State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
[redacted]				
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

f.

State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
		[redacted]		
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

f.

State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
[redacted]				
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f.

State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
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State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
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State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
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State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
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State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
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State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
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f.

State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
[redacted]				

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State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
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f.

State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
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State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
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State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
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State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**

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State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**

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State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
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State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
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[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

f.

State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
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State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
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State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
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State of Arizona

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Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
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State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
[redacted]				

State of Arizona

f.

Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date

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State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
[redacted]				
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State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
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State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
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State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
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[redacted]				[redacted]
[redacted]			[redacted]	[redacted]

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State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
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State of Arizona

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Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date

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State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
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State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
[redacted]				

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State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
[redacted]				

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State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
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[redacted]	[redacted]			[redacted]

f.

State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
[redacted]				

f.

State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
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f.

State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
[redacted]				

State of Arizona

f.

Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
[redacted]				

f.

State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
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f.

State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**

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State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
[redacted]				

f.	State of Arizona				
	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

f.

State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
[redacted]				

f.

State of Arizona				
Description of Non-Compliance	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
		[redacted]		

State of Arizona

g. [redacted]

h. [redacted]

California

State of California	
a.	California Medi-Cal Managed Care
b.	January 2018 - Present
c.	Medical, Behavioral Health, Vision, Transportation, Limited MLTSS
d.	TANF, CHIP, Expansion, DUALs, ABD, LTC, Maternity, and MLTSS
e.	

	State of California				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date

	State of California				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				

	State of California				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				

	State of California				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

	State of California				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Arizona
g.	[redacted]
h.	[redacted]

	State of Arizona
	[redacted]

Florida

State of Florida	
a.	• State of Florida, Florida Healthy Kids (FHK) • State of Florida, Florida Statewide Medicaid Managed Care (SMMC)
b.	• FHK: January 2015 - Present • SMMC: December 2013 - Present
c.	• FHK: Medical, Pharmacy, Behavioral Health, Vision, Transportation (Dental carved out) • SMMC: Medical, Pharmacy, Behavioral Health, Vision, Transportation, LTSS/LTC (Dental is carved out)
d.	• FHK: CHIP ages 5 through 18. Includes children, complex children, PDN, pregnant mothers. Both subsidized and premium-paying Members. • SMMC: TANF and SSI/ABD, Specialty (HIV, Child Welfare, SMI) and LTC/LTSS. Includes non-LTC Duals, elderly, complex children, Disabled
e.	• FHK: [redacted] • SMMC: [redacted]

	State of Florida				
f.	**Description of Non-Compliance**	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
	[redacted]	[redacted]	[redacted]		
	[redacted]	[redacted]	[redacted]		

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]	[redacted]	[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]			[redacted]	
	[redacted]	[redacted]			
	[redacted]	[redacted]		[redacted]	

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
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	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
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	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
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	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
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	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
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	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
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	[redacted]		[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]		[redacted]
	[redacted]	[redacted]	[redacted]		[redacted]

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
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	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
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	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
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	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
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	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
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	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
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	[redacted]		[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]		[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]		[redacted]
	[redacted]		[redacted]	[redacted]	

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]		[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]		[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]		[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]		

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]		[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	

	State of Florida				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]		[redacted]		

	State of Florida
g.	[redacted]
h.	[redacted]

State of Florida
[redacted]

Illinois

State of Illinois	
a.	State of Illinois, HealthChoice Illinois
b.	January 2018 - Present
c.	Medical, Pharmacy, Behavioral Health, Dental, Vision, Transportation, LTSS
d.	Children, pregnant women, adults, older adults, children and adults with disabilities, LTSS, Medicaid expansion, and former youth in care Members
e.	[redacted]

State of Illinois				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]			[redacted]	[redacted]

	State of Illinois				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]		[redacted]		
	[redacted]		[redacted]	[redacted]	[redacted]
	[redacted]		[redacted]	[redacted]	[redacted]
	[redacted]		[redacted]	[redacted]	[redacted]

	State of Illinois				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	State of Illinois				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				

	State of Illinois				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]			[redacted]	[redacted]
	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]		[redacted]	[redacted]

	State of Illinois				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

	State of Illinois				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]		[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]		[redacted]	[redacted]	[redacted]

	State of Illinois				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		

	State of Illinois
g.	[redacted]
h.	[redacted]

State of Illinois


State of Illinois

State of Illinois


State of Illinois

	State of Illinois
	[redacted]

Kentucky

Commonwealth of Kentucky	
a.	Commonwealth of Kentucky, Kentucky Medicaid Managed Care
b.	November 2011 - Present
c.	Medical, Pharmacy, Behavioral Health, Dental, Vision
d.	TANF, ABD, ACA, Duals, CHIP, SSI, SKY (foster/adoption/justice involved)
e.	[redacted]

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]	[redacted]	[redacted]		[redacted]
	[redacted]	[redacted]	[redacted]		[redacted]

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]	[redacted]	[redacted]		
	[redacted]	[redacted]	[redacted]		

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Kentucky				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		

	Commonwealth of Kentucky
g.	[redacted]
h.	[redacted]

Commonwealth of Kentucky

	Commonwealth of Kentucky
	[redacted]

Louisiana

State of Louisiana	
a.	State of Louisiana, Healthy Louisiana
b.	January 2023 - Present
c.	Medical, Pharmacy, Specialize Behavioral Health, Dental, Vision, Transportation
d.	ACA, SBH, CHIP, SSI, TANF, FOSTER (includes children, pregnant women, adults, older adults, children and adults with disabilities, Non-LTSS, Medicaid Expansion)
e.	[redacted]

	State of Louisiana				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				

	State of Louisiana				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	State of Louisiana				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Louisiana				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	State of Louisiana				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	State of Louisiana				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Louisiana				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]		[redacted]
	[redacted]	[redacted]	[redacted]		[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]		[redacted]

	State of Louisiana				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Louisiana				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Louisiana				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Louisiana				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Louisiana				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Louisiana				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Louisiana				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	State of Louisiana				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Louisiana				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Louisiana				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Louisiana				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Louisiana				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Louisiana				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Louisiana				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]		[redacted]		

	State of Louisiana
g.	[redacted]
h.	[redacted]

Maryland

State of Maryland	
a.	State of Maryland - Maryland Health Choice
b.	2017 - Present
c.	Medical, Pharmacy, Vision, Transportation
d.	TANF, CHIP, ACA, and ABD
e.	[redacted]

	State of Maryland				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]	[redacted]	[redacted]	[redacted]	

	State of Maryland
g.	[redacted]
h.	[redacted]

Michigan

State of Michigan	
a.	State of Michigan, Comprehensive Health Care Program for the Michigan Department of Health and Human Services
b.	January 2016 – Present Aetna Better Health of Michigan has held a contract with the State of Michigan to service Medicaid beneficiaries since October 1, 2004. Before October 1, 2004, the predecessor organization, whose license was purchased in 2004, was the first HMO in Michigan, having contracted to service Medicaid enrollees since 1973.
c.	Medical, Pharmacy, Outpatient Behavioral Health, Dental, Vision, Transportation
d.	Temporary Assistance to Need Families/TANF - Children, Adults, Pregnant Women, Aged, Blind and Disabled/ABAD - Older Adults and Adults with disabilities, Children Special

	Health Care Services - Children with disabilities and chronic medical conditions, Healthy Michigan Plan - Medicaid Expansion
e.	[redacted]

	State of Michigan				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	State of Michigan				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	State of Michigan				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				

	State of Michigan				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Michigan				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	State of Michigan				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

	State of Michigan				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Michigan				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Michigan				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Michigan				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Michigan				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Michigan
g.	[redacted]
h.	[redacted]


State of Michigan

State of Michigan

[redacted]

New Jersey

State of New Jersey

a. State of New Jersey, FamilyCare Medicaid

b.	January 2015 - Present
c.	Medical, Pharmacy, dental, vision, inpatient behavioral health and LTSS. NOTE: Outpatient Behavioral health services are covered by New Jersey Medicaid as a carve out for all beneficiaries except LTSS and IDD beneficiaries. Lower mode transportation is covered by New Jersey Medicaid as a carve out for all beneficiaries.
d.	Children, pregnant women, adults, older adults, children and adults with disabilities, and individuals receiving LTSS, Medicaid Expansion
e.	[redacted]

	State of New Jersey				
f.	**Description of Non-Compliance**	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
	[redacted]				

	State of New Jersey				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]		[redacted]		

	State of New Jersey				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				

	State of New Jersey				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	

	State of New Jersey				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				

	State of New Jersey				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	State of New Jersey				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]		[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	

	State of New Jersey				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	State of New Jersey				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]		[redacted]		
	[redacted]	[redacted]	[redacted]		[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]		

	State of New Jersey				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	State of New Jersey				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				

	State of New Jersey				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of New Jersey
g.	[redacted]
h.	[redacted]

	State of New Jersey
	[redacted]

New York

State of New York	
a.	State of New York (Note: there is no branded name for this plan)
b.	December 2023 - Present
c.	Care Management; Home Care, including Nursing Home Health Aide, Occupational, Physical and Speech Therapies; Vision; Dental; Rehab and Respiratory Therapies; Nutrition; Podiatry; Non-emergency Transportation; DME; Home Delivered Meals; Social and Adult Day Care; Prostheses and Orthotics; Social/Environmental Supports; PERS; Nursing Home (90 days only)
d.	Individuals receiving LTSS
e.	[redacted]

	State of New York				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				

	State of New York
g.	[redacted]
h.	[redacted]

Ohio

State of Ohio	
a.	State of Ohio, OhioRISE
b.	July 2022 - Present
c.	Aetna employed care coordinators provide Tier 1 Limited Care Coordination, the lowest intensity of the three tiers of care coordination. The plan also covers: Behavioral health respite, Ohio Children's Initiative (OCI) and Child and Adolescent Needs (CANS) Assessment, Community Psychiatric Supportive Treatment (CPST) Counseling and psychotherapy, Flexible funds and customized goods and services, Inpatient Hospital Substance Use Disorder Services and Psychiatric Services, Intensive home-based treatment (IHBT), Mobile response and stabilization service (MRSS), Psychiatry, Psychiatric residential treatment facility (PRTF), Psychosocial Rehabilitation (PSR), Screening and testing, Services that support treatment goals, Therapeutic Behavioral Service (TBS), Specialized Behavioral Health Services, Substance Use Assessment, Case Management, Intensive Outpatient, Partial Hospitalization, Peer Recovery Support, Residential Treatment, Therapy, and Withdrawal Management.
d.	Children with serious/complex behavioral health needs
e.	[redacted]

	State of Ohio				
f.	**Description of Non-Compliance**	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
	[redacted]				

	State of Ohio				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				

	State of Ohio				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Ohio				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		

	State of Ohio
g.	[redacted]

State of Ohio
[redacted]
h. [redacted]

Pennsylvania

Commonwealth of Pennsylvania
a. • Commonwealth of Pennsylvania, Children's Health Insurance Program (CHIP) • Commonwealth of Pennsylvania, HealthChoices

b.	• CHIP: 1993 - Present • HealthChoices: January 2010 - August 2022
c.	• CHIP: Medical, pharmacy, behavioral health, dental, vision. Non-emergent medical transportation covered through Aetna only. • HealthChoices: Medical, Pharmacy, Dental, Vision
d.	• CHIP: Children from Age 0 - 18 that do not qualify for Medicaid, enrollees who are pregnant, and enrollees with developmental disabilities not eligible for Medicaid • HealthChoices: Medicaid only for Physical Health services for TANF ABD and EXP for all ages. BH services carved out. Adults and Children (including foster care) with disability and not eligible for LTSS.
e.	CHIP: [redacted] HealthChoices: [redacted]

	Commonwealth of Pennsylvania				
f.	**Description of Non-Compliance**	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
	[redacted]				
	[redacted]				
	[redacted]				

	Commonwealth of Pennsylvania				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	Commonwealth of Pennsylvania				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]			[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]
	[redacted]			[redacted]	
			[redacted]		

	Commonwealth of Pennsylvania				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	Commonwealth of Pennsylvania				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	Commonwealth of Pennsylvania				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]			[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]

	Commonwealth of Pennsylvania				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				

	Commonwealth of Pennsylvania
g.	[redacted]
h.	[redacted]

	Commonwealth of Pennsylvania
	[redacted]

Texas

State of Texas	
a.	• State of Texas, STAR and CHIP Program • State of Texas, STAR Kids
b.	• STAR/CHIP: 2006 - Present • STAR Kids: 2017 - Present
c.	• STAR/CHIP: Medical, BH, Pharmacy, Vision, Transportation • STAR Kids: Medical, BH, Pharmacy, Vision, Transportation, LTSS
d.	• STAR/CHIP: TANF, children, pregnant women, and some families • STAR Kids: Children with disabilities including individuals receiving LTSS
e.	STAR/CHIP: [redacted] STAR Kids: [redacted]

	State of Texas				
f.	**Description of Non-Compliance**	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
	[redacted]				
	[redacted]				

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	State of Texas				
f.	**Description of Non-Compliance**	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**
	[redacted]				
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]		[redacted]		
	[redacted]		[redacted]		
	[redacted]		[redacted]		
	[redacted]		[redacted]		
	[redacted]		[redacted]		
	[redacted]		[redacted]		
	[redacted]		[redacted]		
	[redacted]		[redacted]		
	[redacted]		[redacted]		
	[redacted]		[redacted]		

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
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	[redacted]				
	[redacted]				
	[redacted]				

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]	[redacted]	[redacted]		
	[redacted]	[redacted]	[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]		
	[redacted]	[redacted]	[redacted]		

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]			[redacted]	
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]			[redacted]	

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]	[redacted]	[redacted]	[redacted]	

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]				
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]				
	[redacted]				

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]				
	[redacted]			[redacted]	
	[redacted]			[redacted]	

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]			[redacted]	
	[redacted]	[redacted]		[redacted]	
	[redacted]			[redacted]	
	[redacted]			[redacted]	

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]		[redacted]	[redacted]	
	[redacted]		[redacted]	[redacted]	
	[redacted]		[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]		[redacted]	[redacted]	
	[redacted]		[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]		[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]		[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]		[redacted]		
	[redacted]		[redacted]	[redacted]	
	[redacted]		[redacted]	[redacted]	
	[redacted]		[redacted]	[redacted]	

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]		[redacted]	[redacted]	
	[redacted]		[redacted]	[redacted]	

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]	[redacted]	[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]		
	[redacted]	[redacted]	[redacted]		
	[redacted]	[redacted]	[redacted]		

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]	[redacted]	[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]		[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]			[redacted]	

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]		[redacted]	[redacted]	
	[redacted]		[redacted]	[redacted]	
	[redacted]		[redacted]	[redacted]	
	[redacted]		[redacted]	[redacted]	

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]		[redacted]	[redacted]	
	[redacted]		[redacted]	[redacted]	
	[redacted]		[redacted]	[redacted]	
	[redacted]		[redacted]	[redacted]	

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]		[redacted]		
	[redacted]		[redacted]	[redacted]	

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]		[redacted]	[redacted]	
	[redacted]		[redacted]	[redacted]	
	[redacted]		[redacted]	[redacted]	

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]		[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	

	State of Texas				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				

	State of Texas
g.	[redacted]
h.	[redacted]

	State of Texas
	[redacted]

Virginia

Commonwealth of Virginia	
a.	• Commonwealth of Virginia, Cardinal Care • Commonwealth of Virginia, Medallion 4.0 • Commonwealth of Virginia, CCC Plus
b.	• Cardinal Care: October 2023 - Present • Medallion 4.0: August 2018 - October 2023 • CCC Plus: August 2017 - October 2023
c.	• Cardinal Care: Medical, Pharmacy, Behavioral Health, Vision, Hearing, Transportation, LTSS, and Personal Care/Consumer Directed Personal Care • Medallion 4.0: Medical, Pharmacy, Behavioral Health, Vision, Hearing, Transportation, LTSS, and Personal Care/Consumer Directed Personal Care • CCC Plus: Medical, Pharmacy, Behavioral Health, Vision, Hearing, Transportation, LTSS, and Personal Care/Consumer Directed Personal Care
d.	• Cardinal Care: Children, pregnant women, adults, older adults, children and adults with disabilities, individuals receiving LTSS, and Medicaid Expansion. TANF, CHIP, foster care and adoption assistance populations included. • Medallion 4.0: Children, pregnant women, adults, older adults, children and adults with disabilities, individuals receiving LTSS, and Medicaid Expansion. TANF, CHIP, foster care and adoption assistance populations included.

- CCC Plus: Children, pregnant women, adults, older adults, children and adults with disabilities, individuals receiving LTSS, and Medicaid Expansion. TANF, CHIP, foster care and adoption assistance populations are included.

e. Cardinal Care: [redacted]
Medallion 4.0: [redacted]
- CCC Plus: [redacted]

Commonwealth of Virginia

f.

Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
[redacted]				

	Commonwealth of Virginia				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	Commonwealth of Virginia				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Virginia				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]		[redacted]	[redacted]	
	[redacted]		[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]		[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]		

	Commonwealth of Virginia				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Virginia				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	Commonwealth of Virginia				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Virginia				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	Commonwealth of Virginia				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	Commonwealth of Virginia				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]		[redacted]	[redacted]	
	[redacted]		[redacted]	[redacted]	[redacted]
	[redacted]		[redacted]		[redacted]
	[redacted]		[redacted]	[redacted]	[redacted]
	[redacted]		[redacted]	[redacted]	[redacted]
	[redacted]		[redacted]		
	[redacted]		[redacted]	[redacted]	[redacted]

	Commonwealth of Virginia				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
			[redacted]		
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]		[redacted]	[redacted]	
	[redacted]		[redacted]		[redacted]
	[redacted]	[redacted]	[redacted]		[redacted]
	[redacted]		[redacted]	[redacted]	

	Commonwealth of Virginia				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	Commonwealth of Virginia				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]	[redacted]	[redacted]	[redacted]	
		[redacted]	[redacted]	[redacted]	
		[redacted]	[redacted]	[redacted]	
		[redacted]	[redacted]	[redacted]	
		[redacted]	[redacted]	[redacted]	
		[redacted]	[redacted]	[redacted]	

	Commonwealth of Virginia				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]	

	Commonwealth of Virginia				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
		[redacted]		[redacted]	
		[redacted]		[redacted]	
		[redacted]		[redacted]	
		[redacted]			
		[redacted]			
		[redacted]			

	Commonwealth of Virginia				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Virginia				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	Commonwealth of Virginia				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Virginia				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				
	[redacted]				

	Commonwealth of Virginia				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				

	Commonwealth of Virginia
g.	• [redacted]
h.	[redacted]

West Virginia

State of West Virginia	
a.	• State of West Virginia, Mountain Health Trust • State of West Virginia, Mountain Health Promise
b.	• Trust: July 1996 - Present • Promise: March 2020 - Present
c.	• Trust: Medical, Behavioral Health, Dental, Vision • Promise: Medical, Behavioral Health, Dental, Vision
d.	• Trust: TANF, ACA Expansion, ABD/SSI, CHIP, Pregnant Women • Promise: Foster Care; Children with Serious Emotional Disorders Waiver
e.	Trust: Promise:

	State of West Virginia				
f.	**Description of Non-Compliance**	**Action Taken**	**Actions Taken by Aetna**	**Notified Date**	**Corrected Date**

	State of West Virginia				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
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	[redacted]				

	State of West Virginia				
f.	Description of Non-Compliance	Action Taken	Actions Taken by Aetna	Notified Date	Corrected Date
	[redacted]				
	[redacted]				

	State of West Virginia
g.	[redacted]
h.	[redacted]


State of West Virginia

Topic Area 1: Experience and Qualifications

2. Describe an innovative approach the bidder successfully implemented in a program similar to KanCare that the bidder will use to improve timely completion of Member Health Screens in the KanCare program. Include the following in the bidder's response:
   a. A description of the innovative approach and targeted outcomes.
   b. How the bidder measured and monitored improvement.
   c. Lessons learned.
   d. The measurable improvement achieved; and why the bidder anticipates the approach will be successful for improving timely completion of Member Health Screens in the KanCare program.
   e. The projected impact on the KanCare program.

Aetna's approach to innovation and improvement is guided by lessons learned, our experience in Kansas, and the best practices from our affiliated Medicaid health plans across 15 states. We have continuously demonstrated our ability to adapt to changing circumstances, find solutions to meet Members where they are, and **meet KanCare's goals to improve Member experience and satisfaction, leverage data to promote continuous quality improvement, and use cost-effective strategies to improve health outcomes and the service delivery system.** Our programs' processes are built on the use of Continuous Quality Improvement (CQI) principles and methodologies. The Plan-Do-Study-Act (PDSA) model is built into the analytical and evaluative processes we use to adjust our approach to facilitate timely screening—all the while remaining focused on finding what works best for KanCare Members.

As an existing KanCare MCO, Aetna has firsthand knowledge of the challenges and barriers specific to Kansas Members. Like all MCOs, the pandemic years brought their own set of unique challenges to our team. For example, because eligibility renewals were paused and redeterminations did not happen for a few years, our outreach teams were working from outdated contact information. We also know that the in-depth nature of the Health Screening Tool (HST) itself can be a barrier for some Members to be able to complete on their own. As such, our outreach methods include the support of our highly trained staff to assist the Member in moving through the completion process. **As a result of our focused approach and flexibility in adapting solutions, Aetna achieved a 32% improvement in our HST completion rate from January 2020 to November 2023 in Kansas.**

Early and frequent Member engagement leads to higher quality outcomes and lower overall costs. As such, we continue to invest in training, resources, programs, and technology to improve the Member experience, starting with their HST. Our robust Care Coordination program and approach to screenings, coupled with our focus on continuous improvement, provides confidence we can continue to implement new and innovative solutions designed to engage Members in ways that best fit their needs. Our approach and the tools we use fully comply with the Member Health Screening, Health Risk Assessments, and Needs Assessments requirements in **Scope of Services Section 7.4.2,** including new requirements for completion within 10 days of enrollment, appointment accommodations, and SDOH referrals.

a. Innovative Approaches and Targeted Outcomes

Ongoing engagement with KanCare Members over the past five years has enabled us to better understand their preferences and learn what approaches work best for them, particularly as it relates to HST completion. During this time, Aetna has implemented several approaches and achieved the outcomes highlighted below.

Early into our tenure, we implemented our initial Member outreach approaches, all of which we still use today. For example, we use welcome calls to reach out to Members as the first opportunity to engage and understand their needs, with the intent of coordinating appropriate services and supports. We begin outreach efforts when we identify new Members in the 834-enrollment file, making a minimum of three attempts to reach Members via IVR phone calls during the first 10 days of enrollment, including a warm transfer to the Care Coordination team to complete their HST upon successful contact. This call can also engage Member's family and/or circle of support if the Member grants permission.

When initial outreach occurs and we do not have an active or legitimate phone number for a Member, it diverts that Member to an **Unable to Reach list.** The Care Coordination team pulls this list daily and then diligently researches each Member on this list to identify additional and alternative information that would enable contact. For example, our team will contact Providers, ancillary Providers, and pharmacies to find missing or incorrect information on Members. As a CVS Health company, we also leverage CVS retail pharmacy data to find new contact information for difficult to reach Members because frequently the pharmacy, as the point-of-sale,

has more recent data. When new information is found, our Care Coordination team uses the new information to conduct live outreach calls to complete the HST. Additionally, if we receive updated Member demographic information because of this outreach, we send this information to The Kansas Department of Health and Environment (KDHE) so they can update their eligibility system. **These initial strategies resulted in a 14.2% HST completion rate in 2019.**

In 2020, our teams began to receive real-time ADT alerts from Health Information Exchange (HIE) and hospital electronic health records. We instantly started to use these notifications as another source of Member contact information as well as opportunities to engage face-to-face with inpatient Members to complete their HST and assist with discharge planning.

Also, with the onset of the pandemic, we identified a 1% decline in HST completion rates, which prompted us to quickly deploy additional intervention strategies, including the rollout of our Care Coordination Outreach team. This initiative involved the redesign of our Care Coordination team to include dedicated non-clinical staff focused on making phone calls to increase HST completion rates, enrollment in care coordination, and to provide additional support during natural disasters for Members in priority populations (e.g., Members reintegrating in their community after incarceration). This team also assumed responsibility for research and additional outreach attempts for priority populations who were not reached by the initial outreach attempts to complete their HST. **The Care Coordination Outreach team made an average of over 9,500 calls per week, with a total of 135,000 calls from September through November 2021 in a targeted campaign approach. As a result of this effort, 2,958 HSTs were completed for KanCare Members.** Our team also used data regarding contact preferences obtained from engaged Members, and feedback from the Member Advisory Committee and Member surveys, to pursue new strategies to not only get back to pre-pandemic success rates but to surpass those rates.

By implementing timely initiatives and interventions in response to Member preferences and feedback, **we were able to reverse the pandemic-related decline and achieve overall measurable improvements to 17.7%.** In 2021, our initiatives included a targeted Member campaign where we partnered with a vendor to leverage technology to assist with automatic outreaches every 90 days to Members without completed health screens as well as Members that were due for a HST renewal. The campaign initiative focused on two outreach modalities—IVR and SMS. **The results of the successful contact rates for IVR outreach in the last 12 months were 53,971 and SMS 160,643 respectively, and we have seen a 12.5% increase in HST completion rates as a direct correlation to the increased outreach efforts.** The outreach efforts cover the entire membership on a continual basis.

We also developed and deployed the innovative Aetna Advice Call Management Warming Campaign during this time. For this campaign, Members receive a text/voicemail in advance of the Care Coordination Outreach team contacting them to complete the HST. We found that through this approach, Members are more likely to answer the phone from an unknown number and respond to the person calling. **We experienced a 7.2% increase in response rates across Aetna Medicaid markets through these warming campaigns.**

b. How Aetna Measures and Monitors Improvement

To measure and monitor improvement of the Member health screening process, we use several tools to track specific metrics. One of the key indicators we track is the percentage of new Members who complete their health screens, and when indicated Health Risk Assessments, Needs Assessments, and enrollment into care coordination. Aetna monitors call outreach efforts as well as the percentage of Members we are unable to contact, and Members who decline care coordination. These metrics give us insights into Member engagement and help us identify areas for improvement. By analyzing these data elements, we develop targeted interventions to improve Member engagement, such as adjusting our outreach strategies or creating new programs that better meet the needs of our KanCare Members.

Our operational dashboards provide leadership visibility into and oversight of care coordination processes. Monthly and quarterly findings are reported through our Quality Management Oversight Committee (QMOC). For example, Aetna has made significant strides to improve our overall Member assessments with targeted populations over the past two years. **From 2021 to 2023, we increased overall Member screening assessments by 39%, which includes the HST.** Our commitment to continuous improvement, data-driven decision-making, and collaboration with Providers and community partners has enabled us to make significant progress in enhancing Member engagement, increasing HST completion, and improving health outcomes.

Health Equity Gains in HST Screening

Between October 2021–October 2023 we have seen across the board improvement in HST screening rate including:

- Rural Members – Up 25.3%
- Urban Members – Up 39.4%
- Hispanic Members (all) – Up 62.1%
- Black Members (all) – Up 33.5%
- Female Members (all) – Up 38.1%
- Female Hispanic Members – Up 59.8%
- Female Black Members – Up 36.8%

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c. Lessons Learned

We have learned a great deal about our Members' preferences and the best ways to outreach to KanCare Members. For example, one lesson learned from early outreach campaigns and Member feedback is that many of our Members prefer to communicate by text message when possible. As such, we intentionally designed a campaign with mPulse to include a text message component. We leverage mPulse to cover a variety of targets for KanCare Members including EPSDT, flu, a food insecurity survey, and campaigns specific to completion of the HST. The results of this innovative approach show that some modes of outreach, including phone, face-to-face, text, and email, are far more effective and have a greater impact than one or two modes. **During the last 24-month analysis, this approach had a strong cumulative effect on Members accessing services, with 20% more obtaining services if they received four modes of outreach.**

mPulse combines behavioral science, analytics, and industry expertise to deliver tailored conversations that drive results and help Members adopt healthy behaviors.

157.KS23

We also adapted our Care Coordination team to find the right balance of staffing for outreach calls versus incoming calls. We instituted several adjustments to confirm our staff can handle the call volume while also conducting effective research for new contact information for focused outreach to Members we were unable to reach with the initial welcome call. In 2023, we have continued to reassess the approaches used in previous years, including health screening-specific

mPulse campaigns. **In Q1 of 2023, we outreached 3,727 Members for HSTs. In one campaign, we contacted 245 Members and achieved 100% HST completion.**

We continue to build upon these lessons learned with new strategies for 2024 and beyond including:

Mail out HSTs with Welcome Packets. While today Members are encouraged to reach out to Aetna directly to complete their HST, we are exploring an initiative whereby HSTs will be sent to the Member as part of their welcome packet. This enables the Member to complete the HST on their own time and either submit it online via QR Code, through the member portal, or mail it back to us. Incentives have proven to be a reliable mechanism in Kansas to engage Members in addressing their health care needs. Going forward, we will implement a new incentive program specific to HST completion. **Every Member who completes their HST through any of our communication channels will receive a $25 incentive card.**

Community Health Worker (CHW) Unable to Reach (UTR) Team. In 2024, we are expanding to include a dedicated team of CHWs who will focus additional efforts to contact high-risk Members who have not been reached by traditional methods. This team will leverage their knowledge of the Member's community in combination with our Member Alternate Contact dashboard to perform enhanced outreach, which may include a visit to the Member's last known address or Provider office. **This approach was piloted in our affiliated Ohio health plan and had a 42% success rate for reaching previously hard to reach Members**. The table below details how we would apply this approach in Kansas.

CHW Unable to Reach Program Key Elements
Use of CHW Unable to Reach program to follow up for incomplete HST, Members not reached for welcome calls, and returned mail.
Use of Member Alternate Contact dashboard that incorporates CVS Health Retail Pharmacy contact information and most recent prescriptions, USPS address validation, Member demographic information received on 837 claim files, and consolidated information from our vendors and subcontractors where Member data and information is known.
Use of our Homeless Management Information System (HMIS) through which we track Member interactions with Community-Based Organizations (CBOs).
Use of Hospital and Emergency Department (ED) inpatient census tools.
Review business agreements with CBOs that allow us to share Unable to Reach lists to aid in finding Members.
Leverage ED Frequent Flyer Unable to Reach lists shared with hospitals for on-site CM engagement.
Leverage on the street CHWs who visit Member homes, CBOs, Providers, health agencies etc., to find and connect Members.

Member Real Engagement and Community Help (REACH) Team. As part of our Social Impact team, the Member REACH team will perform outbound calls to low-risk Members who were not reached by IVR but may have SDOH needs based on our Social Analytics dashboard. The Member REACH team will conduct the HST and ask additional CMS SDOH questions to identify SDOH needs. This team will assist Members with community resource referrals to

address their SDOH needs and connect Members to care coordination when their HST indicates a care management need.

Member Alternate Contact Report. In 2024, we will implement our proprietary Member Alternate Contact report to create a single platform of Members and their information from a variety of sources so we can reach them sooner which is crucial to addressing their needs. Our Care Coordination team, Member REACH team, and CHW Unable to Reach team will all have access to a unique and proprietary self-service look up report through CVS Health analytics that provides updated demographic information on Members from over nine data sources, including, but not limited to, CVS store and pharmacy interactions, vendor provided data, and HIE-ADT information.

CVS HST Innovation and Partnership with Pursuant Health. While the CVS retail location footprint in Kansas is currently concentrated in urban areas, there is still a significant benefit offered from these locations. With 52 pharmacy locations, including 10 MinuteClinic® and HealthHUBS™ sites, KanCare Members made 769 visits to MinuteClinics in Kansas in the past year. In partnership with Pursuant Health, we will be offering Members the option to complete their HST at self-service kiosks in targeted CVS retail stores in Kansas. **This provides an additional option for KanCare Members to complete their HST and receive their $25 incentive immediately.** We are also exploring the possibility of **partnering with community agencies to expand the kiosk option to non-CVS locations, making it available to a much wider area of the State, including more rural areas.** We are confident this program can help us further improve HST completion rates, drive quality improvement, close gaps in care, and increase Member satisfaction.

Health screening efforts in our affiliate health plan in Illinois have resulted in a **54.2% overall success rate, an increase of 9.7% from Q4 2022 to Q3 2023.**
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Leveraging the Success of Other Medicaid Markets. As we continue to evolve and develop ways to drive up the HST rate in Kansas, we look to success rates in other markets for ideas. Our affiliated Illinois health plan is an excellent example. In the past several months, the Illinois plan has implemented several initiatives to increase their initial health screening rates including an After-Hours Care Coordination Outreach team. **Since the implementation of the After-Hours team in February 2023, a total of 3,142 health screens were completed via phone (an average of two per hour).** Additionally, they have expanded their CHW team to key ZIP codes. Through this effort, **Illinois has found that CHWs have a 20% success rate in finding unable to reach Members.**

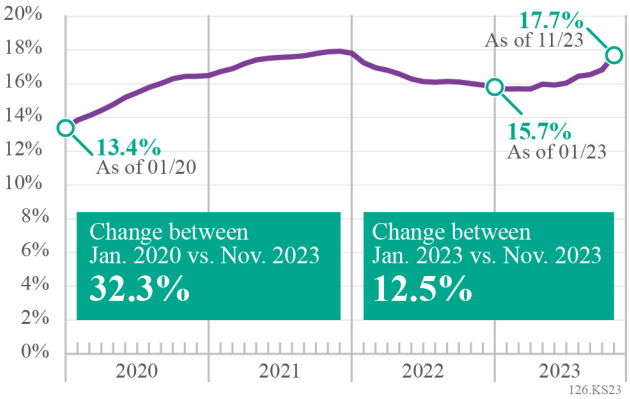

Figure 2-1: HST Completion Rate. *Percent of Members with completed HST screenings.*

For KanCare, we will be implementing our own After-Hours Outreach support in 2024. Through this mechanism, Members identified as needing HSTs will have the opportunity to complete the screening during intake calls with member services. We are also continuously working on the expansion of our CHW team in Kansas.

d. Measurable Improvement Achieved

As shown in **Figure 2-1,** our **HST completion rate in Kansas is 17.7% as of November 2023.** We remain fully committed to keeping this pace of growth in the coming years.

This achievement is the result of our efforts to deliver more personalized care and services to Members through innovative and evidence-based approaches. We focus on addressing the unique needs and preferences of each Member, providing them with tools, resources, and support to help them achieve their health goals. We believe that through the future initiatives detailed above, we will be able to continue this upward trend and implement approaches that will be successful well into the future.

e. Projected Impact on KanCare Program

As the above lessons learned, ongoing initiatives, and our future strategies demonstrate, Aetna remains fully committed to improving the HST rate in Kansas. We know KanCare Members, their preferences, and the barriers we must overcome to continue recent upward trend of improvement in this critical area. Our future initiatives for HST completion rate growth will enable us to build upon the strong foundation we have in place today. Through the After-Hours Outreach team, kiosks, mobile app capabilities, and the various enhanced data mining solutions we will put in place, **we are confident to make meaningful gains in our HST completion rate, meeting or exceeding the State's targeted rate.** Most importantly, these efforts will help us achieve improved health outcomes for KanCare Members through better Member engagement. HSTs, while just one aspect of care, are a critical way for us to make sure we **achieve the State's vision for KanCare Members to get the support they need to achieve better health, wellness, and independence.**

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Topic Area 1: Experience and Qualifications

3. The State is seeking to contract with MCOs that will be collaborative, adaptable, and supportive partners with the State, Providers, Medicaid Fiscal Agent, and each other to achieve the State's vision and goals for the KanCare program. Describe the actions the bidder will take to be an effective partner. Include specific examples of the bidder's experience with such partnering in a program similar to KanCare and how that experience will be leveraged to promote partnering in KanCare.

The State of Kansas' vision for KanCare centers on collaboration and partnership between the State, Providers, the Medicaid Fiscal Agent, and all MCOs to achieve program excellence and optimal health outcomes for Members. The rapidly evolving health care landscape of the last few years has made the need for an adaptive, collaborative MCO partner imperative to the ongoing success of the KanCare program. Since 2019, Aetna has had one goal—**to be the most supportive partner for the State. We share the State's goals to improve both Member and Provider experiences, reduce health disparities, and improve health outcomes by providing holistic care that recognizes the impact of SDOH.**

Over the past several years, our team has worked closely with the Kansas Department of Health and Environment (KDHE), the Kansas Department for Aging and Disability Services (KDADS), the Medicaid Fiscal Agent, KanCare Providers, and other state agencies to make sure our services and supports meet the unique needs of KanCare Members. To achieve our shared vision of partnership with Kansas, Aetna's approach includes the following:

- **Foster open, collaborative relationships** with all KanCare stakeholders to make sure our services and supports meet the State's goals.
- **Adapt quickly to changing circumstances** and shift effectively to alternative solutions that best meet the needs of Kansas' evolving health landscape.
- **Provide responsive support to the State** whenever and however we can to confirm KanCare Members receive the best care, in the right setting, at the right time.

During the past five years, we have done all of this and more, and **we have done so in true partnership with KDHE, KDADS, the Medicaid Fiscal Agent, Providers, and each other.** We met the challenges of our early tenure with the State head on, working tirelessly to quickly overcome them and adapt our approaches to best meet the State's needs and the needs of the KanCare Members we serve. Through the actions of our Aetna team, we consistently demonstrate our dedication to being a flexible, collaborative, and responsive partner for Kansas.

A Collaborative, Adaptive, and Supportive Partner for Kansas

As the following examples demonstrate, we have enjoyed a collaborative partnership with all KanCare stakeholders over the past several years.

Pandemic Partnership

Aetna approached everything during the recent pandemic with one focus—**collaboration.** Whether with state agencies, MCOs, Providers, or Members, our team did everything we could to provide Kansas the best support during the worst possible time. We worked in lockstep with KDHE and KDADS, holding weekly or biweekly meetings to discuss a wide array of issues, including policy liberalizations and Member and Provider concerns. Aetna supported KDADS with the distribution of federal SPARK funding for Providers. We also supported KDADS with calculating and dispersing federal retention funding to get needed dollars to Providers who were at risk of closing their doors during the pandemic. This process involved complex financial analysis to determine accurate funding. It also required Aetna to educate our Provider network on required forms to be submitted on behalf of KDADS. Most importantly, time was of the essence as we had to get funds to Providers so they could keep their doors open during this unprecedented time.

As a committed partner to KDHE and KDADS, we did our part to provide relief during a difficult time. We instituted a temporary policy liberalization on specific prior authorizations (e.g., acute, nursing facilities, skilled nursing facilities). We created a task force for all markets to confirm Public Health Emergency (PHE) policy updates were implemented quickly and accurately. As demonstration of our adaptability, we were able to configure our system quickly to meet demand. We also stopped all recovery activity for a period to make sure Providers did not encounter cash flow concerns. We offered Providers Personal Protective Equipment (PPE) via CVS Health to help protect the State's health care workforce. Additionally, **Aetna was the only MCO to offer an incentive to Members who successfully received their full COVID vaccination. Between 2021 and 2022, Aetna spent more than $810,000 on this incentive, with 32,403 Aetna KanCare Members taking advantage of it.**

Aetna was the only Kansas MCO to offer an incentive to Members who successfully received their Covid vaccination.
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When it came to working with the other MCOs in Kansas, our approach was collaborative, not competitive. We understood it was a time to come together and brainstorm, finding creative and innovative ways to resolve problems during one of the most challenging times in recent years. We met each day with our MCO counterparts to discuss and find ways to resolve any barriers to care and reduce Provider burden, allowing Providers and hospitals to focus fully on caring for Kansans. We held ad hoc meetings among the three MCOs, Agency staff, and the Kansas Hospital Association to discuss opportunities to reduce burden on hospital systems during this time. **We also provided a $50,000 investment to the Kansas Statewide Continuum of Care to support building data fields to collect MCO information, which benefits all MCOs and all Kansans on Medicaid.**

Partnership and Collaboration Where It Matters Most

Over the past few years, our Aetna team has had the opportunity to partner and collaborate with KDHE, KDADS, MCOs, and Providers on initiatives designed to improve the Member experience, reduce Provider burden, and drive quality outcomes. This thought leadership and ongoing collaboration enable us to work with the State and other MCOs to find help with interventions and improve health outcomes for KanCare Members. For example, we collaborated with KDADS on the rollout of their mobile crisis response benefit,

paying claims and providing the State's Provider the data they needed to set up this important program.

The Aetna team also continuously collaborates with our stakeholders, including KDHE and KDADS, to improve transitions of care for Members. We do this through a variety of activities, several of which we lead, including those listed the table below.

Partnerships to Improve Transitions of Care for Members	Impact/Outcome for KanCare Members
Collaborated with KDADS, KDHE, Meadowbrook, and MCOs on a quarterly meeting to collaborate on the needs of Brain Injury (BI) Members.	Quarterly meetings have been scheduled since December 2021. In 2023, there have been 25 discharges to date from the Brain Injury Resource Foundation (BIRF) in Kansas.
Weekly collaboration meetings with nine major hospitals throughout the State to review Members' transition needs, including step down and discharge planning.	These meetings help facilitate the authorization process, optimize access to Case Managers (CMs) for discharge planning, and promote communications between Service Coordinators/CMs and hospital DC planners.
Collaborative workgroup with KDHE that addresses all aspects of blood screening and issues resulting from high lead levels.	In addition to ongoing meetings, this workgroup has developed a handbook related to lead exposure prevention.
Collaboration with our Certified Community Behavioral Health Clinic (CCBHC)/Community Mental Health Centers (CMHC) Provider on new processes for discussions, support, and planning needs for Members in acute settings.	We meet with MHASK and Valeo to work on bridging gaps in discharge discussions, preventing re-admission, and making certain resources are available for Members.
Ongoing engagement with KDADS (HealthSource) regarding transition needs of Members currently inpatient in State Institutional Alternative (SIA) beds.	The Care Advocate Team acts as a single point of contact for SIA discharge discussions, bridging gaps, and providing access to resources Members need once they are home.

Our team is quite active with KDADS and Tribal communities as it relates to the care of Members in the foster care system. We participate in several workgroups including: KanCare in Foster Care; Psychotropic Medication Workgroup; KDADS PRTF Workgroup; Family First Prevention Services; and Kansas Strong Studies Workgroup. We also have quarterly meetings with Foster Care Contractors and the Tribal Nations to discuss the following: services and supports available to Tribal Nations; educational topics, such as EPSDT and HCBS Waivers; and how Aetna can assist the Foster Care Contractor (Tribal Nation) with its goals for programming.

Over the past five years, the LTSS department has actively been engaged in various workgroups, committees, subcommittees, and ongoing collaborative meetings, as shown in the table below. Our partnerships with KDADS, KDHE, HCBS/Community Providers, and the other KanCare MCOs enable us to maximize access to care for our LTSS Members.

Community Collaborations and State Workgroups Purpose	
LTSS Stakeholder Calls	Partnership and discussions on any related LTSS topics that are impacting Members. Audience includes KDHE, KDADS, LTSS Providers, and community stakeholders.
Person-Centered Service Plan (PCSP) Signature Collaboration between MCOs/KDADS	Goal to increase the effort in getting signatures on PCSPs and have MCOs align with one another on messaging out to Members post-PHE.
Home Modification Workgroups	MCOs met to redesign the processes on how each MCO approves assistive services and home modifications. Collaborated with the State on key findings and opportunities resulting in significant process simplification.
Technology First	Workgroup with KDADS to collaborate on ways technology could help solve for workforce shortages.
MCO and LTC Association Meeting	The purpose of this meeting is to collaborate with community partners. The audience includes Adult Care Executives (KACE), Leading Age, and the Kansas Health Care Association.
Money Follows the Person	Stakeholder group and breakout sessions to explore program development. The audience includes KDADS, HCBS Providers, long-term care facilities, and other community stakeholders.

Our LTSS team is also heavily engaged in Waiver specific workgroups for IDD, serious emotional disturbance, Technology-Assisted, and BI Members.

We worked alongside KDHE and KDADS on the rollout of the new CCBHC Model, supporting the agencies and the CMHC Provider community on claims submission requirements and reimbursement models. As thought leaders, our team brought their expertise and experience with relevant issues and suggestions for the manual and encounter processing. We also collaborate with KDHE Supports and Training for Employing People Successfully (STEPS) Providers, and other MCOs through our participation in quarterly calls for the STEPS Pilot Advisory Committee. Together we work through any STEPS-related topics that might be impacting our Members.

We also partnered with KDHE and Via Christie Hospital to address the homeless issue in Wichita. In a recent call with our team, the concern was raised about the Wichita winter shelter not opening and how that would impact Via and the overall community. As a result of our conversations, we were able to share our concerns at different council hearings and forums. By using our voice and making the needs of our partners heard, these conversations led to an approval by the city council of a new winter shelter site to serve those who would be impacted.

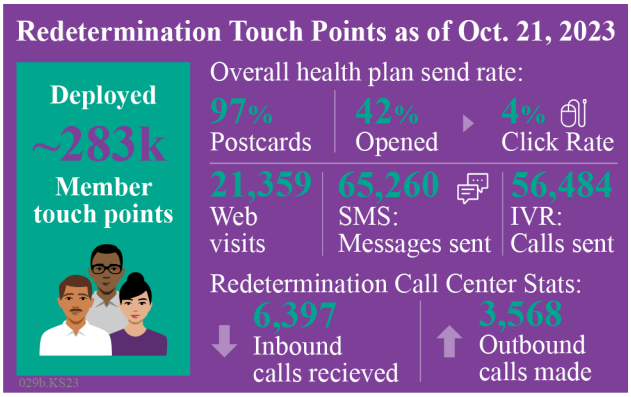
Collaboration with other KanCare MCOs

We collaborated with the other MCOs to leverage a Kansas-based small business vendor to perform audits and validations of HCBS Providers across all our plans. Because many HCBS Providers lack large-scale staff to deal with administrative tasks, the MCOs worked

together to use this small business so these Providers could respond to one request versus three, reducing their burden and making their participation in KanCare even easier. Additionally, our community teams regularly collaborate with the other MCOs. For example, if there are events that will benefit KanCare Members, we share that information with the other MCOs so we can all have representation and KanCare Members can engage with all MCOs. There is no competition when it comes to educating Members on their KanCare benefits. We want them to have an opportunity to learn about their benefits regardless of the MCO they choose. When we are in the community providing Aetna handouts, we make sure CBOs/Providers/etc. are aware of the KDADS list of Value-Added Benefits (VABs) that has all three MCOs listed, so they are better able to compare and understand all that is offered.

Ongoing Support to Address Eligibility Redetermination

We fully support KDHE in their goal to make Medicaid redeterminations as efficient and impactful as possible using the robust guidelines and resources provided by KDHE and CMS. Aetna's support of KDHE is aimed at mitigating coverage losses, streamlining processes, and quickly implementing KDHE eligibility policies, engaging with Members and Providers, and conducting awareness campaigns. These strategic support efforts have strengthened our relationship with KDHE and enhanced our customer service capabilities, with **the goal to improve the Member experience and their overall satisfaction.**



For example, we employ various strategies to encourage Members to reach out to KDHE to complete the redetermination process. We use multiple outreach channels, including text messages, email, and paper mail to keep them informed about the necessary steps to maintain their coverage. To date, we have initiated 283,000 outreach attempts to educate Members about the transition away from continuous enrollment provisions, stress the importance of updating their contact information with KDHE, and emphasize the need for prompt responses to Medicaid renewal forms and notices when received. We not only provide reminders and assistance navigating information when Members call the member services line, but we also deployed a redetermination call center whose sole focus is addressing Member questions in this key area.

We also **partner with Providers** in this effort, as they already have ongoing communication with Members while providing care coordination and other member services. To assist Members, we send Providers reports containing renewal information, enabling them to engage Members in conversations about the necessary steps to renew their coverage when they seek care. Additionally, during this critical redetermination phase, it is vital that individuals on home and community-based waivers with complex medical needs, those receiving home care services, including older adults, and those dually eligible for Medicare and Medicaid, maintain their coverage. Our **Win Back campaign** specifically targets Members who have been procedurally terminated. The Win Back campaign involves continued outreach through email, text messages, and communication with Members in their 90-day post termination period. Our goal is to inform them they can still submit their documentation, and, if determined eligible by the KDHE

eligibility department, their enrollment will be retroactively reinstated to their termination date. It is incumbent upon us to collaborate with KDHE during normal times and during national health emergencies to confirm services are delivered and no interruption in care occurs.

Adaptable, Collaborative, and Responsive Support for System Implementations and Migrations

Whenever the State needs to implement new state or federal requirements that impact the KanCare program, Aetna is there to make sure we do all we can to support that effort—making it as smooth as possible for the agencies and all KanCare program stakeholders.

From 2020 to 2022, **we supported KDHE's system migration to the new Kansas Modular Medicaid System (KMMS).** We deployed a cross-functional migration team to support the changes needed in our system and files to adapt to the new state system. We worked with the State on any issues or concerns that arose during system reviews, offered expertise and suggestions for work prioritization changes that might impact the timeline, and were a collaborative partner when the State had to decide between various options. Not only did we provide project management and thought leadership on these complex file layouts, we also quickly adapted to changes to meet timelines. We escalated concerns to agency staff, facilitating collaborative conversations to brainstorm ways to mitigate those concerns. We also conducted meetings with other MCOs to discuss the anticipated changes and create new MCO standards in downstream files/processes due to the new system. We also collaborated with KDHE and the Medical Fiscal Agent on the rollout of the OneCare Kansas program in 2020, as well as the Kansas Pharmacy Recovery Network (KsPRN) Provider network file enrollment process.

> We fully supported KDHE's migration to the new KMMS, adapting our own systems to accommodate the new system and meeting all our timelines in the State Agency Project Plan.
> 097.KS23

In 2023, **we collaborated with KDHE and KDADS to implement new Electronic Visit Verification (EVV) requirements based on the 21st Century Cures Act.** The go live date for this implementation was Dec. 3, 2023. Our implementation efforts include file testing, process design, and educating Providers on the new requirements. We have dedicated provider representatives for HCBS Providers to help smooth the process along. We also developed provider bulletins, easy-to-use EVV notification forms, and provider education tools to confirm a successful roll out.

Aetna provides ongoing support to KDADS, including meetings and engagements, to address the continued needs resulting from the Olmstead lawsuit presented in the State, which impacts Nursing Facilities for Mental Health (NFMH) Members. The Aetna Care Advocate Team (CAT) is a single point of contact for KDADS regarding this initiative and acts as a bridge to communication regarding processes, outreach, and discharge planning. Our team was an integral participant in development of the process for KDADS.

Future Goals and Partnership Strategies

The partnerships we have developed with the agencies, other MCOs, and Providers in the past five years as a KanCare MCO provide an excellent foundation for continued, collective efforts

going forward. We look to these collaborations for inspiration and leverage what we are doing in other markets to bring the best possible solutions to the KanCare program.

Support for Centralized Credentialing

For example, we embrace KDHE's initiative to use a **centralized credentialing** process and look forward to partnering as the agency moves to this new solution. While design and development continue, we will confirm our existing credentialing solution, which is in place today and meets all requirements defined in **Section 7.5.1.** While we are fully prepared to use our existing solution for as long as we need to, we also stand ready to move to the centralized solution as soon as KDHE is ready. Importantly, Aetna has invaluable experience in our other states, such as Ohio and Texas, supporting the design and implementation of centralized credentialing systems. Our affiliated health plans in Ohio and Texas use the services of a centralized credentials verification organization for primary source verification. Although both programs are new, Providers are reporting satisfaction with the streamlined processes, reduced administrative burden, lower overhead costs, and the convenience of having one credentialing/re-credentialing date. In Texas, our affiliate plan embraced the Texas Association of Health Plans' Consolidated credentials verification organization initiative to reduce the credentialing burden for Texas Providers. This simplified process positively affected both Providers and MCOs. In addition, our affiliated Ohio health plan recently partnered with the state of Ohio on a similar initiative. We are ready to bring our experts to the table and partner with KDHE to support a successful implementation of centralized credentialing in Kansas. We will bring our lessons learned from both implementations to Kansas.

Care Collaboration: Aetna's FamilyCare Central (FCC)

We are launching FCC in Kansas in 2024. FCC is a pioneer application in the complex care space and currently supports medically complex Members (i.e., foster care children) in our affiliate health plans in Kentucky, Louisiana, Ohio, Oklahoma, and West Virginia. FCC supports comprehensive care coordination by including features needed for specialized care coordination activities. This innovative solution makes key information available to all authorized individuals in a Member's Care team. It is designed to foster important care collaboration among parents, mental health services, caregivers, the Kansas Department of Children and Families (DCF), OneCare Kansas, KDADS, foster care contractors, disability services, CBOs, Aetna, and authorized representatives (e.g., schools). FCC represents the single source of information that provides alignment in services and goals and is the key to continuity of care for physical health, behavioral health, and socially necessary services.

We bring our heart, thought leadership, knowledge of KanCare and its Member populations, and our established, collaborative relationships with KDHE and KDADS to find solutions that, together, help us advance the State's vision and goals. Aetna looks forward to leveraging our experience from Kansas, and other Medicaid programs, to make us an invaluable partner to the State for future initiatives.

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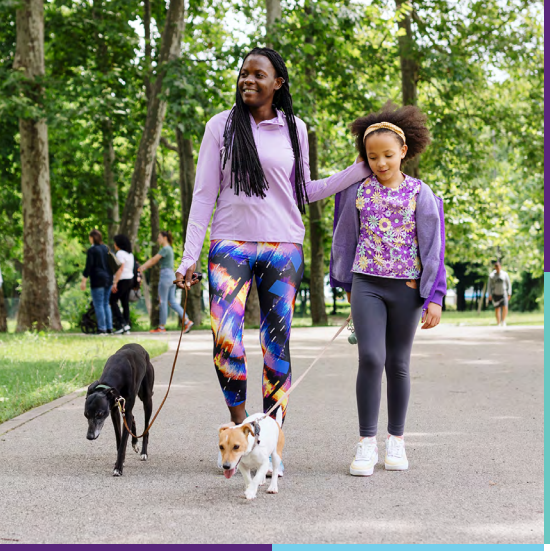



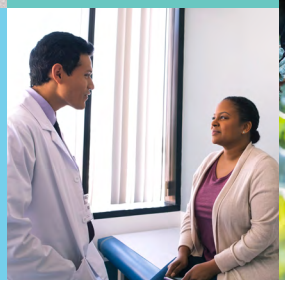

Topic Area 2: Member Experience

Tab 7b

Topic Area 2: Member Experience

4. Describe the bidder's approach to encouraging and engaging KanCare Members to actively participate in their health care and meet their personally defined health and wellness goals and cross service system needs.
Provide an example of a strategy the bidder has successfully used in a program similar to KanCare, including the impact of the approach on outcomes.

Aetna Better Health of Kansas Inc. (Aetna) understands that encouraging active Member engagement is important in driving long-term health outcomes, creating healthier communities, and achieving sustainability within the health care system. To prioritize overall health and well-being, we apply principles of health equity and inclusion, incorporate Member feedback, and develop customized Value-Added Benefits (VABs). We approach Member engagement with the focus and commitment needed to drive positive, long-term change and to motivate Members to take an active role in the decisions impacting their health and well-being. As a current KanCare MCO, we use the following three core domains to improve our engagement model and increase Member engagement:

1. **People:** Our care coordinators, member services representatives, Community Health Workers (CHWs), Community Development team, and Care Advocacy Team (CAT) all play critical roles in fostering active member engagement by creating trusting relationships with Members and through frequent non-transactional interactions. Our people have the training and tools they need to achieve consistently high levels of Member engagement, which is reflected in our outcomes.
2. **Strategies and Processes:** Our member education, outreach, identification, and incentive offerings are all strategically aligned to drive increased member engagement and active participation. We deploy accessible, culturally sensitive member-facing materials and targeted outreach initiatives that build awareness of service availability, emphasize the importance of disease management and preventative care, while offering support with navigating the health care system. This includes collaborating directly with Members and employing member-informed strategies to provide resources and support that empower Members to achieve their personalized goals, including housing, education, transportation, and food security.
3. **Technology and Systems:** Aetna uses innovative tools and platforms to engage and empower Members by offering multiple communication channels, including deploying innovative outreach approaches to Members that are hard to reach. We use a data driven approach to identify, stratify, and connect with Members consistently and timely.

Across these three domains, we measure and monitor the outcomes of all our Member Engagement strategies and initiatives. We use this performance data to refine and improve our processes, inclusive of any feedback we receive, in an intentional manner. Our objective is to innovate, improve, and expand our engagement strategies so that Members have what they need to actively achieve better health and outcomes.

People—Driving Member Engagement

Our Integrated Care Management model was developed on the foundation of a person-centered care coordination approach, in which Member engagement is critical. We encourage engagement throughout a continuum of interactions from preventive care to acute, complex, and chronic

needs including SDOH. Our people are strategically organized across the care continuum to improve member engagement:

- **Care coordinators** establish relationships with Member through frequent check ins. Additionally, care coordinators identify Member needs through screenings and assessments, which are reflected in Person-Centered Service Plans (PCSPs). We identify opportunities during each Member interaction to alleviate barriers and connect Members to the resources and health care services they need. Trust and connection between Members and care coordinators fosters better participation among all parties. **We have over 200 care coordinators in Kansas today, supporting LTSS and non-LTSS Members. Our care coordinators are distributed across the State and are familiar with local issues, health care needs, and cultural considerations.**
- **The Member Real Engagement and Community Help (REACH) team, an SDOH call center, drives empowerment and engagement.** The Reach team uses social risk analytics, claims data from Z Codes, and data received from health information exchanges **to proactively identify and engage Members at risk for SDOH needs.** If a need is identified, the team connects a Member with resources. To aid in this process, we use our proprietary closed-loop Community Resource Directory (CRD) to help connect Members to resources that address their needs. To further empower Members, we ask them if they want to contact the resource Provider themselves or have us make the connection.
- **The Community Collaboration and Real Engagement Solutions (CARES) Team** helps build resources in Kansas' overburdened social safety net system. We support and invest in Community-Based Organizations (CBOs) who increase engagement by working directly with Members across the State to obtain the vital resources they need including those that help with maternal and infant health, housing, food insecurity, oral health, and employment. We have further wrapped this team with a unique incentive structure which provides resources, like rent assistance, to our most vulnerable Members.
- **Community Health Workers (CHWs)/Community Health Representatives (CHRs) e**ngage with Members who present challenges in completing assessments or have gaps in care. CHWs are regionally based and come from the same communities as our Members. Because we **embrace** the criticality of the CHW role within the care continuum, **Aetna will have 10 CHWs by Jan. 1, 2025. In this same timeframe, we will also have two CHRs** who will also focus on health equity issues by providing culturally appropriate care to groups that are historically underserved and where there is a history of health disparities and worsening health outcomes, such as in Tribal communities.

Strategies and Processes—Driving Member Engagement Through Our Initiatives

Members face challenges and stress that come with health disparities, poverty, unemployment, social isolation, and a host of other clinical and non-clinical factors. These factors are critical to understand to better encourage Members to actively engage and participate in their health care journey. Aetna deploys a comprehensive suite of strategies that all result in increased Member engagement, including:

- **Outbound Welcome Calls:** Every Member receives an outbound welcome call with health risk screening within 10 days of enrollment. We use these welcome calls to engage newly enrolled Members, to identify any care needs they may have, and to identify their physical health, behavioral health, and substance use and/or social related needs. These welcome call

responses trigger a warm transfer to our Care Coordination Engagement Hub team who then directly outreach to the Member to foster further participation and the completion of our comprehensive screening tool. **In 2022, 2,678 transfers were completed,** a 6.3% increase from the year prior, indicating that welcome calls assist with fostering increased levels of engagement with new Members. In another example, between 2022 and 2023, we achieved a 45% increase in the utilization of our No Place Like Home VAB to support Members struggling with housing insecurity or homelessness. Through October 2023, we have supported [redacted] This growth is a result of Members sharing their concerns, and then engaging with us long term to close their care gaps. Housing gaps do not lend themselves to quick solutions, and ongoing Member engagement is critical to making certain we leverage the full power of our VABs.

- **Health Screening Tool (HST):** The HST is the first step in assessing and developing a Member's holistic health profile, wellness goals, and cross service system needs. The HST scores Members' responses to questions about their known physical and behavioral health conditions, including functional level, support system, existing Provider relationships, SDOH needs, and current treatment plans. By deploying the HST timely and consistently, we foster and encourage Members to actively engage in their health care by motivating them to respond to our questions and identify their concerns proactively, allowing them to be an active participant and drive decision-making in every step of the process. **Newly enrolled pregnant Members who received a successful outreach call completed a prenatal visit during their first trimester or within 42 days of enrollment, an increase from 31.0% in 2021 to 43.7% in 2022.** To further promote completing the HST, we make it accessible by deploying the HST to be linguistically friendly (and translated), as well as disability accessible in compliance with all state and federal rules. Further, we meet the Member when they are available, and will work with them to complete the tool at a time of their choosing, in a format that they are comfortable (including telephonically, or in person for those already engaged in care coordination programs).

  Between January 2020 and November 2023, we have **increased HST completion rates by 32.3%** 165a.KS23
- **Additional Screening Tools: Health Risk Assessment (HRA**) and **interRAI Assessment** are both evidence-based comprehensive assessments to ascertain Members' medical, behavioral, SDOH needs, environmental conditions, and key family members and Providers to include in their goal setting and treatment planning process. These tools drive further Member engagement by fostering participation on behalf of the Member to share their personal goals and desired outcomes. Based on the responses, care coordinators offer additional education and resources to address any Member-identified gaps. These tools are highly collaborative by design and increase Member engagement through their grounding in the person-centered model. Our team is educated in Charting the LifeCourse framework, a holistic person-centered approach focused on Member empowerment. Additionally, they **know how** to help individuals and families of all abilities and ages develop a vision for a good life. By emphasizing understanding and designing supports in life domains such as education, employment, living situation, personal development, health and wellness, and social supports, our team drives strong engagement with completing not only our key screening tools, but also collaborating with Members to build and support pathways for a brighter future.
- **Outreach:** Our staff meet with Members at convenient times per their preference. We understand that to drive Member engagement, we need to meet the Member in their preferred

style and format. During initial assessments, we document the Member's preferred method of communication in our Clinical Documentation System, which is accessible to all authorized Care team members. We deploy the following outreach efforts:

- **Face-to-face visits** at a time and location convenient for the Member.
- **Telephonically through targeted outbound call campaigns,** using industry best practices by conducting multiple outreach attempts at various times throughout a day. When possible, we make certain "Aetna" is displayed on caller identification technology. Our outreach teams complete a 16 week onboarding program to better understand the needs of Kansans and learn about available internal and external resources.
  - **Secure Text Messaging with Member consent.** Aetna initiated text messaging campaigns based on national and local feedback, which included the Member Advisory Committee and D- SNP Member Advisory Committee. We learned that Members want to receive more information on their phones and screens and less in written formats. For example, in 2022, we reached out to Members with text reminders to get flu shots, resulting in a 48% increase for Members receiving a text reminder.
  - **Written Letters** and correspondence at the appropriate reading level, confirming information is communicated not only verbally but also in writing.
- **Bilingual staff and interpretation services** to engage in a culturally appropriate manner including the use of our Language Line, assistance and documents for Members who are blind, and TTY for Members who are deaf or hard of hearing. We use interpreter services if needed or requested for any reason.
  - **The 24/7 Nurse Advice Line nurses** who address Members' immediate health care needs and complete intake forms, which can trigger outreach and enrollment into care coordination.
- **Member Educational Materials:** We offer a host of linguistically and culturally appropriate member-facing educational materials with graphics that mirror KanCare populations. We produce our content in English and Spanish, and in other languages when needed. With state approval, we share Member educational content through paper copies available in the community, in monthly online newsletters, through targeted mailers, via text messages, and electronic means to Members to increase screening rates, enrollment in integrated care coordination, and to provide wellness and condition specific Member education. For example, **we have sent over 930 mailings since 2019 on topics ranging from Tobacco Cessation to how to effectively use a nebulizer.** We also send and distribute **brochures about care coordination** to educate and encourage Members to self-refer into care coordination. We also educate Members about care coordination in their welcome packets and Member Handbook.
- **Member Incentives:** We offer a host of VABs and Member incentives, ranging from incentive cards to rewards for completing health screenings, prenatal visits, immunizations, and other activities meant to drive engagement and improve outcomes. **In 2022, we spent over $1.8 million on Member incentive programs.** Member incentives have proven to be an effective way to gain initial Member engagement, which results in stronger long-term engagement. We measured this by studying the outcomes of Members who have received incentives, followed by their health

Aetna deploys an annual targeted influenza vaccination education campaign, sending both text reminders and informational mailers to drive engagement and increase rate of immunizations. Each year we see results of immunization rates as much as 3% higher for Members who received either our text message or mailer. Since not all Members opt in for text messages, we have mailed over 20,000 mailers in 2022 alone.

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journey for 12 months post incentive. For example, Members who received incentives for prenatal and post-partum care, showed a higher percentage of full-term pregnancies by 12%, compared to those who did not.

Innovative Tools and Platforms: Empower and Engage

Aetna uses technology, tools, and a variety of communication styles and channels to drive engagement and motivate Members to actively participate in their health care journey in a format and style they are comfortable with. We promote information sharing with Members through a variety of technological solutions. Examples include:

- **24/7 Member Services:** Outside of business hours, Members may leave a voicemail or **chat with us** via our website or mobile app.
- **Cogito: An artificial intelligence tool implemented in 2022 that provides** real time soft skill guidance on tone level, pace, dead air, and pitch level.
- **Post-call survey** to measure caller satisfaction. The survey incorporates the Net Promoter Score (NPS), an industry standard measurement, which asks if a Member would recommend Aetna to a friend. **In part, due to implementing Cogito, we have experienced an increase in year over year NPS results, as detailed in the Net Promoter Score Percent table.**

Net Promoter Score Percent	
2022	**83.5%**
2021	**82.4%**
2020	**80.4%**

- **Closed-Loop Community Resource Directory (CRD):** We use our proprietary and closed-loop CRD, a nationwide repository and directory of Community-Based Organizations (CBOs) and agencies who address the full spectrum of SDOH needs. This platform connects, tracks, and evaluates Member referrals. **Launched in June 2023, our current-closed loop referral rate is 40%.** We will use this rate as baseline to measure and compare our closed-loop referral to national standards.
- **Pyx Health (Pyx): A platform that addresses loneliness and social isolation supporting Member wellness goals.** There are two components. One is a **mobile app with a chatbot personality** that builds a trusted and loyal relationship with the end-users. The chatbot is compassionate and humorous and focuses on self-management. The mobile platform can screen Members for loneliness, depression, and anxiety. In addition, Pyx can offer SDOH resources to Members and connect them with our 24/7 Nurse Advice Line. The menu offering within the tool also links to the member portal, find a Provider, and suicide hotline. We use Pyx across five Aetna health plans. We are the only KanCare MCO to offer this innovative technology. **The second component is their Compassionate Call Center.** Pyx employees onboard Members over the phone. They make outbound companionship calls when Members have a low sentiment score and reach out within one business day to follow up on an urgent need. **Since the launch of Pyx, we have seen over 1,800 Members sign up for the platform. Of those Members, we show an engagement rate of over 90%.** Furthermore, as an expansion of our Pyx partnership, in 2023 we deployed an outbound call campaign seeking to increase the engagement of pregnant Members in their prenatal and

From Pyx Dashboard Third Quarter 2023

- 40 is the average age of Members who engage
- Of the approximate 1,800 Members engaged, 91% did so through the Pyx application
- The top four needs are food, housing, medication, and employment.
- 40% of screened Members have at least one urgent need, which triggers a contact within one business day.

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postnatal journey. Through this campaign, Pyx was able to get over 200 additional Members scheduled for appointments to meet with their Providers.

- [redacted]
- **Careforth** provides caregiver support through health coaches, serves as a resource on various issues and conditions, and connects caregivers to support one another. This HIPAA secure mobile platform is easy to use and available 24/7. It focuses on increasing caregiver engagement on the Member's behalf and reducing caregiver burnout. As the complexity of the Member and burden of caregiving responsibilities increase, caregivers rely more heavily on coaching supports and move to higher intensity program tiers. By having caregivers, who can be comfortable in their role long term, we are creating a supportive environment where Members can more easily navigate the health system, and work toward their care goals without worrying about who will provide their daily care. **Our Clinical team completed over 60 referrals to CareForth in first month of operation and are on track for engaging over 500 caregivers by the end of 2024.**
- **Telehealth Capability:** Members are desiring more flexible virtual care options. Providers have responded to this demand and are moving toward offering certain services via telehealth. Additionally, telehealth increases supply, improves access, and makes it easier for Members to engage in services. Telehealth capabilities expand access and help keep Members healthy through outreach and engagement on a real-time basis. We have identified new and novel Telehealth Providers, such as Ouma Health, and MDLive, to expand access to telehealth options around prenatal care, as well as pediatric behavioral health options hard to access in some of our communities. Offering the latest options to our Members, supports their engagement in their health care journey in a flexible manner allowing for greater long-term adherence to treatment plans.

> *From a Home Away housing VAB recipient*
>
> **First time we move in Topeka it was scary for her, another place, another country, we don't have relative. We come across good people, kind people for the volunteers who help us. I appreciate it because I am in USA. I am starting over. This housing opportunity gives Polina and me hope.**
>
> 165b.KS23

- **FamilyCare Central (FCC):** Provides access to assessment and care plans to Members, authorized representatives, caregivers, and Providers. This allows the Member and their Care team to review documents and collaborate with one another through secure messaging in real time. Information is now readily available for all parties fostering strong interdisciplinary approaches, capable of developing and addressing Member goals as quickly as possible.
- **Point-of-Care/Point-of-Sale:** We use multiple strategies and means of communication to connect with our Members including data mining for best contact information, in-person visits, Provider intervention and assistance, point of care interactions (including on-site care coordinators in high-volume Provider sites), and point-of-sale data available through CVS.

Our Care Coordination team has access to a proprietary database through CVS Health that provides updated demographic information on Members through CVS stores, pharmacy interactions, and recent PCP visits, emergency room visits, or other points of care. We also use our Member REACH team to engage hard to reach Members who are not in care coordination but have identified or predicted SDOH needs.

Outcomes

Aetna obtains feedback from all Members through multiple targeted Member Satisfaction surveys, our Member Advisory Committee, and through direct and indirect feedback channels such as post-call analytics and Net Promoter Scores. We act based on the results we receive. For example, Aetna began offering D-SNP Members the opportunity to participate in D-SNP Member Advisory Committees. **As a result of their feedback, we will be offering our D-SNP Members the ability to communicate with their D-SNP Care team via text message.** Survey outcomes are used to enhance processes and staff performance. We use survey feedback to identify and evaluate opportunities for improvement and implement appropriate follow up actions. Additional examples of outcomes focusing on further enhancing Member engagement include:

- **Expanding Care:** Children and young adults make up over 60% of our health plan population, and their overall health outcomes serve as a key performance indicator for Member engagement in the health system and being able to navigate it. In 2022, we executed targeted initiatives to educate Members and caregivers on accessing the right care at the right time as part of our Aetna Advice Campaign. Between 2021 and 2022, our Consumer CAHPS survey for Medicaid Children (age 12 and under during the measurement year) showed a 1.06% increase for Getting Needed Care and a 2.36% increase for Getting Care Quickly—both scores exceeding the Medicaid average and the NCQA national average.
- **LTSS Member Engagement:** For Members receiving LTSS services, our overall engagement rates for 2022 and 2021 exceeded the goal of 90% with both years **averaging just over 93%. This is a direct result of our multiple interventions, staff approach, and overall person-centered model. We monitor these numbers consistently and look for further opportunities to implement changes that Members find helpful. For example, we developed VABs around dental needs based on Member feedback.**

Care Coordination Favorable Satisfaction Results	
2022	95.65%
2021	91.30%
2020	94.67%
2019	95.25%

- **Member Satisfaction with Care Coordination/Care Management:** Each year, Aetna conducts a Member survey that measures multiple aspects of our Members' experience. **As the Care Coordination Favorable Satisfaction Results table shows, in 2022, we had a satisfaction rate of 95.65% for care coordination, the highest in four years of operation.**

Example of Similar Program—Engagement with D-SNP Members

Like Medicaid Members, D-SNP Members are actively engaged and encouraged to participate in their health care journey and goals through outreach, incentives, and care coordination. We outreach to every D-SNP Member within 90 days of enrollment to complete an initial Health Risk Assessment (HRA) that we use for case management prioritization. When the Member is reached, the goal is to either complete the HRA or schedule a follow-up appointment at another convenient time. If the Member is agreeable, the HRA is completed telephonically and

documented in the Care Management System. If the Member is not reached, three attempts are made via telephone outreach and a letter is sent to encourage the Member to return the phone call. **For the 2024 STAR ratings, our initial HRA completion rate was 61.4% and our reassessment completion rate was 70.4 %. The overall completion rate for both initial HRAs and reassessments was 65.3%, an increase from 63% in the previous year.**

Healthy Rewards Incentive Program for D-SNP Members and Utilization

We incentivize Members to engage in their health care with our Healthy Rewards Program. Members earned incentives of $50 for completing the following activities, which may be redeemed at any time throughout the year. Some results as of October 2023 include:

- 5,414 Members or **69% of all D-SNP Members redeemed an award for completing their HRA.**
- **1,222 Members or 15.5% of all D-SNP Members redeemed an award for completing a Healthy Home Visit** with a nurse practitioner who reviews the Member's condition, functional status, home safety, SDOH needs, and completes a medication reconciliation**.**
- **1,977 Members or 13.3% of all D-SNP Member redeemed an award for completing a diabetic care activity, such as an A1c test, diabetic eye exam, kidney evaluation, and following their Provider's care plan.**

Encouraging Members to engage with us and actively participate in their care journey to better health are critical components of our managed care model. Aetna supports Members daily by building and expanding on Member-centric strategies that result in increased engagement and positive health outcomes. In 2025 and beyond, Aetna plans to deploy additional strategies around workforce development; increased efforts around independent living and employment support; additional Member education and outreach efforts through new modalities; like tablets and short videos; and the latest technological solutions to our market. By leveraging our multiprong approach and incorporating feedback of what works and does not work, we look forward to driving Member engagement to new heights in the coming years.

Topic Area 2: Member Experience

5. Describe the bidder's approach to soliciting and reviewing feedback from KanCare Members and their families, and using this feedback to improve Member and family experience and the KanCare program.

Aetna values and proactively solicits feedback from Members, their families/caregivers, and stakeholders. **We obtain both quantitative and qualitative feedback through multiple channels to improve** the quality and access of covered care and services. It is our policy to seek, review, and address all meaningful feedback in a consistent, thoughtful, and targeted manner across our membership using a system wide Quality Improvement (QI) methodology. We have a holistic end-to-end process to solicit input, recognize concerns and opportunities, and address any feedback. We then reassess actions taken and begin the feedback cycle again.

We collect feedback through surveys, post-call audits of member services calls, Net Promoter Scores, monthly review of member grievances, our standing Member Advisory Committee and D-SNP Member Advisory Council, and through third parties like Community-Based Organizations (CBOs) who receive anecdotal feedback. To provide the highest level of interdisciplinary engagement and support, all feedback, interventions, and results are shared with our Leadership team, including the board of directors and health plan Chief Executive Officer (CEO), Jane Brown.

We use Member feedback to inform our benefit and service design, enhance how we communicate, and improve how we operate. **We believe that Members are more likely to engage in their health care, when working with an MCO that solicits their feedback, listens and makes changes based on what they say.** Listening to Members helps us achieve high scores with accreditation bodies such as NCQA. In turn, health plan accreditations help assure Members that they are enrolled in a plan that is committed to quality and invested in listening to their concerns. Our performance with NCQA accreditation has been exemplary, with results that help Members feel confident in our commitment to KanCare. Our results, detailed below, also demonstrate our performance as a health plan when compared with national standards and benchmarks.

- Achieved Health Equity NCQA Accreditation in 2022 with a current score of 100%.
- Achieved Health Plan NCQA Accreditation in 2023 with a current score of 99%.
- Achieved LTSS Distinction in 2023, the first MCO in Kansas to achieve this, with a current score of 100%.
- Scored 100% on our last federally required audit for our Quality Assurance Performance Improvement (QAPI) program.

From 2022 to 2023 Aetna's market share has grown over
3.75%
illustrating Member confidence in our approach
159.KS23

Quality Improvement Structure

Our Board of Directors (BOD) is accountable for quality management **and addressing Members' and other stakeholders' feedback and concerns.** The BOD meets quarterly and delegates the implementation and ongoing surveillance of the Quality program to the Kansas Senior Leadership team, which includes our CEO, CMO, and other key personnel. We support our highly effective governance structure through committees, subcommittees, and ad hoc work groups accountable to our Quality Management Oversight Committee and our local BOD.

The Source and Type of Feedback Drives Which Committee(S) Addresses the Members' Input

Regardless of which committee is responsible, they all follow the same workflow; aggregate and analyze data, develop an action plan, assign internal strategic accountable owners, monitor the implementation of action plans, and monitor improvement results. Committee members integrate health plan medical functions, operations departments, and provider network functions into the Quality Management program through the participation of their representatives on one or more committees, overlapping membership and leadership responsibilities, and integrated reporting requirements. As described below in Example 1, due to feedback from Members, advocates, and caregivers, we researched and provided an additional resource for caregivers. We will seek Member and caregiver feedback from those who use our new solution to adjust our new program. In two other examples described below, Members stated how they preferred member materials, what tools they needed, and how they wished to communicate. We have implemented their solutions and continue to obtain their involvement in identifying and finding solutions to their concerns.

We provide Members with multiple opportunities to express their satisfaction level for the support Aetna provides. We obtain Member feedback through a regimen of monthly, quarterly, and annual surveys. The surveys provide results by age and diagnoses and include the CAHPS® Survey, Behavioral Health (BH) Member Satisfaction Survey, LTSS Experience Member Survey, Integrated Care Management Satisfaction Survey, HCBS Satisfaction Survey, Condition Management Survey for Members with Diabetes, Member Services Line Survey, and Multi-cultural Line Experience Survey. In addition, we obtain information from the External Quality Review Organizations (EQROs) and EQRO Mental Health reports.

January	February	March
Care Management Survey	CAHPS - Adult and Child	CAHPS - Adult and Child
National Core Indicators - Aging/Disabled	Care Management Survey	HCBS Experience
Condition Mgmt. Survey - Diabetes	National Core Indicators Aging/Disabled	Care Management Survey
Call Center	Condition Mgmt. Survey Diabetes	National Core Indicators - Aging/Disabled
	Call Center	Condition Mgmt. Survey - Diabetes
		Call Center

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Figure 5-1: First Quarter 2024 Survey Schedule.

Surveys schedule for Q1 2024 are shown in **Figure 5-1.**

Our approach to soliciting Member feedback and involving them in solutions are illustrated in the five examples below. Each example demonstrate how we use a variety of feedback channels to solicit Member and family/caregiver feedback and, based on what we receive, develop interventions/action plans. We review results of these interventions and, as applicable, change our model to improve our Members' experiences in multiple areas.

Example 1: Feedback From LTSS Members

Example 2: Member Feedback About Member Services Representatives

The importance of positive interaction between Members and Aetna cannot be overstated. Member Services phone conversations may be the first or only interactions that many Members have with Aetna. Member services representatives communicate with Members and resolve their questions or concerns during one-on-one inbound calls in compliance with all contractual requirements, which includes appropriate documentation, call recording, average speed of answering, and hours of operation. Representatives are well-versed in covered benefits, Value-Added Benefits (VAB), and our Care Coordination model. They understand health plan operations and who to contact with the goal of a first call resolution. Their knowledge is complemented with empathetic and positive communication skills. To evaluate performance, we rely on two key feedback mechanisms:

- **Post-Call Survey and Net Promoter Score Results**
  To improve Member experience, Members calling the member services line can participate in a **post-call survey.** We achieve these high results because our entire Leadership team monitors NPS performance monthly and addresses any concerns that are identified through that channel. We set specific NPS score objectives each year and deploy a work plan to ensure we hit our goals.

- **CAHPS Survey Results**
  The annual CAHPS Survey also asks Members about their contacts with a plan representative. Results from 2023 CAHPS Survey, shown in the table below, illustrate improvement with our children's population and maintaining our current high adult population satisfaction. Our response rates for CAHPS in 2023 were 22.45% for adult Members, 18.73% for Medicaid children, and 17% for CHIP Members.

CAHPS Surveys – Customer Service Satisfaction (Always and Usually)			
Year	**2023**	**2022**	**2021**
Adults	90.08%	90.70%	89.13%
Children Medicaid	95.28%	88.89%	95.35%
Children CHIP	91.67%	87.88%	91.59%

Actions we have taken to improve Member and family experience with our Member Services team, as measured by NPS performance and the CAHPS survey, include:

[redacted]

- **Orienting and requiring ongoing training for member services representatives on health plan topics and effective communication skills.** Supervisors and managers monitor performance to confirm accurate information, resolutions, and concerns are communicated and managed expeditiously. We train members services representatives to help callers who are blind or visually impaired, converse via TTY with callers who are deaf or hard of hearing, and how to obtain interpreter services when needed. For callers who prefer or need a language other than English, we use the Language Line. We provide communication access and additional assistance to comply with accessibility guidelines so that Members feel comfortable, heard, and understood. We communicate and provide language and resources to all Members equally. **Aetna earned a Health Equity NCQA Accreditation** in part because Members may communicate and provide feedback in their language of choice, and because we demonstrate the ability to meet required accessibility and language standards.
- Mailing or directing Members to written information online at the required reading level

Example 3: Community Feedback and Participation

Through our deep ties to Kansas communities and participation in community activities, we have developed a robust communication channel with our Community-Based Organizations (CBOs)/ resource Providers partners, through which they offer meaningful and actionable feedback about the KanCare program and our performance as a health plan. **Since 2019, we have met with over 143,000 KanCare** Members, CBOs, and community residents. At these engagement opportunities, we invite Members to participate in our MAC, offer education and seek input about covered and VABs and services, and help individual Members with their immediate concerns. Through our **Community Development department,** we interact with hundreds of CBOs, resource Providers, and community health councils throughout the state to seek input and collaborate on solutions. These organizations are instrumental in providing information about the SDOH needs of their specific communities, access issues about network Providers, or feedback they have obtained from Members. We meet with and learn about CBOs' needs, capacities, services to help with SDOH and clinical needs, and opportunities for community investment.

CBO feedback informs our prioritization of community investments and which VABs to add or adjust. We seek collaboration with CBOs that are focused on promoting health equity and closing health disparities based on the community's and Aetna's subpopulations. In this way, we partner with several highly engaged CBOs who collaborate with us to promote healthier outcomes for entire communities. We will continue to engage our CBO partners to recruit Members to our MAC so that its composition reflects our diverse Kansans from across the State.

In the past two years, we invested over $1 million dollars in CBOs to address housing, food, education, and maternal and infant health. 162.KS23

Example 4: Feedback From D-SNP Members

We know that if D-SNP Members are not fully engaged, they may overlook opportunities to thrive in a less restrictive setting or improve health outcomes. We have used their previous feedback to help us develop action plans to increase their overall level of satisfaction. CMS' Medicare STAR Ratings program measures the quality of care and Member experience provided by each Medicare health plan. The STAR program includes 40 quality measures including member experience as measured in the CAHPS Survey. In October 2023, **Aetna Kansas D-SNP plans received a 5 STAR Overall Rating, the highest score possible for CAHPS.**

CAHPS D-SNP Measurement	Star Rating for Aetna Kansas D-SNP Plans
Care Coordination	5
Getting Needed Care	4
Getting Needed Prescription Drugs	5
Overall Rating	5

Actions we took to earn this high rating include:

- Offering care management assistance to 100% of our D-SNP Members.
- Inviting D-SNP Members to participate in Member Advisory Committees. Due to this group's feedback, we are now offering D-SNP Members the ability to communicate with their Care team via text message.
- Conducting an annual off-cycle CAHPS Survey in the fall to gain more insight into our Members' experience. Eight hundred Kansas D-SNP Members were included in the last one.

Example 5: Feedback From Aetna's Member Advisory Committee

Aetna obtains valuable feedback from our **quarterly MAC.** All Members, caregivers, and family are welcome to participate. Recognizing that MAC participation is voluntary, our community development director and his team strive to recruit diverse MAC participation from across the State for each meeting including LTSS and those receiving behavioral health services. We use various technologies to make MAC meetings accessible from anywhere in the State, including rural and frontier areas. During meetings, Aetna staff from multiple departments respond to questions, provide clarifications, solicit feedback on a variety of topics, and address individual needs. Actions we have taken to address feedback coming through this forum include:

- Improved the readability of letters sent to Members describing medical information and making certain that the material is easy to follow, visually pleasing, and effectively uses illustrations as well as written text
- Assisted with improvements for Access2Care application regarding NEMT benefit
- Increased timely delivery of Healthy Rewards incentive cards. A change in fulfillment vendors has already enhanced usability and allowed for a broader choice of retailers such as Walmart, Family Dollar, Target, and others. We will offer one reloadable card for all incentive

programs, with online and phone application options to track incentives and offer opportunities for further rewards.

Based on recent feedback from our Q3 2023 MAC meeting that focused on Member Materials, we learned what Members want to see and we are addressing their feedback directly by providing information in ways that helps improve usability of our documents and strengthen Members' health literacy, including:

- The use of videos for explanations. We will produce a video about how to use Aetna's Provider directory. We will obtain MAC input as it is being produced to make it user-friendly.
- Clearer explanations of benefits and services.
- Increased educational information that is mobile friendly.
- Information specific to Kansas, which MAC participants stated is more interesting than generic articles about health and disease management.
- A new tool, **PassPort to Health,** which helps Members communicate with their Providers. PassPort to Health includes information about medications (dosages and number of refills left), PCP contact information, and additional information about specialists. Input was given to improve this tool by a MAC participant who is the mother of a child with special needs.

Future agenda topics for the MAC will include discussions about:

- How we can get more Members to participate in these meetings and what are the barriers they face with the goal to have the MAC reflect all populations we serve in and from all regions.
- Upcoming Member Surveys and that they may be randomly selected to be sent one. Because we can ask supplemental questions in addition to those on the standardized Member Surveys, we will ask the MAC if there are specific questions that should be added to better inform Aetna about Providers, quality of care, or any aspect of Aetna operations. Our goal is to increase survey response rates that represent all the populations we serve.

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Topic Area 2: Member Experience

6. Describe the bidder's approaches related to the following with respect to the bidder's Provider directory for KanCare:
   a. The elements of information included, beyond those specified in the RFP, for each participating Provider.
   b. The bidder's approach to developing, maintaining, validating, and monitoring the accuracy of the information in its Provider directory.
   c. The features of the bidder's online, electronic Provider directory that promote Member usability.
   d. The bidder's strategies to reduce Provider burden associated with providing information to create and maintain an up-to-date Provider directory.

A well-maintained Provider directory is crucial for Members to access the care they need in their local communities. Members may want a change in PCPs due to auto-assignment on enrollment, a second opinion from a specialist or subspecialist, to find the closest pharmacy, or locate the nearest urgent care center. Because of their individual needs, Aetna Better Health of Kansas, Inc. (Aetna) uses an array of methodologies to produce a contractually compliant **Provider directory that is accurate, accessible, and user-friendly for Members, their families, and caregivers.** Aetna has been an active partner with the Kansas Department of Health and Environment (KDHE) since 2019 and the inception of a State-sponsored, single point-of-entry portal for Provider data—the Kansas Medical Assistance Program (KMAP) portal. This process created one **"source of truth"** for Provider demographic and practice information. We import this data to configure our operating systems such as contract profiles, credentialing, claims, and to produce an accurate and comprehensive Provider directory.

Due to our experience with the State's Provider Network file (PRN), we have mastered the processes to intake demographic and Provider practice data from the PRN directly into our dedicated Medicaid database. Our customized system architecture, built and maintained exclusively for our KanCare program, keeps Medicaid Provider data separate from our other lines of business. We do not merge or mingle Medicaid Provider data with any other database. We use the following proven procedures and systems that we have refined through years of experience to give Members accurate and usable Provider directories.

- **We use ruled-based automated processes which use the PRN daily** to update our system with the most up-to-date and accurate information available to populate our Provider directory. The PRN data is uploaded into our Provider Book of Record platform that we use for contracting, claims, credentialing, and other health plan operations for consistency of information throughout various functions.
- **Validation checks** of our database confirm accurate formatting of data. We link to the United States Postal Service files to validate accurate address formats. Other important Provider data validations are done on 1099s (invalid ZIP code, tax identification, missing/duplicate mailing/physical address), addresses (missing/duplicate address, invalid fax, or phone number), affiliations (invalid accepting new patients, ancillary, hospitals), National Provider Identification (NPI), invalid Drug Enforcement Administration number, license number, date of birth, no credentialing record, and duplicate NPI. If a Provider record has an error in formatting, our operations analyst will reach out to the State Medicaid Fiscal Agent to make

them aware of error. If needed, our provider relations representatives reach out to the Providers to make them aware of need to update their information in the KMAP portal.

- **Our nimble and flexible database system** that can be adapted to make further adjustments the State may require going forward. Throughout our tenure as a KanCare MCO, we have finessed our systems to fine-tune usable output. Aetna can send data in a bi-directional flow. **We produce an up-to-date and accurate Provider directory** from which Members may search for network Providers including by region, by specialty, by hospitals, by pharmacies, or by ZIP code. We provide links to comprehensive pharmacy, dental, and vision Provider directories. We hold our Provider network subcontractors to the same state, federal and NCQA standards under which we operate and work with them to remediate accuracy issues in a timely manner. Our vision and dental subcontractor SKYGEN has provider relations representatives who are in constant contact with their network through visits, phone calls, and trainings. They verify the accuracy of Provider information and make updates daily. CVS Caremark, Aetna's affiliated NCQA accredited PBM, proactively keeps pharmacy locations data current and easy to use through similar methods.

Figure 6-1 below shows the flow of data utilized to produce our Provider directory.

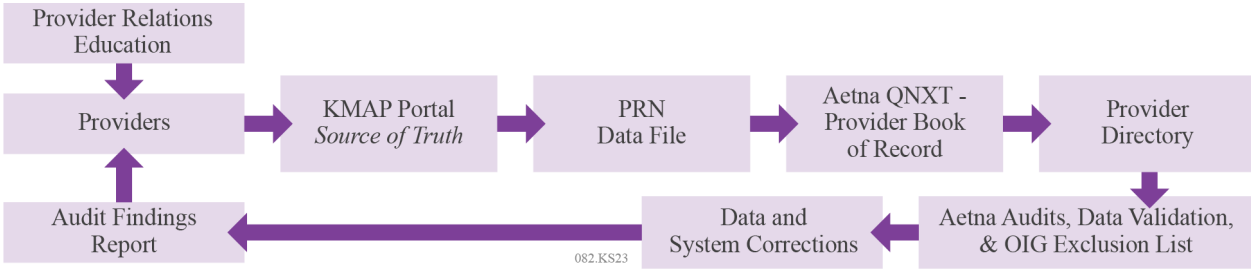


Figure 6-1: End-to-End Process. *How data for the Provider directory flows to Aetna and back.*

a. Elements of Information to be Added

Above and beyond all contractually required elements, we will add the elements listed **below in addition to information we have in our current and compliant Provider directory** for each Participating Provider as applicable. Members and caregivers will be able to find these **specialized Providers through a drop-down menu capability online or through a designation in printed copies, including those in alternate formats.**

- **Telehealth Capability:** Members are desiring more flexible virtual care options. Providers have responded to this demand and are moving toward offering certain services via telehealth. We want our Members to know which Providers offer this convenient alternative to in-person care. In addition to the drop-down menu online, we will make telehealth more visible on the public landing page search criteria.
- **Sedation Dentists:** As identified through Provider feedback, distinct levels of sedation dentistry exist including nitrous oxide in-office IV sedation and sedation in a hospital or outpatient surgery center that can be delivered by a dentist or a dentist with a mobile anesthesia Provider. In collaboration with Oral Health Kansas, Aetna will survey Members and Providers to understand their wants/needs when looking for sedation dentistry Providers. We will incorporate their feedback into our Provider directory design. We will combine the dental and medical Providers with a directory drop down option so that Members can see a comprehensive listing of sedation dentistry offered in our network online and in printed hard

copy. We will share our directory with subject matter experts on the Sedation Dentistry Taskforce run by Oral Health Kansas—a group that includes Providers and Members with lived experience with whom we will confer and collaborate—to confirm we are displaying sedation dentists in a manner that is easy to identify based on Member and Provider feedback.

- **Special Care Practices for Members with IDD:** Caregivers and family members need information about which Providers treat individuals with IDD. A designation in our Provider directory and those of our subcontractors will help them with their role of overseeing their loved one's care. We will identify and designate Providers that treat Members with IDD by reconciling Member diagnoses with claims to identify Providers and then we will follow up with outreach to these Providers to confirm they accept Members with IDD.
- **LGBTQ Friendly Practice:** Based on Member feedback, we learned that Members want to know which Provider practices specialize in LGBTQ issues, such as behavioral health therapists who specialize in family counseling or Providers who specialize in hormonal or surgical treatment for transgender care. We will initially identify LGBTQ friendly Providers by reaching out to our connections in the LGBTQ community across Kansas to confirm their practice status. As a first step, we can narrow down our field of Providers to contact by pulling data on prescribing patterns for medications historically associated with gender affirming care.
- **Interpretation, Language Services, and Alternate Formats:** Based on Provider feedback, we are adding information in our Provider directory (printed and online) that interpretation services and a language line are available for those who need this assistance and how to easily access these services. We will also add that we will provide a directory in alternate formats for Members who are blind or visually impaired upon request.
- Aetna has the system capability **to add a quality rating of Providers in our directory as applicable per established criteria** subject to KDHE approval and Provider input.

b. Approach to Maintaining, Validating, and Monitoring Accuracy

Aetna has deployed a highly comprehensive approach to the maintaining, validating, and monitoring our Provider directory. We use the following processes to generate an accurate and useful tool for Members and their caregivers:

- **Scheduled updates:** Promptly update changes based on newly received data from the PRN.
- **Provider communication:** Encourage Providers to promptly report changes in their contact information, availability, or services offered in the KMAP portal.
- **Member feedback mechanism:** Maintain a system of Members to report discrepancies or issues with the Provider directory and use Member feedback to improve the accessibility and functionality of the directory.
- **Accessibility updates:** Continuously improve the directory's accessibility with the goal of making it user-friendly for people with any disabilities.
- **Quality reviews:** Conduct regular audits of the directory for accuracy and compliance, and review for duplicate entries, outdated information, accessibility features, and other elements.
- **Technology:** Use technology to streamline the update process and maintain software that can accept real-time updates. We will explore options for the Provider directory integration to other Member resources like mobile applications and online portals.

Dedicated Auditing Teams

We validate the integrity of our Provider directory by proactively performing multiple audits of Provider data used to populate the Provider directory. The KanCare Program Annual External Quality Review Technical Report 2022–2023 Reporting Cycle, dated April 26, 2023, indicated that our Provider directory has no issues that have not been fully addressed and resolved. **To achieve these positive results,** ongoing **audits of Provider data are conducted by:**

- **An Operations team** who completes a monthly Provider directory audit to ascertain that all contractually and NCQA required elements are included. Each monthly audit of at least 200 Providers includes a review of foundational specialty types including acute care and psychiatric hospitals, family practitioners, and pediatricians. We review the following Provider and practice information:
  - Appears in the online Provider directory and that all elements are correct.
  - Matches what is in our Provider Book of Record platform.
  - Is included on the quarterly network file(s) submitted to the State.
  - Annually the operations team checks every Provider type and specialty combination at least once, using a randomizer to select solo practitioners or group practices.
- **Provider Relations Representatives (PRRs)** began conducting monthly audits in July 2021. **Through October 2023, 28 monthly audits were completed with 47,297 Provider data elements audited. Our average accuracy rate was 98.27% over this period.** PRRs continuously gather and validate data at office visits, teleconference/online calls, and phone calls. They note updates in cultural competency, change in hours of operation, and information about open and closed panels of PCPs. PRR audits include PCP panel counts—information we use to correctly assign Members to available PCPs and that PCPs are accurately reflected in our Provider Book of Record platform.

In addition, each quarter we extract the Provider directory information out of our Medicaid system and submit it to the State to validate. We receive feedback and then we make changes based on that feedback. With the audits and validation checks described above, we are continuously monitoring and updating our Provider directory. We will use **secret shoppers** to validate multiple aspects of Provider practices including accessibility for Members to schedule appointments within contractual standards and to validate demographic information.

Correcting Inaccuracies

If an audit identifies inaccuracies in data or errors of any type, the record is placed on a fall-out report and worked by our Operations and Provider Relations teams. When results of audits indicate inaccuracies, our findings are sent to Providers to review for accuracy. We educate them about how to interpret the report and how to make any changes required. The PRR reminds the Provider or office staff to make changes in the KMAP portal. Inaccuracies are corrected in our system if the error is on our side. We couple this with a monthly review of the Office of Inspector General's exclusion list to promptly remove applicable Providers from our network and directory.

c. Key Features of Provider Directory Usability

We obtain Member feedback to improve the usability of our Provider directory. Our Member Advisory Committee (MAC) provides qualitative feedback at each of their quarterly meetings about benefits, health plan operations, and Member materials. At a future MAC meeting, we will

obtain their insights on a video we will produce to instruct Members how to access and use our Provider directory and our subcontractors' Provider directories. In March 2023, we asked a focus group of Members to navigate our online Provider directory. Participants, age 24–54, who make their own health care decisions, were asked to find a specialist, access subcontractor networks, and find urgent care Providers. Based on the time it took participants to find a specific Provider type and ease of navigation, we received overall positive comments. As a result of their feedback, we have given our Provider search capability a complete redesign that was completed in May 2023. The new simplified search criteria leverage industry best practices for user experience. The Provider directory redesign updates included:

- Contrasting colors to improve navigation efficiency
- Simplifying heading structures to clearly display content hierarchy
- Adding body copy to provide context and give clear directions

Provider Directory Online Hits	Number of Visits	Unique Visitors
Pre-Redesign January 2022–May 2023	**2,828**	**2,191**
Post Redesign June–October 2023	10,238	9,741
Percent Change	**262%**	**345%**

Results achieved were extremely positive. **As per the table, the number of visits and the number of unique visitors increased significantly.** We will continue to obtain feedback from our MAC and ask the group how they like Provider subspecialties on drop down menus and designations in printed versions.

We adhere to the Web Content Accessibility Guidelines—health plan and industry standards—for perceivable, operable, understandable, and robust websites and with the American Disabilities Act. Additionally, Members can find Providers by:

- Accessing the Provider directory through our website, secure Member portal, and the Aetna Better Health mobile application.
- Downloading a searchable and printable Provider directory from our website at any time by regions or specialties, which enhance a user's experience. Upon a Member's request, printed copies are mailed free of charge.
- Using online search tools to locate a Provider by name, specialty type, hospitals, pharmacies, HCBS professionals, or region.
- Accessing our subcontractors' Provider directories. Our dental and vision subcontractor SKYGEN offers a Member portal that includes a real-time online Provider search tool. Members can search for Providers by name, geographic proximity, gender, language, specialty, accessibility, and view the Provider's location on a map. Members can also search for Providers using SKYGEN's Mobile Member Application for either Apple or Android devices.
- CVS Caremark keeps locations up to date as new pharmacies are brought into the network to better serve Members.

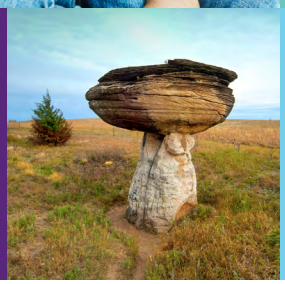
Additionally, D-SNP Members may find Providers within our expansive Medicare Provider network using Aetna's Medicare Provider directory. To facilitate ease of use, we list each Medicare Provider that also participates in Medicaid. This information is updated monthly.

d. Strategies to Reduce Provider Burden

We minimize Provider burden associated with generating information necessary to creating and maintaining an up-to-date Provider directory by:

- **A Centralized Data Management Approach.** We consistently educate Providers of the convenience of the KMAP portal **as a single point of data entry** to update their demographic and practice information. We believe that a single source of truth is an industry best practice, and we have long since implemented a model where we use the State's data as that source. We relay these key messages when Providers contact us about joining our network, at their initial orientation, during on-site visits to their offices and facilities, via Townhalls meetings, and through our provider bulletins. We further enforce this message by not contracting or paying claims unless Providers are enrolled in the KMAP portal, including Providers who have entered into single case agreements with us.
- **Member Education.** We are adding clear and easy to follow video tutorials for Members about how to effectively use the Provider directory. By educating Members, we help reduce unnecessary calls to Provider offices, help Members identify and choose the right Provider(s), and support Provider goals of adding patients to their practices.
- **Provider Education.** We are deploying a comprehensive video-based Provider facing tutorial campaign for Providers directly to their online landing page about the end-to-end process of the KMAP portal, the importance of a single point of data entry and importance of the output of an accessible, Member-facing directory.
- **Regulatory Adherence.** We consistently review state and federal regulations specific to Medicaid and when changes are necessary, they are executed once and in the least burdensome approach. By partnering with KDHE on the KMAP portal and keeping abreast of its status and requirements, we reduce Provider administrative burden in having to resubmit information unnecessarily.
- **Technical Support.** We support Providers by assisting with data updates on the KMAP portal if we find a Provider's office needs help regardless of their status on our network. We have helped numerous Providers select their specialty's taxonomy and navigate various technical issues by serving as a bridge between Provider practices and the state's system.
- **Association Partnerships for Provider Education.** We partner with the Kansas Hospital Association, medical societies, and all Kansas-based Provider Associations to educate their membership on KMAP portal enrollment and updates. We have provided information and updates and served as a resource for follow-up questions. Examples include:
  - At the request of the Community Care Network who hosted a FQHC conference, Aetna collaborated with the other MCOs to create a unique FQHC training that included an overview of the Provider enrollment process.
  - During a Community Mental Health Centers/Certified Community Behavioral Health Clinics Association meeting, we helped Providers to confirm they are registered and affiliated on KMAP with the appropriate NPIs, which allows for accurate claims payment.

> **Aetna has been invaluable in helping us navigate the KMAP process and ensuring that our information is accurately reflected in the Provider Directory. This has saved us time and resources.**
>
> ***Shane Hudson***
> *President & CEO, CFK Addiction Treatment*
> 147.KS23



Topic Area 3: Integrated, Whole-Person Care

Tab 7c

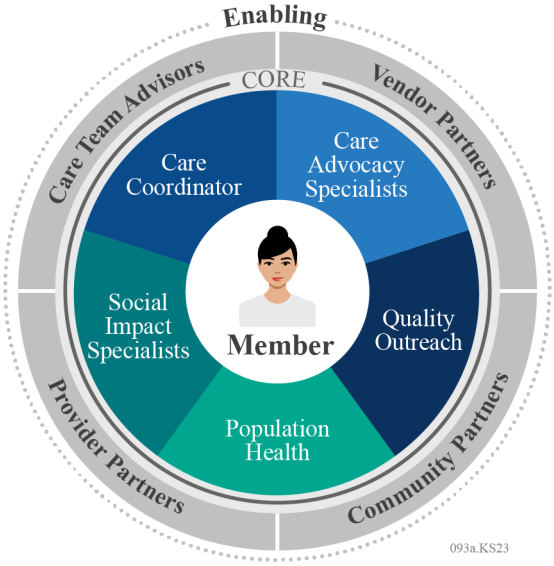
Topic Area 3: Integrated, Whole-Person Care

7. Describe the bidder's proposed MCO staffed care coordination model for KanCare and include the following in the bidder's response:
   a. The bidder's proposed care coordinator staff distribution and location.
   b. The bidder's approach to avoiding duplication of care coordination with delegated or other models of care coordination (e.g., Community care coordination, targeted case management [TCM coordination], Certified Community Behavioral Health Clinic [CCBHC], OneCare Kansas).
   c. The roles, responsibilities, and functions for staff performing care coordination responsibilities.
   d. The bidder's approach and strategies to effectively engaging Members, particularly those who may be more challenging to engage, to participate in care coordination.
   e. The bidder's proposed care coordination caseload ratios, process for establishing ratios, and the approach for monitoring to ensure ratios are adequate to meet care coordination requirements.
   f. Case assignment considerations and how the bidder monitors and manages vacancies to ensure Members' continuity of care.
   g. How the bidder's care coordination program will identify and support the needs of Members who are not on a 1915(c) HCBS Waiver and have a temporary or transitional need for care coordination.
   h. How the bidder's care coordination program interfaces with its disease management resources and activities.
   i. The bidder's processes and systems that will be used to share and exchange information with those involved in the care and treatment of the KanCare Member to optimize integrated, longitudinal, whole-person care.
   j. The bidder's approach to monitoring and ensuring that KanCare Members receive necessary services, supports, and resources necessary to improve individual and population outcomes.

Aetna Better Health of Kansas Inc. (Aetna) operates a fully integrated Care Coordination model focused on improving health outcomes, enhancing member satisfaction, and reducing overall health care costs by providing comprehensive, coordinated, and person-centered care. **Aetna currently serves nearly 140,000 Kansans and Aetna Medicaid is a national leader in providing care coordination that has improved the lives of over 2.6 million Members across 15 states.**

Members are at the heart of our care coordination approach. We focus on person-centered, culturally appropriate, reliable, high-quality care. **Aetna shares KanCare's vision to achieve health, wellness, and independence for a healthier population.** We are committed to Member voice

Aetna's One Team, One Member Integrated Whole-Person Care Approach



and choice and empower Members to direct their services, and identify their circle of support to include family, friends, caregivers, Providers, and community stakeholders. Our current internal team includes highly trained care coordinators, member outreach staff, social workers, behavioral health specialists, population health professionals, and community-based social support staff. Our team brings unique expertise through a highly integrated, **One Team, One Member** approach. We help Members achieve the life they want to live, building on their strengths and aspirations, and making certain their voices and choices are at the forefront of their care. Our functional structure is illustrated in **Figure 7-1:**

Figure 7-1: Aetna's Care Coordination Functional Structure. *Aetna's functional structure illustrates our member-centric care coordination approach to integrated, whole-person care.*

a. Care Coordinator Staff Distribution and Location

At Aetna, we believe that tailored care coordination should be person-centered and local. We built our staffing model on the principle of Kansans serving Kansans. This belief is central to our person-centered approach which starts with understanding Member needs and where they are located. Our staff understand local cultural dynamics. They are knowledgeable about the Medicaid and non-Medicaid community resources available to address Members' physical, behavioral, and social health needs. Additionally, they are familiar with local health disparities and community social risk levels. Appropriate staffing levels are essential to a successful Care Coordination program. **We use a proprietary Workload Driver (WLD) staffing ratio tool that considers risk stratification and time (how long it takes to complete all necessary Member engagement activities).** Having staff geographically close to Members allows for greater and improved access to addressing Member needs. When assigning staff, we also consider other metrics such as acuity, race, ethnicity, language, and whether they are enrolled in waiver or LTSS programs. We also use geo-access tools such as Maptive to assign Members to the right care coordinator located within 10 miles of their home and monitor overall staff distribution across Kansas. Lastly, we hire care coordinators, with relevant backgrounds and lived experience to foster relationships with Members based on mutual trust and respect.

In 2022, **98.13% of HCBS Members** reported satisfaction with their care coordinator.
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b. Approach to Avoiding Duplication of Care Coordination

We designed our Care Coordination model to avoid duplication by establishing a **single point of contact to serve as the key organizer** and coordinator of all efforts to meet a Member's goals and needs. Care coordinators adapt to Member choice and avoids duplication of care coordination through proactive and measurable strategies.

Strong LTSS Member Satisfaction

Our integrated approach to care planning produces strong Member engagement with **93.7% of LTSS Members** stating that things that are important to them are included in their person-centered service plan.

Source: 2022 Member Satisfaction Surveys.

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We coordinate with each Member's PCP and others involved in the Member's circle with a focus on eliminating duplication of services, improving continuity of care, and facilitating the coordination of benefits in a person-centered, integrated approach. When a community-based case manager or case worker is involved with an LTSS Member, Aetna's care coordinator is the single point of contact. Upon enrollment, LTSS Members are offered the opportunity to work with a contracted community care coordinator or an Aetna care coordinator. If a Member selects a community care coordinator, the community care coordinator is the single point of contact and Aetna's care coordinator is secondary. For example, in our affiliated Illinois health plan, Aetna contracted with community providers as care coordination entities. They are set up as Aetna staff extenders that have full access to Aetna clinical systems and act as the Member's single point of contact. Aetna clinicians are secondary and work closely with the primary care coordinator to oversee care coordination efforts, co-manage the Member as part of the Interdisciplinary Care Team (ICT), and approve person-centered care planning and assessment completion. **We will pilot a similar process in Kansas through a partnership with Minds Matter who will serve as an Aetna staff extender. Members will have the option to select community care coordination through Minds Matter. To provide a seamless experience and prevent duplication, Members selecting Minds Matter will receive secondary support from Aetna care coordinators as illustrated in the following table.**

Activity	Role of Community Care Coordinator when Primary	Role of Aetna Care Coordinator when Secondary
Health Screen	Not applicable	• Complete during initial visit, offer community care coordinator versus Aetna as primary
Options Counseling	Not applicable	• Complete during initial visit, offer community care coordinator versus Aetna as primary
Annual Assessment	Completion	• Review and approval
In-person Visits	Present for all in-person visits	• Must be present for at least 2 visits with the community care coordinator, and with Member agreement
Person-Centered Service Plan	Development, implementation, and ongoing monitoring	• Review and approval of initial, annual, and any changes • Participate in interdisciplinary reviews during the year and review utilization

Activity	Role of Community Care Coordinator when Primary	Role of Aetna Care Coordinator when Secondary
Ongoing Contact	Primary, include secondary as needed/with Member agreement	• Secondary, always have primary on phone with Member
Coordination of Needs	Communication with Member	• Follow up to secure transport, behavioral health, physical health, and community linkages

When another case manager, other than an Aetna care coordinator, is involved with a non-LTSS Member's care we defer to the Member's choice of for single point of contact except in cases where the Member is on the waiting list for the IDD waiver, PD waiver, adults and children engaged with Certified Community Behavioral Health Clinics (CCBHC)/Community Mental Health Centers (CMHC), and Members participating in OneCare Kansas (OCK). In these cases, either the Targeted Case Manager (TCM) for the IDD waiver or the community care coordinator serve as the primary point of contact. Aetna care coordinators play a supporting role by completing the health screening tool, monitoring health and safety, or connecting Members to health and social resources. Our care coordinators assist with arranging for and scheduling specialty care, transportation services, prior authorizations, or other activities not provided by external case managers. In all cases, **we clarify roles and responsibilities early in our work** to eliminate confusion and duplication and maintain a consistent single point of contact.

Aetna will pilot integration of care coordination for Members waiting for the IDD waiver to increase access to non-waiver services and meet the pilot outcomes illustrated in Figure 7-2. We will provide outreach to Members on the IDD waitlist offering support to locate targeted case management services. Additionally, we will facilitate engagement and provide secondary support to the Member by offering Value-Added Benefits (VABs) and access to care advocate specialists for SDOH outreach and resource connection.

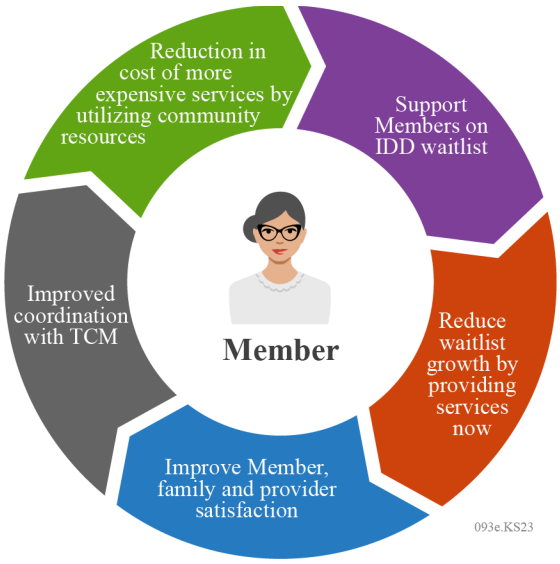


Figure 7-2: Aetna's Targeted Case Management Pilot. *Aetna continually tests new ideas to improve integrated, whole-person care.*

Aetna has a robust technology ecosystem. We use a wide variety of data sources (e.g., claims and Admission, Discharge, and Transfer (ADT) data) and technology tools (e.g., care coordination business system) to identify and remediate any sign of duplication providing Members and their Care team with a seamless experience. For example, we use information available in our claims system to identify Providers who also provide some form of care management. Before any meeting with the Member, either in-person or by phone, we review claims and utilization patterns to avoid duplication in services and identify gaps in care. Members and their care teams have access to the same information through the care coordination system fostering consistency and reducing duplication across care team members.

When working with other case managers such as a TCM or a CCBHC/CMHC, we use our fully integrated care coordination business system to support a Member's personalized care experience and securely provide program transparency and accountability to ICT participants.

Our comprehensive care coordination business system interfaces with **FamilyCare Central (FCC), our purpose-built solution that allows bi-directional data sharing** with Members, their circle of support, including case management and Providers. FCC also includes features that prevent duplication such as:

- Collection, storage, and integration of administrative data, call center communications, health screening tools (i.e., social needs, health equity data), assessment data, PCPs, and care coordination notes are shared across a single Aetna solution that allows internal and external partners to coordinate effectively.
- Consolidated Outreach and Risk Evaluation 2.0 (CORE™) stratification algorithm data from medical claims, prescription claims, public data on SDOH, health screening and demographics, and known health disparities at the local/regional and population specific levels to calculate a risk score for each Member.
- Direct Secure Messaging capabilities enabled through a Health Information Service Provider (HISP) to gather and exchange actionable clinically coded information with the designated Member Care Team eRoster, as documented in the Aetna USCDI+ dataset, aka Comprehensive Member Record or CMR, (e.g., care coordination case data, continuity of care documents, Care Plan Ledgers, ADT alerts, SDOH Z Codes, and Electronic Medical Records) to securely and quickly exchange information, reducing duplication and improving continuity of care.

Aetna is the only payer that is leveraging a HISP partnership to exchange clinical code data in a manner that allows us access to all available market clinical data regardless of Provider participation with an health information exchange or national EMR. 094j.KS23

We routinely deploy the following additional interventions to make sure we avoid duplication in our care coordination model:

- **Co-location.** We co-locate where possible to streamline coordination. We have Community Health Workers (CHWs) embedded in two CCBHCs (ComCare in Sedgwick County and Johnson County Mental Health) and registered nurses embedded in Kansas hospitals (University of Kansas Medical Center, Wesley Medical Center, and Via Christi Medical Center).
- **Care Coordination Staff Specialists.** Care coordinators support Member needs and avoid potential duplication of services by tapping into diverse, multi-disciplinary staff specialists at the point of care including socials workers with foster care experience, health equity expertise, medical directors, care managers, LTSS care managers, CHWs, care advocates including a housing specialist, workforce specialist, recovery and resilience administrator, adult systems of care administrator, transition of care administrator, and IDD administrator who provide Members the expert care coordination, guidance, and support related to their health and social needs.
- **Risk and Mitigation Strategies.** Aetna uses our multidisciplinary case rounds to discuss areas of concern that may arise through our partnerships with other care managers and when data indicates a need. The Aetna team develops an action plan to remediate any duplication and support a seamless care coordination experience.

- **Partnerships.** Aetna builds relationships with external care coordinators, internal and external CHWs, case managers, and case workers at enrollment. When another case manager or CHW has a role in Member's PCSP, we quickly establish a relationship that has clearly defined roles, responsibilities, and expectations that include avoiding potential duplication of services.
- **Communication that Facilitates Coordination.** Ongoing communication with other care managers leads to strong coordination of services and supports. Our care coordination business system provides technology to comprehensively capture care coordination activities. Members and their ICT use FCC to monitor PCSP goals and address changes in care quickly. For example, if a Member is assessed for potential waiver eligibility, we send a referral to initiate the waiver assessment. Once we receive an outcome and approval for the waiver, we collaborate with the LTSS team to facilitate a smooth transition. For Members on the IDD waitlist, we coordinate activities and maintain a collaborative relationship with TCMs, Community Developmental Disability Organizations, and other community supports to fully meet Member needs.

c. Member-Focused Care Coordination Roles, Responsibilities, and Functions

The following table provides detail on our Member-focused care coordination roles, responsibilities, and functions including LTSS-related roles.

Care Coordination Director	• Independently clinically licensed as a registered nurse or BH clinician. • Leads the clinical team that supports timely health risk screenings, comprehensive assessments, PCSP development, and Member interventions in accordance with the Aetna Stratification Framework and state contractual requirements. • Develops and manages clinical operations focused on improving clinical and financial outcomes, member engagement and satisfaction, and use of best practices and standards.
Care Coordination Manager	• Independently clinically licensed as a registered nurse or BH clinician. • Responsible for day-to-day oversight of clinical team processes including the organization and development of high-performing teams. • Confirms care coordination activities across the continuum of care (assessing, planning, implementing, coordinating, monitoring, and evaluating).
Clinical Care Coordinator	• Independently clinically licensed as a registered nurse or BH clinician. • Leads the collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes. • Often assigned to Members with a Level II or III risk stratification.
Non-Clinical Care Coordinator	• Bachelor's or master's level with access to licensed staff for consultation and supervision. • Provides education on the impacts of conditions and psychosocial variables as well as how to use available services effectively. • Assigned to Members in need of monitoring or a Level I risk stratification.
Care Coordinator Associate	• High school graduate, associate's, or bachelor's level. • Assists Members and the Care Coordination team with non-clinical activities such as initial outreach calls, completing screeners and questionnaires,

arranging transportation, helping Members with scheduling appointments, and other activities that support Members and the Care Coordination team.
- Associates have access to licensed staff for consultation and supervision and work within the scope of practice following contractual requirements regarding the tasks they perform.
- Associates are often the first point of contact with Members during the initial screening process and provide non-clinical assistance in managing care for Members at low risk.

Care Connection Specialists

Aetna care coordinators also have access to Kansas staff specialists (e.g., population health specialists, behavioral health clinical liaisons) to provide a specific personalized approach to connect Members to resources many of us might take for granted, such as food, housing, and companionship. They live in the Kansas communities we serve, giving us valuable insight around concerns Members face. This helps us build trust and credibility, creating more authentic relationships with Members and breaking down barriers preventing them from accessing care. We recruit culturally diverse staff who better represent the populations we serve. They are indispensable members of our Care Coordination team participating in ICT meetings, providing insight during multidisciplinary case rounds, identifying Members who require additional assistance, engaging Members who are difficult to reach, meeting and sharing Member information, and collaborating across the Care Coordination team and with other care managers involved in a Member's care. We do not use these specialist roles to extend staffing ratios of care coordinators to Members. These specialists are a crucial part of the care coordination process to help improve Member outcomes:

- **Care advocate specialists** have state-specific experience in their designated system area and help Members connect to all forms of health services, and housing, employment, healthy food, transportation, and other living supports to optimize resiliency and independence.
- **CHWs** live in the neighborhoods they serve and are part of the cultural fabric of their communities. They engage Members by locating and linking them to care coordinators, connecting them to resources, helping them attend appointments, and educating them on appropriate use of health care resources, such as the Emergency Department (ED).

Care Coordination Extenders

Our Social Impact team serve as care coordination extenders offering Members access to social supports uniquely positioned to their culture and language as noted below:

- **Member Real Engagement and Community Help (REACH) team** uses data analytics and other sources, such as Z Codes, to proactively outreach to Members who are not enrolled in care coordination and have unmet SDOH needs.
- **Community Collaboration and Real Engagement Solutions (CARES) team** works with nonprofits, CBOs, and other stakeholders to identify community SDOH-related issues.
- **Better Together: Social Impact team** focuses on developing solutions to address different SDOH, such as building community partnership by embedding boots on the ground teams and making data-driven financial investments.

Establishing clear roles, responsibilities, and functions of all staff supporting care coordination leads to integrated, whole-person care by reducing duplication within the Aetna

team and between Aetna care coordination and other Kansas case management models (e.g., community care coordination, targeted case management, CCBHCs/CMHCs, OneCare Kansas).

d. Approach and Strategies to Effectively Engage Members

To better serve KanCare Members, we developed a global Care Coordination Engagement strategy, the strategy consists of eight pillars illustrated in **Figure 7-3** and described below:

Personalized Communication

Member preference drives our personalized approach. We establish trust through consistent and empathetic interactions. We assign care coordinators as single points of contact to build continuity and tailor our approach to each Member's needs. Our written communications are easy to understand and are linguistically and culturally appropriate incorporating formats (e.g., Braille, offering translation and interpreter services) and graphics that mirror KanCare Members.

Flexible Communication

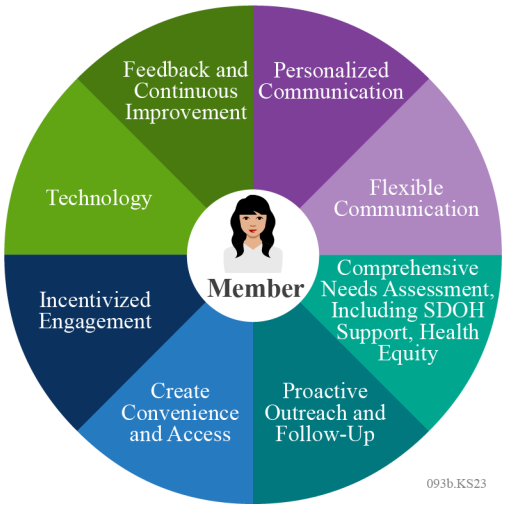


Figure 7-3: Member Engagement. *Aetna's eight-pillars illustrate how we effectively engage our Members.*

Aetna recognizes that we need to tailor our approach to meet the Member where they are. We use multi-channel engagement tools such as phone calls, text messages, IVR, emails, and written mail to reach Members. When we recognize that one approach is not working, we explore alternatives. For example, if we make multiple outreach attempts telephonically without success, we send a letter in the mail. Alternatively, if we send written communication in the mail and it comes back unopened, we seek a different address or triage that Member for telephonic outreach. If we have difficulty locating Members, we leverage our redetermination outreach program or identifying recent Providers and pharmacies through prior authorization or claims data to ask for updated Member contact information. One approach will not work for all Members, so we keep flexibility at the core of our strategy.

Comprehensive Needs Assessment, Including SDOH Support, Health Equity

After completing the initial Health Screening Tool (HST) and SDOH Health-Related Social Needs Screening, we risk stratify Members and based on their responses prioritize Members with the highest risk. We follow up with the Members and their circle of support (with Member consent) to complete a comprehensive assessment where we learn about their strengths and barriers, gaining an understanding of the full scope of each Member's Physical Health (PH), Behavioral Health (BH), and social needs. **We engage with the Member to identify their priorities** which informs our outreach strategy. For example, if a Member has identified that housing is their biggest challenge regardless of disease state, we will focus on closing those housing insecurity challenges.

Active care coordination engagement (e.g., onsite, telephonic, virtual) for Members with SMI **increased by 112.1% from July 2021 (5.8%) to November 2023 (12.3%). It also increased 21.8% since June 2023 (10.1%).**
133k.KS23

Proactive Outreach and Follow-Up

Aetna is **above 90th percentile for follow-up after emergency department visit for mental illness** 30 days (total) at 77.51 and 7-day (total) at 65.2. 133e.KS23

Over the last few years, we have learned that proactive outreach and follow-up leads to success. We maintain contact with Members to reduce the number who are challenging to reach. For example, when Members are hospitalized, we may visit them to address needs and assist them post-discharge. **We found 28.8% fewer 30-day readmissions for Members engaged in our Readmission Avoidance Program (RAP) program.** Through proactive outreach, we can provide resources to the Member and attempt to engage them in ongoing care coordination which leads to better health and social care outcomes. When we are unable to reach Members, we have CHWs or other care coordination staff visit the Member's home or contact the Member's PCP, Community Pharmacy Enhanced Services Network (CPESN), EDs, or other points of care. Our CHWs know their local communities well. They use their experience and knowledge of community resources to engage and connect with hard-to-reach Members when needed.

To increase engagement and improve health outcomes, **Aetna conducted outreach to 1.5 million unique Members in 2022 and facilitated 421 active campaigns.** 133i.KS23

Create Convenience and Access

Aetna contracts with CBOs to include Member data sharing. **We reach out to local homeless shelters, hospitals, food pantries, libraries, and clinics to locate Members in need of care coordination and connect with Members through our Community Resource Centers (CRC).** CRCs improve access to care in underserved communities by enabling telehealth, partnering FQHCs for in-person primary care services, offering health and wellness programming tailored to meet the needs of the community, and connecting Members to the available resources in the community to address SDOH needs.

Incentivized Engagement

Through Member outreach, we share information about our VAB. These benefits incentivize Members to get and stay engaged in achieving their health and wellness goals. For example, we offer healthy rewards for the completion of wellness activities such as a $25 incentive card for the annual flu vaccine or the redeemable reward of $75 for a pregnant Members' first prenatal visit within the first trimester or within 42 days of plan enrollment. We design VAB to increase engagement, support health and wellness, and improve quality and health outcomes. **Aetna provided the highest dollar amount for VABs in Kansas, surpassing other MCOs in 2020, 2021, and more than doubling access in 2022.**

Technology

To engage Members, we are unable to contact or who are hard to reach, **Aetna has developed a robust technology infrastructure**, including our Clinical Engagement Console, claims and authorization data, PeopleSafe (a CVS Pharmacy platform), and PointClickCare. In addition to our successful provision of navigation services, broadband access, and telehealth hot spots in CRCs, we use our HISP-enabled CMR to reconcile data with other systems (the Homeless Information Management System, HIEs, ADT).

Feedback and Continuous Improvement

We built our Care Coordination program on the foundation of continuous quality improvement

principles and methodologies (**Figure 7-4**). **We embed the utilization of the Plan-Do-Study-Act (PDSA) model into our analytical and evaluative processes and use this continuous feedback loop to adjust our approach.** Aetna staff annually review and update care coordination processes and resources including how we engage Members throughout their health care journey. We also monitor ongoing processes using dashboards to identify opportunities to develop improvement plans. This ongoing review includes measurements of Member enrollment, engagement, clinical trends, community needs, and satisfaction outcomes. We support our quality governance structure through committees and ad hoc work groups accountable to our Quality Management Oversight Committee (QMOC) and guided by our Service Improvement Committee (SIC).

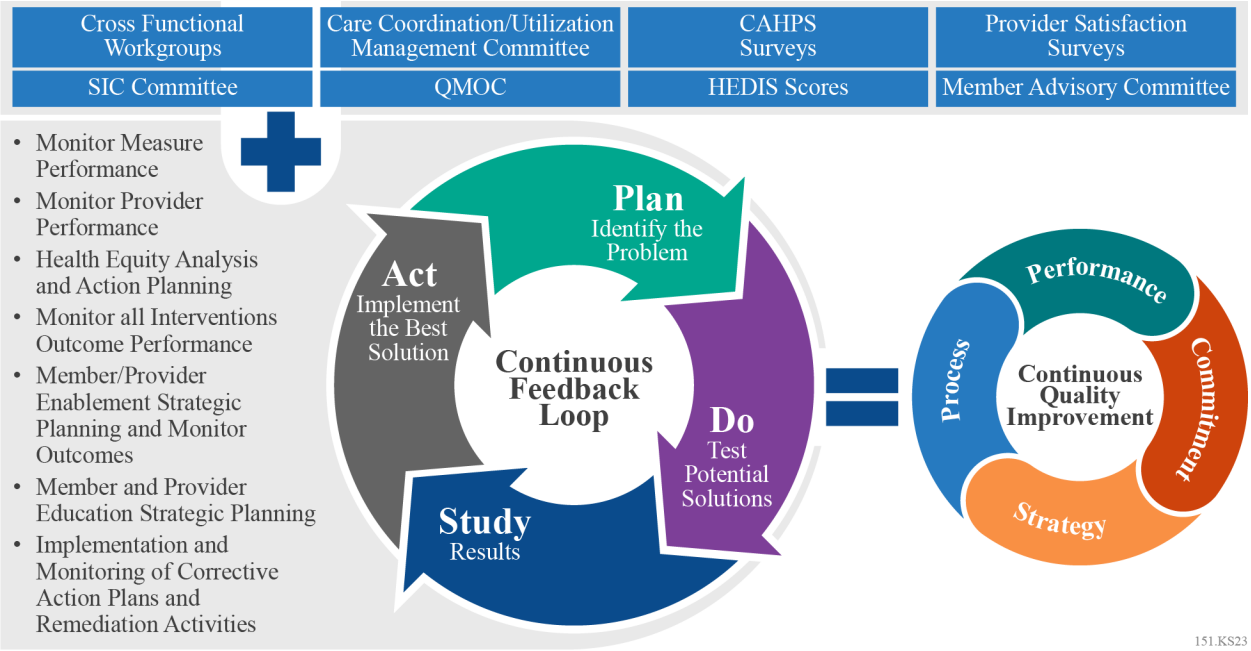


Figure 7-4: Aetna's PDSA CQI Cycle. *Aetna's continuous quality improvement cycle is used to test new ideas, monitor progress, and advance integrated, whole-person care.*

e. Establishing Care Coordination Caseload Ratios and Monitoring

Because we currently support KanCare Members, we know and understand who they are and what they need. We recognize the variability and complexity of waiver and non-waiver Members. When determining care coordination ratios, we consider a Member's cultural, linguistic, or other preferences in our staffing model to support health equity and help Members attain their PH and BH goals and tackle health disparities.

Aetna uses caseload ratios to advance the coordination of services supported by care coordinators best positioned to meet each Member's needs and preferences. Our staffing model incorporates comprehensive member identification, screening, care coordination contact requirements, and risk stratification, along with active outreach and engagement, in-depth member assessment, and PCSP.

Since August 2021,
screenings for depression
increased 17.3%
for our Members in foster care.
133c.KS23

The maximum number of Members that a care coordinator can manage are as follows:

Caseload				
Service Level	**Non-LTSS Caseload Ratio**	**LTSS Caseload Ratio**	**Foster Care Caseload Ratio**	**Maternity**
Level III. Complex/High-Risk	1:39	1:35 (HCBS/Community) 1:50 (Nursing Facility)	1:17	1:33
Level II. Chronic Long-Term Needs	1:56	1:50 (HCBS/Community) 1:130 (Nursing Facility)	1:36	Not applicable
Level I. Short-Term/Transition of Care Needs	1:179	Not applicable	1:350	1:65

Care coordination managers are responsible for adjusting staffing allocations to maintain the staffing ratios and can take on care coordinator responsibilities or leverage care coordination extenders as needed to coordinate care for all Members. We conduct time studies to update the WLD including confirming or changing our assumptions related to the time it takes to complete care coordination tasks and the average frequency of task activities by program type and setting.

Approach for monitoring to make certain ratios are adequate to meet care coordination requirements. In compliance with our case ratio monitoring policy, care coordination managers and staff use real-time tools (Care Coordination Operational dashboard and Caseload and Case Weight reports) to routinely review caseloads to verify that they do not exceed the caseload or total case weight limit. These tools identify when we need staffing adjustments due to Member enrollment/disenrollment, opt in/opt out, transitions, changes in acuity levels, and when care coordinators are at max for caseloads and case weights if managing mixed cases. Managers determine caseload distribution between teams to maximize available staff and adjust caseloads and care coordinator assignments, as necessary. We know that the needs of our Members change. We use our tools and dashboards to continually monitor gaps in care. Using our rapid cycle PDSA approach, we develop targeted, measurable interventions that could result in the need for additional staff or a different mix of staff.

Since October 2022,
self-inflicted harm events
decreased 9.2%
for our Members in foster care.
133d.KS23

f. Case Assignment Considerations and Managing Vacancies

Case ratios and assignments change as the needs of Members change. **We proactively adjust our staffing model to anticipate changes and manage vacancies within the context of KanCare Member needs and workforce trends.** We recognize that staff Members do turn over and have policies in place to monitor continuity of care for Members during those transition periods.

We monitor for vacancies and address these as soon as they arise. We use different tools and models to ensure early identification of upcoming vacancies and transition of care protocols to meet Member needs. Our care coordination managers meet regularly with care coordinators to check on progress, provide constructive feedback, celebrate wins, and address challenges. We recognize some of the challenges staff face addressing Member needs, especially those who are complex. Employee satisfaction surveys help our care coordination managers adapt to the changing needs of our care coordinators. **On a daily basis, our care coordination managers**

monitor staff turnover by using employee dashboards and monitor the downstream impact of staff changes by using case weight and caseload dashboards.

To address staffing vacancies, we recruit staff using a wide variety of strategies such as advertising internally on the health plan landing page and on the CVS Career site, use of our employee referral email campaign which reaches all Aetna/CVS staff in Kansas, conducting virtual job fairs, advertising with local schools and universities, career-building websites, social media, our Aetna Diversity and Military Outreach unit, and sign-on bonuses for harder to fill roles or regions. When we identify a staffing deficiency, care coordination managers request additional care coordination staff through our Human Resource (HR) systems, which includes a Medicaid-specific Staffing Review Committee (SRC) process. Care coordination managers have the responsibility to complete the requests and, once approved, work with our HR business partners on recruitment, hiring, onboarding, and addressing staff training requirements.

Beyond recruitment, we strive to improve internal processes that impact employee hiring, retention, and quality. For example, we made recent changes to the hiring process to onboard care coordinators quicker and we prioritize working smarter by streamlining operations (e.g., expanding the role of CHWs and care coordinator associates) and improving technology (e.g., FCC), a proven driver of employee retention, to increase care coordinator availability and accessibility for what matters most to our Members.

g. Supporting the Temporary or Transitional Need for Care Coordination

When we identify Members who need temporary or transitional care coordination, we assign a care coordinator and work with the Member to complete an initial HST and SDOH Screening. If needed, our care advocate specialists connect the Member to resources (e.g., housing, employment supports, food) through our Community Resource Directory (CRD). The care coordinator follows-up with the Member to check on whether they access the resources needed to meet their goals.

A Member discharging from a hospital after a short-term stay may need intermittent assistance such as transitional care coordination and housing support. We proactively contact Members discharged from any inpatient or residential setting using automated texts and calls to educate Members about the importance of attending follow-up appointments, taking their medications as instructed, and how to contact the 24/7 Nurse Line. We connect the Member to our CHWs or care advocate specialists to address SDOH needs and support the Member with discharge planning including at least one in-person visit from the care coordinator and telephonic contact after discharge. Because hospital stays increase risk for readmission and institutionalization, our care coordinators remain available to the Member as needed and at least annually.

Members in need of temporary or transitional care coordination may enter our Readmission Avoidance Program (RAP). The RAP targets Members with inpatient admissions at high risk for readmission; they receive health plan support, such as targeted care coordination to prevent readmission and lower associated costs. We focus on at-risk Members with an inpatient admission who have a readmission risk score of at least 50%.

Aetna Members transitioning from institutional to community settings **increased 39%** from 2019 to 2022. We supported 550 Members in their successful transitions in 2022, promoting independence and wellness in alignment with KanCare goals. 134b.KS23

Care coordination managers contact Members in RAP or their circle of support within two business days of admittance notification, and if possible while still inpatient. During outreach, care coordinators complete a RAP questionnaire evaluating the care the Member received before admission and identifies any issues with access to care, BH, health literacy, or medication adherence. Care coordinators confirm Members receive and understand their discharge instructions, obtained all medications, and understand why they are taking medications. Care coordinators resolve any gaps identified, and work with pharmacists to conduct a medication reconciliation that includes review of discharge notes, lab data, utilization history, and any other pertinent information. Pharmacists work with care coordinators to resolve concerns and make suggestions to improve outcomes and prevent future adverse events. **In 2022, Members receiving care coordination with access to our RAP experienced a 4.5% reduction in readmission rate and a 14.3% decrease in cost per readmission.**

Aetna also identifies Members who need temporary or transitional care coordination through self-reported information from health risk appraisals, screening tools, questionnaires, 24/7 Nurse Line intake, requests for support, ad hoc contacts, data analytics, and referrals. The two tables below describe the data analytics and referrals used.

Data Analytics
• Aetnalytics HUB providing an analysis of clinical, operational, and supplemental data and used to prepare data for Quality and HEDIS reporting • Predictive modeling using claim/encounter information, pharmacy, lab, and local SDOH data • Member demographic data, ZIP code, race, and ethnicity as available • Internally available data and reports such as the Health Care Equity (HCE) dashboard, operational dashboards, and through Utilization Management (UM) and other processes • EHRs and HIEs • Organizational partners providing data utilization of emergency and inpatient admissions and discharges and pharmacy and laboratory testing and results

Referrals
• Enrollment, clinical files, or referrals received from state, federal and community-based institutions, agencies and organizations, and other program stakeholders • Known involvement from educational or judicial services • Referrals from plan departmental staff such as grievance and appeals, population health management, chronic condition self-management, UM, wellness, or health coaching programs • Referrals from Providers of care and services, including primary treating physicians, specialty Providers, and practitioners, health homes, external case managers, and other supports

Lastly, Aetna uses the HCE dashboard to identify Members who may need temporary or transitional care coordination. This dashboard consists of state, regional, local, and Member level data related to SDOH, condition prevalence, and potential disparities within a market. This dashboard along with other datasets, such as the Population Health Member Demographics and the Member Conditions dashboards, are also available and used to support the identification of Members who may benefit from temporary or transitional care coordination. Care coordinators use the aggregate data to pinpoint SDOH hot spots. Once identified, we unroll the data to the Member-level enabling the Care Coordination team to conduct outreach.

h. How Care Coordination Interfaces with Disease Management

Aetna integrates disease management into our Care Coordination and Population Health Management (PHM) strategies for waiver and non-waiver Members. We offer a full continuum of programs focused on reducing burden and improving the quality of care and outcomes for Members living with asthma, cardiovascular disease, chronic obstructive pulmonary disease, diabetes, SMI, and other chronic conditions.

Year-over-year, **125.7% more Members** had at least one Rx fill to treat diabetes in the last 12 months. 133b.KS23

Aetna approaches chronic disease management with the same attention and support as all other Member care categories. We promote wellness before a disease or condition occurs (e.g., poor nutritional habits) and becomes chronic. **Our tiered prevention and management approaches screen for early identification and provide educational materials and programs to reduce the burden of illness in Members already diagnosed with a chronic condition**. For example, our Diabetes Management program embraces three critical areas: unified clinical support, Member optimal outcomes through their personal experience, and supportive care delivery. Member support includes monitoring HbA1c levels, providing retinal eye exams and other screenings, addressing SDOH, supporting medication management and adherence, dietary guidance and education, and personalized care plans. Our Disease Management program aids our holistic personalized Member focus by including medication adherence/compliance, preventive and maintenance screenings, reliable glucose and vitals monitoring, lifestyle changes (e.g., weight management and activity support), and comorbidity management.

In rural Kansas, **Rx adherence for diabetes increased 32.9%** for Members with both diabetes and obesity year-over-year. 133g.KS23

Through an interdisciplinary approach to self-management support, we empower Members to assume greater responsibilities for their health. We do this through collaboration, engagement, identification of strengths, and leveraging those strengths to enhance resiliency resulting in Members' improved condition management and self-efficacy. We offer and support Members through self-management tools and resources found on the member portal.

Our care coordinators assess each Member's chronic condition(s) to determine interventions. Members who engage in care coordination activities are more likely to see improvement in their health and well-being. **When comparing Member outcomes for those receiving and not receiving care coordination, we find that Members with BH needs receiving care coordination were 26% more likely to have a seven-day follow-up after a BH-related ED visit and Members with SUDs had 7% less ED visits that were avoidable.**

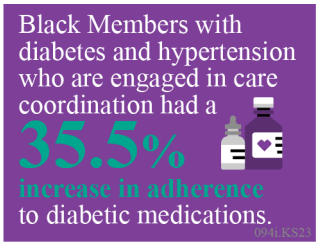
Diana, a KanCare Member, was experiencing consistent depression and anxiety symptoms due to a family issue. She was feeling like a burden to others but was reluctant to attend community mental health services because of her difficulty building rapport with Providers.

Her Aetna care coordinator provided her with access to educational resources to promote Member choice and interest in community mental health services and resources. Diana had several discussions with her care coordinator about the potential outcomes of these services. This allowed her to make an informed decision with known expectations.

Today, Diana is actively involved with a mental health service Provider. She has reported a decrease of depression and anxiety symptoms and improved management of symptoms through coping techniques. 050.KS23

In addition to Aetna's Healthy Rewards incentives for yearly checkups, diabetic eye exams, and A1C tests, we offer additional VABs to support disease management such as:

- The University of Kansas Weight Management program, which provides a 12-week membership to a weight management class to address healthy eating, exercise, and behavior change. **From fiscal year 2020–Oct. 31, 2023, we supported 225 unique Members (229 Members completed classes, 19 Members currently enrolled in the program, and 17 Members pending program start) with a total spend of over $33,250.**
- The Healthy Food Incentive Card, a new 2024 VAB, which provides Members $30 a month for three months on a reloadable incentive card restricted to healthy food. At the end of the 3-month period, care coordinators help Members sign up for SNAP benefits.
- [redacted]



Aetna aligns disease management interventions with Member risk stratification which may include:

- Conducting face-to-face or telephonic coaching and education to the Member and/or their circle of support using disease specific clinical practice guidelines to improve care plan adherence and adjusting tasks to align with the Member's culture, language, and religion.
- Providing the Member with appropriate resources, training, access to lifestyle modification programs, and support to help them complete tasks and achieve care plan goals.
- Assisting Members and their family to develop self-management action plans, cultivate a relationship with their PCP or specialists, and communicate about their conditions/treatment.
- Deploying CHWs to conduct home visits for Members with chronic conditions to reinforce the care plan, identify health care needs, and provide disease management education.
- Expanding Member-specific resources to include remote patient monitoring, care coordination education, and coaching to drive behavior change and improve outcomes.
- Focusing on utilization medical management, gaps-in-care resolution, treatment adherence support, hospital admission, and readmission reduction.
- Reevaluating exacerbations and barriers to adherence.
- Accessing pharmacy medication management and pharmacy supported comorbid condition management programs.
- Offering transitional care coordination.

We target the same conditions at various levels of care coordination depending on severity of the condition, presence of other chronic conditions, SDOH needs, or other factors that indicate a need for a higher or lower level of care coordination. Care coordinators have access to a library of resources and condition specific toolkits to assist them in managing Members' conditions.

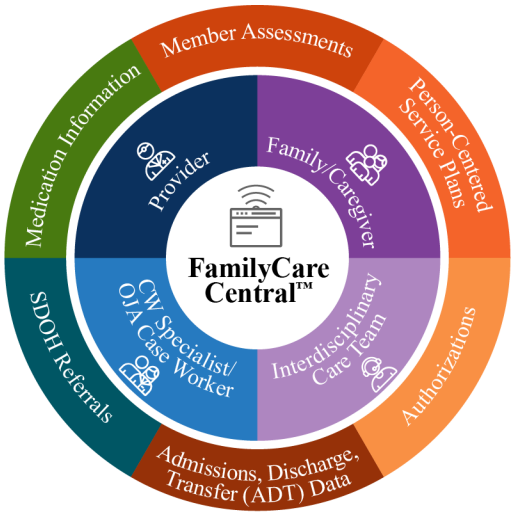
i. Processes and Systems Used to Share and Exchange Information

We share information with members to improve care coordination, while complying with Member choice on information exchange. Care coordinators, health care and social support

specialists, Providers, families, and other involved parties can quickly access a single, integrated, up-to-date Member care coordination portal that allows them to follow the Member's progress and challenges in near real-time. We do this through advanced technology that includes a complete suite of evidence-based functional, PH, and BH assessments, PCSP tools, and functions. We pair our technology infrastructure for care coordination activities (e.g., our electronic care coordination business system, mobile applications, and telehealth solutions) with the flexibility to integrate our data needs into that solution. This includes data from the entire community of the Member's preferred supports, primary and PH Providers, specialty and LTSS Providers, and community organizations; data from all assessments; their PCSPs; LTSS claims data; and key SDOH. **The interoperability of these systems enhances our ability to achieve Kansas goals of improving quality and access to care through care coordination and collaborative delivery of services.**

[redacted]

We train our Care Coordination team on our Standard Operating Procedure (SOP) documents to guide their work and documentation in our care coordination system. To address compliance with contract requirements and clinical best practices, our Performance Optimization team regularly audits Member records for alignment with SOPs and that the information shared through our Member and Provider portals, and FCC is accurate, complete, and consistent. We audit our care coordinators and require each meet or exceed documentation standards for data integrity.



FamilyCare Central is a proprietary platform that convenes multiple data sources into a consolidated view of Member information. FamilyCare Central supports seamless coordination of care by making key information available to all individuals in an Member's care circle. 093c.KS23

Internally, staff use the Aetna Comprehensive Member Record, a broad data inventory that exceeds federal ONC quality and data format standards. This data comprises operational and clinical data such as enrollment, claims, Provider assignments, prior authorizations, care management and coordination like SDOH Z codes, consolidate clinical documentation architecture, and ADTs from Kansas HIE/HISP Partner. We further enrich this dataset by supplementary sources (i.e., lab, pharmacy, dental, state, justice system) and Aetna collected data (i.e., HST and SDOH). Aetna USCDI+ is a CFR 438.242-compliant, digitized data inventory representing the most accurate, complete Member EHR record available.

j. Approach to Monitoring Receipt of Services, Supports, and Resources

During meetings with Members our care coordinators review services and ask Members to share whether they met PCSP needs and goals. Each month, care coordinators conduct an interval assessment based on level of care coordination.

Black Members with at least **one behavioral health telehealth visit increased 55.6%** and at least **one physical health telehealth visit increased by 45%** between July 2022 and June 2023. 133h.KS23

For LTSS Members, care coordinators check on receipt of services, supports, and resources at least every 30 days. Care coordination activities are the primary source of identification of a Member's unmet needs and gaps in care. Aetna's dashboards calculate contractual obligations, organize caseloads, assist with the management of in-person visits and telephonic outreaches, and summarize care coordination system data. We update the dashboard daily pulling in information from the 834-enrollment file and from UM and claims data. Care coordinators and leadership review the dashboard daily, and when specific gaps are recognized at the Member level, additional interventions and supports are deployed.

We have a system in place of ongoing monitoring. In addition to the Gaps in Care Dashboard and EVV monitoring, our Care Coordination team monitors service and support delivery by using a comprehensive suite of tools and processes, including the:

- LTSS Compliance Dashboard identifying gaps between service plans and rendered services
- Interval assessments, care plans and progress toward goals
- Clinical Engagement Console snapshot
- Care Coordination Daily Operational dashboard
- Care Coordination Member File and Observational Audit Reports
- Service Plan Audits
- Care Coordination Summary report
- HEDIS Care Coordination Trends report
- Care Coordinator to Member Geo-Access report
- Compliance with NCQA and Standard Operating Best Practice Requirement

Care Management enrollment, for Members with SMI, **increased by 128.7% from July 2021 (10.8%) vs. Nov. 2023 (24.7%); and 42% increase since June 2023 (17.4%).** 133j.KS23

When gaps are identified, our Care Coordination team deploys a Member-centric, trauma-informed, and resiliency focused approach to quickly close those gaps. We prioritize integrated and holistic PH, BH, SUD, and SDOH goals and outcomes tackling health disparities and addressing crisis safety planning. We bring our heart to Kansas striving to improve easy access to care, offering expertise Kansans can trust, and advancing whole health that puts our Members first.

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Topic Area 3: Integrated, Whole-Person Care

8. Community Health Workers (CHWs) and Community Health Representatives (CHRs) offer a unique and important role in outreaching, educating, and connecting KanCare Members to health care Providers, social service systems, and their MCO. Describe the bidder's approach to
   a. Utilizing and promoting the use of certified CHWs/CHRs as MCO staff and/or Providers located within local communities across Kansas.
   b. Identifying the roles and responsibilities of certified CHWs/CHRs and providing the training necessary to support certified CHWs/CHRs to successfully perform their roles and responsibilities.
   c. Measuring, monitoring, and evaluating whether certified CHWs/CHRs are effectively fulfilling their roles and responsibilities to improve Member care, individual outcomes, and population health.

Aetna understands the criticality of the Community Health Worker (CHW) and Community Health Representative (CHR) roles within the care continuum. As trusted members of local communities, they can quickly outreach, educate, and connect our Members to Providers, social service systems, and back to us as their MCO. Our goal is to further enhance the reach and impact of CHWs and CHRs in Kansas to improve health care access, community engagement, and health outcomes. **Our established group of Kansas CHWs provide culturally and linguistically appropriate services to our Members, which advances health equity for everyone.** These crucial staff members also serve as CHRs in our Indian communities with services for health care, health promotion, and disease prevention.

Member Success Story

Josephina*

Josephina is an 18-year-old from the Kansas City area who was formerly part of the foster care system. She recently found out she is pregnant with her first child but has only seen her primary care provider for the initial exam. Anna Lucia, a bilingual Spanish speaking CHW with Aetna, has been supporting Spanish speaking mothers and families for over five years and was assigned to outreach Josephina because our records had revealed a potential gap in care with no prenatal follow up visits.

Our CHW, Anna Lucia, reached out to Josephina by phone and when she realized that Anna Lucia spoke Spanish, her native language, she expressed relief and gratitude. Josephina didn't realize she could request someone who spoke Spanish, so she always felt nervous about following up with her prenatal care. Anna Lucia used Motivational Interviewing skills and culturally competent care to establish positive communication and a safe place where Josephina felt comfortable sharing her situation to discuss some of her anxieties about her pregnancy, home life, and why she hadn't been in to see the doctor to check on her.

With more than five years supporting Spanish speaking mothers and families within Kansas, Anna Lucia was able to connect Josephina with a network of community resources and supports that helped to educate Josephina and provided her with a sense of security in making the right decisions for her baby and herself. This prepared her to visit a doctor and receive her first prenatal appointment and make follow-ups. Anna Lucia also shared information about the value-added benefit Baby Talk and the Promise Pregnancy program so Josephina could feel empowered to learn more about her pregnancy and care. Our CHW also helped Josephina sign up for care management services and address Josephina's mental and physical health needs.

**Member name changed to protect identity*

078.KS23

Our CHW experience in Kansas, and across the U.S., provides a clear path for the continued growth and outreach of our Kansas CHW team. **Working closely and purposefully with the KanCare population, our CHWs work every day to meet the Healthy Kansans 2030 goals**

(tobacco cessation, diabetes management, access to care, etc.) and contract requirements by identifying and providing solutions to barriers associated with all SDOH.

a. Utilizing and Promoting the Use of CHWs/CHRs

Aetna CHWs are the faces, hearts, and helping hands for our Members, and the eyes and ears of our health plan—they make person-centered care possible. As trusted public health workers and culturally informed liaisons working in the community and on the front lines, they create connections among Members, care coordinators, case managers, the health care system, Community-Based Organizations (CBOs), and other social support Providers. We currently use and employ two types of CHWs:

In Kansas we meet Members where they are. We prioritize hiring bilingual CHWs—75% of our Kansas CHWs are bilingual, speaking both Spanish and English. 100a.KS23

Embedded CHWs serve a large portion of their time on-site at one of the Certified Community Behavioral Health Clinics or Licensed Community Mental Health Centers that we partner with in Kansas. CHWs must be woven into the fabric of our health care delivery system to unlock their full potential. Co-locating CHWs in Provider practices builds a critical relationship that serves to close care and resource gaps for Members. **They will be physically on-site within two regional community mental health centers** providing services to Members in person and through virtual and telephonic outreach.

Non-embedded CHWs support Members directly throughout their communities and collaborate with CBOs, faith-based organizations, and Providers. Our CHWs must reside in the communities they serve giving them the unique ability to not only understand the needs of their community but to identify resources and where they are most needed. They will support our care managers by being the person-to-person contact that assists Members with finding Providers for mental health or SUD treatment, applying for internet assistance, WIC, or other vital resources.

Our embedded and non-embedded CHWs, as part of our **One Team, One Member** approach, work closely with physical and behavioral health staff, Providers, Members, and the community daily. They participate in case round meetings and multidisciplinary care team meetings for targeted Members to provide feedback on what may be happening within the Member's community that could potentially be impacting the care they receive. CHWs share Member needs and SDOH concerns that they discover through their work within the community. **For example, CHWs successfully helped Members in need of shoes and clothing access the United Methodist Open Door Ministries (Open Door) for those necessities.**

We also have integrated a CHW representative as part of our Quality Management Oversight, Health Equity, Member, and Provider Advisory Committees. Further, our weekly CHW meetings are attended by our team of specialized behavioral health care coordination managers, clinical managers, medical directors, and other Aetna leadership. This constant cross-departmental collaboration allows CHWs to provide seamless continuity of care coordination where invested entities work together to provide the best quality of care for our Members.

Increasing statewide education and awareness about the roles and benefits of CHWs is critical and we have developed a strategic statewide campaign to highlight how CHWs can improve community health across Kansas in a way that is sustainable, impactful, and tailored to the

diverse needs of Kansas communities. Through provider relations materials and things like business cards, CHWs can leave an imprint of their capabilities with Members and Providers. Our approach promotes CHWs to a target audience of community organizations, Providers, faith-based organizations, and directly to Members. Our campaign will deliver information about the roles and responsibilities of CHWs and feature success stories and testimonials from around Kansas.

Partnership Testimonial

The connections that COPE CHW has been able to build and share with clients at KU Medically Complex Clinic (MCC) have been great and continue to grow. From CHW connections with other MCC team members and support services for clients in Sedgwick County, Kansas as well as others surrounding counties. For example, a five-year old male client of McPherson, Kansas, travels with his parents to the KU MCC in Wichita, Kansas. His parents were able to complete an intake assessment with the CHW during his appointment and discuss SDOH resources for the family and household. With the help of the Aetna CHW, the boy's parents were able to connect with additional services with COPE partners at Heart spring Occupational Therapy as well as get assistance with IDD Waiver application and program sign up.

146b.KS23

CHW Expansion

We will continue to grow our existing CHW program to connect Members to the assistance they need. **By January 2025, we intend to grow our staff to have 10 CHWs throughout Kansas.** As our CHW team grows, we will continue to refine their roles to include targeted responsibilities in alignment with KanCare 2030 goals around tobacco cessation, maternal health, and obesity.

Frontier Regions. Kansas has a unique, large geographical region. With this population in mind, in 2024 Aetna will be launching our Advancing Rural Communities (ARC) program to promote the Affordable Connectivity Program. Our CHWs are vital in growing the ARC program by referring, and helping Members apply, for the Affordable Connectivity program to improve their ability to access and afford broadband internet for telehealth and other essential digital services. The CHWs that help Members with this process will gather data and insight into connectivity gaps and can provide this information to help grow Aetna's strategy for reaching rural Members. For example, in Liberal County, based on data we gathered, we were able to develop a plan to create a dedicated telehealth space for Members to circumvent connectivity issues.

Tribal Nations. Community Health Representatives (CHRs), who operate much like CHWs, have proven to be essential in building relationships with Indigenous communities. As liaisons, they work exclusively in their own community, understanding the unique culture and health care needs of their population. Because CHWs/CHRs have a strong emphasis on culturally relevant health education, they play a key role in preserving and integrating traditional health care practices with modern medicine among tribal Members. During 2023, our CHRs began attending Tribal Nations and Foster Care Contractor meetings (connecting the Prairie Band Potawatomi Nation, Sac and Fox Nation of Missouri in Kansas and Nebraska, and Iowa Tribe of Kansas and Nebraska). Our goal in joining these meetings is to build upon our current relationships with the Tribal Nations and offer culturally sensitive support and additional CHRs to support Members with care management. By working directly with the existing CHRs in the tribal communities, we can work together to close care gaps and develop system improvements in a culturally competent manner.

Path Forward, Continued Program Support and Growth

Technology and Resource Support. To augment our team and unlock their full capabilities, we provide our CHWs with necessary technology, like tablets, for data collection, Member tracking, and access to Aetna CVS Health's proprietary Community Resource Directory (CRD). The CRD is an easy to navigate system with more than 15,000 resources. As a nationwide directory of CBOs and agencies providing services that can help address Members social care needs, the CRD helps CHWs quickly address real-life needs of our Members**.** From helping find school supplies through various back to school drives, to sharing about the Table of Hope Thanksgiving Dinner in Wichita, to the Catholic Charities Shining Star program in Kansas City, to the United Way of Douglas County Mengel Free Pool Pass program, the CRD helps connect members with culturally sensitive and community-based support groups. It also can help CHWs find area Providers to address Member physical and behavioral health needs. From Alcoholics Anonymous to the Willow Domestic Violence Center, which provides support for women and Trans individuals experiencing domestic violence in Lawrence, Kansas, we have Members covered.

Partnership with Community Organizations - Community Engagement & Feedback

We offer targeted CHW outreach and services to Members that meet state contract requirements and plan level care coordination protocols. Our CHWs work alongside Members, Providers, caregivers, health system supports, CBOs, and Aetna and CVS Health resources to identify solutions to barriers associated with SDOH, while addressing chronic conditions, behavioral health, and functional needs for Members. Currently, we have a CHW embedded with the mental health and substance use program, COMCARE of Sedgwick County, and the Johnson County Mental Health (JOCO MH), with plans for expansion in number of CHWs at each location and a move into other locations. Our CHWs currently focus on adult medical services and medication adherence, with an emphasis on SUD treatment compliance, connecting Members to Aetna services (through transportation, attending doctor appointments with Members), making appointments, applying for food and housing assistance, and providing care coordination.

Socializing our CHWs' capabilities to our community partners and Providers requires a multipronged approach—it is the first step in creating a successful, health equity focused CHW program. Embedded CHWs support our partners by conducting regular outreach to the Member, including home visits, to provide education, identify barriers and SDOH, link the Member to needed community services, and assist with transitions. These tasks are monitored, by volume, on a weekly basis. They collaborate to review the Member's progress and address additional actions if needed. Our CHWs work with our partners to make sure Members receive necessary preventive services, coordinating both behavioral health and physical health screenings. Building on these relationships, **CHWs become valuable partners to Providers.** As our relationships with organizations like JOCO MH and COMCARE grow, a future endeavor is to expand CHW capacities to crisis services, child and family, and foster care populations. In 2025 we aim to hire six additional CHWs to address rural disparities and assist in the transition of Members from integrated care management to waiver/LTSS services.

Non-embedded staff forge relationships with local community resources, such as school systems, food pantries, homeless shelters, and other groups serving their communities, as well as key stakeholders, and Providers. To confirm that the community is aware of our local social support resources, our CHWs collaborate with Aetna resources that are focused on enhancing the Kansas

system of care. These include our Care Advocate Team and the Community Collaboration and Real Engagement Solutions (CARES) team who work in tandem to drive SDOH priorities in Kansas and build relationships with organizations and systems to create a sustainable social safety net.

Working Together to Grow Partnerships

Members are easily connected to things like a local food pantry and meal sites. Our Medicaid and Medicare teams work together to have booths at local organizations. CHWs work with our Community CARES team to help Members connect to these services. **Recently, we partnered with Open Door to serve more than 100 Kansans with food boxes.** Our connections to organizations like these are what allow us to reach out and help Members everywhere.

Making Headlines

Aetna took a significant stride this year in community well-being through a transformative partnership with Wyandotte County. We recently joined forces with local initiatives to distribute free food boxes, benefiting families in Wyandotte County during this Thanksgiving season. This impactful partnership reflects Aetna's commitment to addressing community needs, promoting health, and fostering resilience. By actively participating in local efforts and promoting those efforts through our CHWs, Aetna demonstrates its dedication to creating a positive impact in Wyandotte County, illustrating a shared vision for a healthier and more vibrant community. 146a.KS23

Better than the Rest

Richly Staffed with Collaborative CHWs and Licensed Clinicians. CHWs are vital for the health outcomes of any MCO's Members. However, CHWs on their own are not enough to sustain and support Member's needs. **Aetna is proud to go beyond emerging industry trends, our CHWs collaborate and partner with the Clinicians to provide true wraparound care and support for both clinical and social needs. This staffing choice allows our CHWs to focus on reducing barriers associated with SDOH and addressing unmet critical social needs.** We wrap around and collaborate with our Members and provide strengths-based goals setting.

b. Roles and Responsibilities

CHWs play crucial roles in the lives of our Members and in the Medicaid program by serving as the bridge between health care systems and communities, especially in underserved areas. CHWs play a vital role in the following ways:

1. **Outreach and Education:** CHWs provide health education to Members about preventative care, chronic disease management, nutrition, and healthy lifestyle choices. They also conduct outreach efforts to raise awareness about available services and local resources that are available. **Each month CHWs have a special focus for education and outreach to Members, Providers, and CBOs.** In December 2023, our focus was on the flu vaccine. CHWs worked with Members and Providers to coordinate the vaccination of vulnerable Members.
2. **Navigation Support:** CHWs assist Members in navigating the health care system, including understanding their Medicaid benefits, finding health care Providers, and scheduling appointments or rides to get to appointments. Additional resource navigation is provided around critical social gaps.

Navigating Critical Social Gaps

Aetna CHWs have assisted 8,490 Members with access to food delivery, clothing, education, telehealth, transportation, cellphones, and internet. 122.KS23

3. **Advocacy:** CHWs act as advocates for our Members, making sure their voices are heard and they offer tools and knowledge directly to Members so they can advocate for their health needs. **As participants in our Member Advisory Committee, CHWs can bring up concerns for local Members. Recently, a CHW was able to bring information on the closure of a homeless shelter to the meeting and we were able to help Members experiencing homeless find new shelter before it closed.**
4. **Cultural Competence:** CHWs bridge cultural knowledge gaps by providing appropriate education and advocacy efforts to Providers. By living in their communities, they recognize the cultural and social characteristics of the community they serve and build direct intentional awareness around these elements for Providers, and within our own organization. **Members and Providers need CHWs who understand them. Because of this, we prioritize hiring and currently employ, bilingual CHWs.**
5. **Data Collection:** CHWs gather data on community health needs, and the effectiveness of health programs. They support the completion of surveys, focus groups, and community assessments. They bring all this feedback back to our organization for inclusion in our quality programs, our clinical model, and to our Leadership team. They operate bidirectionally, and share key findings with Providers and CBOs to confirm broad based knowledge and alignment of Members' needs or community gaps.
6. **Building Relationships and Eliminating Barriers:** CHWs establish strong relationships with local Providers, faith-based organizations, community organizations, and key stakeholders. **Through attending events held within local communities that give back and link Members with services that help them meet their basic needs and promote social connectedness where they live, CHWs maintain robust networks** in their communities of resources that can support a variety of needs. These relationships also promote health equity and eliminate barriers in access to care. **We have built relationships and connections with organizations by attending and participating in events such as preparing meals for families staying at the Ronald McDonald Houses in Kansas City, donating clothes to the Klothing Kloset in Wichita, and giving out shoes at Shelter KC's holiday event for individuals experiencing homelessness.**

CHW/CHRs identify Members through data-driven deployment. We engage Members immediately by reaching out via phone, or if in an embedded institution, in person. **As part of the Clinical team, CHWs document, monitor, and evaluate the outcomes for each of their engaged Members—we do this using our Clinical Documentation System.** Documentation is incorporated within the standard clinical care workflow.

Training and Education

We provide consistent, high-quality standards for CHWs and use a standardized, state-accredited training program for our CHW team because we know that getting the basics right is critical. **We leverage the expertise of our entire organization to deliver the necessary training and continuing education to help our CHWs be prepared for any role they may need to fill.** Based on requirements, 100% of our CHWs obtain certification from the State or the National Community Health Worker Training Center at the time of hire or within 12 months of their hire date. **All our current CHWs are certified or are on a path to certification.** We provide core training in a variety of modalities including instructor led training, virtual instructor led training, and asynchronous courses, such as:

- Cultural Competencies and Health Equity
- Adverse Childhood Experiences and Resilience: The Biology of Stress and the Science of Hope/Trauma Informed Care
- Charting the LifeCourse™
- Core CHW Training Courses (Introduction to CHWs, Care Management Foundations)
- Motivational Interviewing
- Tobacco Treatment Education through University of Kansas (Tobacco Treatment Specialist Training, Tailored Trainings for Tobacco Treatment, and Tobacco Cessation Support Training)
- Youth and Adult Mental Health First Aid Certifications

For training and development purposes, **CHWs go through four mock audits in their first two months: two documentation and two observational audits with a score requirement of 90% or above.** Failure to meet this goal results in a Performance Improvement Action Plan (PIAP) to bring CHW performance to a place that fully meets Member needs. **We are proud to have no CHWs on PIAPs, as they are effectively managing their workloads and providing positive outcomes to Members.** Weekly team huddles allow supervisors to continuously monitor and identify areas for personal and professional development, which happens in real time.

Ongoing Professional Development

Continuous growth and development. We foster our CHWs by providing multiple training opportunities (tobacco cessation, etc.), networking opportunities, and care advancement pathways. Additionally, we fund our CHWs' Community Health Worker and KSCHW certifications.

Attrition Rate. Since 2023**,** our CHWs have a 0% attrition rate. We are proud of our employee development program's focus on employee well-being and professional growth.

c. Measuring, Monitoring, and Evaluating CHW/CHRs

We believe in a data-driven impact assessment for our CHWs. As important parts of the Kansas health care systems, we know we must measure, monitor, and evaluate our CHWs' effectiveness in fulling their roles and responsibilities. Monitoring CHW/CHR measures of effectiveness and engagement is incorporated into our standard workflow and tracked in our Clinical Documentation System. We have implemented a system of tracking and analyzing key metrics defined in the following table.

CHW Intervention	Outcome Measurement
Contact the Member and/or guardian to complete the Health Screening Tool (HST)	Members identified for CHW engagement will have completed the HST within 14 days of CHW engagement unless already completed due to open episode.
Develop Service Plan with Members	A service plan is developed for Members assigned to service coordination and support level of care coordination to assist with non-clinical service coordination and support needs. This level of case management is intended to be short in duration, no longer than one to two weeks, and is to be managed by CHWs.
Educate Members engaged in CHW services on appropriate	Decrease by 2% annually the number of Emergency Department (ED) and inpatient encounters for Members engaged in CHW

CHW Intervention	Outcome Measurement
level of care, importance of PCP relationship, and alternative resources	services and the number of ED encounters for Members identified for CHW engagement and services from baseline.
Complete Health Care Equity Contact Assessment (in addition to other screeners as indicated within two weeks of the outreach questionnaire)	• Increase one to two community resource or referrals events for each Member • Improve Member connection with community resources to address needs and reduce barriers to needed services and educate Members on services available in their community to improve Member health.
Face-to-Face Visit	• Conduct at least one Member face-to-face visit during the CHW engagement period, in a location of Member preference and convenience. • Develop rapport with the Member in their environment, facilitating understanding of the Member's inequities, barriers, challenges, and needs.
Member Education	• Increase materials requests by one to two during the CHW engagement period with CHW as primary or secondary owner. • Provide Member education to promote health literacy.
Address Gaps in Care	• Address all Gaps in Care identified in the episode. • Address HEDIS gaps in care facilitates by proactively managing Member's health, early detection of health issues, improved health outcomes and Member literacy, and preventative health care. • Increase <2–5%> annually HEDIS state performance/incentive measures for Members engaged in CHW services from baseline.

Our operational model includes weekly team huddles, where the team collaborates and problem solves ways to partner with our Members and Providers to overcome barriers and improve access to care. Our weekly CHW meetings, led by our Clinical Health Services Manager, Jillian Fitzmorris, alongside our interdisciplinary care team meetings, provide the discussion and information needed to quickly address knowledge gaps of CHWs and increase understanding and ability of CHWs for cross-functional team support. Supervisors conduct frequent documentation and observational audits to make sure we accurately measure, monitor, and evaluate our team's success and developmental needs.

Topic Area 3: Integrated, Whole-Person Care

9. Describe the bidder's top three (3) strategies for advancing integrated, whole-person care for its KanCare Members and how the bidder will measure, monitor, and evaluate the effectiveness of the strategies.

Aetna top three strategies for advancing integrated, whole-person care have a Member, Provider, and community focus led by local Aetna staff in Kansas. We define integrated, whole-person care as the **coordination and service delivery model for a holistic, person-centered approach addressing Physical Health (PH), Behavioral Health (BH), long-term, dental, pharmacy, and socioeconomic needs of Members.** We incorporate health equity principles, including making certain individuals have a fair and just opportunity, to be as healthy as possible. We also promote the delivery of integrated services through a specially designed operational structure that includes all key functional teams internal to Aetna, and external professionals and Providers of all types focused on the same objectives.

Our top three strategies for advancing integrated, whole-person care are:
1. **Deliver an end-to-end Care model** featuring population health-wide strategies, identification of SDOH needs, offering wraparound support and services, and interdisciplinary case rounds
2. **Expand Value-Based Purchasing (VBP) and provider incentives** to improve outcomes
3. **Strengthen our Community Development program** with local connections to address Member and community needs focusing on nonmedical factors that influence health outcomes

Since 2019, we have **met with over 143,000 Members, prospective Members, and community residents** (as reported annually to the State) in Kansas to obtain feedback, educate about benefits and services, and learn more about community-based organizations' capacities, services, and opportunities for community investment.
134f.KS23

As an incumbent KanCare MCO, we recognize providing high-quality, integrated, well-coordinated, and cost-effective services is a journey that evolves over time. Our understanding of KanCare populations, the State's geography as it relates to access to care, and the complexities of the Provider and health care systems inform our top three strategies in alignment with KanCare goals for advancing integrated, whole-person care. We use data-driven, rapid-cycle system transformation to measure, monitor, and evaluate the effectiveness of our strategies and adjust them to make sure they are as impactful as possible to the overall mission of advancing integrated, whole person care for KanCare Members.

Strategy 1: Advancing Integrated, Whole-Person Care

Aetna's 5-year tenure as a KanCare MCO has enabled our health plan to develop—and continually improve, expand, and diversify—a comprehensive, localized **end-to-end Care Model** that addresses the needs of Members at both the population health level, and through targeted one-on-one interventions. Our approach improves the Member experience, satisfaction with the KanCare program, and results in improved overall health outcomes. Our model is focused on holistic care to Members recognizing the impact of SDOH; educating, engaging, and empowering Members to personally define their health and wellness goals; and providing appropriate levels of person-centered care coordination. Our model is built on the following strategic approach:

- Deploying **population-wide health strategies** focused on identifying health gaps, access to care issues, and deploying strategic interventions to address those gaps
- Conducting **interdisciplinary case rounds** that address all aspects of a Member's integrated, whole-person care
- Applying **continuous process enhancement built** on quality improvement principles and incorporating Member, Provider, and stakeholder feedback

Population Health-Wide Approach to Advancing Integrated, Whole-Person Care

In 2019, we reviewed all clinical information, claims data, authorization data, and prescription data available to us to develop population health strategies aimed at advancing whole-person care, because we believed that medical and behavioral health integration was the key to improved health outcomes for Members. However, we now know that clinical data alone is not enough. As a result, in 2022 we began **capturing information about nonmedical factors that influence a Member's overall health** status recognizing this is a vital set of factors that we must incorporate in our overall approach to advancing holistic, whole person care. We recognized **we cannot operate an end-to end Care model without reliable information and understanding a Member's social context,** which we now use as foundation for all our activities.

To make certain we have robust data, starting in 2022, we **incentivized Providers through VBPs to capture and share Z Code information.** Additionally, we now leverage the power of Socially Determined (SD), a platform designed to analyze social factors at the ZIP code level by integrating and analyzing a wide-range of data sources, including clinical data, social and economic data, and community-level information. SD offers insights and guidance on where we need to develop strategies to address health disparities across Kansas, which our teams routinely review. For example, an **analysis of our Z Code and Community Resource Directory (CRD) data showed that food insecurity was both a top Z Code submission** and the most frequent referral request in our CRD for the Wichita area. We hosted a Community Health Council of community leaders in Wichita and worked together to **manage the sustainability of community refrigeration systems to provide access to perishable items** for those facing food insecurity.

Going forward, we are launching our **Member Real Engagement and Community Help (REACH) team, which is an SDOH call center that addresses Members' social needs.** The Member REACH staff have lived Medicaid experience: they have received Medicaid benefits and services or have been a caregiver for a family member enrolled in Medicaid. This team, which will be locally based and staffed by Kansans, with a target launch date of Jan. 1, 2024, uses social risk analytics and claims data, as well as data received from health information exchanges to proactively identify and contact Members at risk for SDOH needs.

The Member REACH team meets monthly with our Kansas-based **Community Collaboration and Real Engagement Solutions (CARES)** team to review call center data, which in turn drives new and innovative SDOH and health equity programming. Our Community CARES team leverages this data, along with Z Code data and our internal social risk analytics, to build community collaborations and investment strategy. For example, our affiliated Florida plan **analyzed internal risk analytics and learned that health literacy was a significant barrier** in Miami-Dade County. To deepen our understanding of Member needs, we reviewed our Member REACH team data and learned that 30% of all referrals for Members living in Miami-Dade County were related to health literacy, with a majority of these Members requesting information

and resources around perinatal health. This **analysis drove strategic investments and partnerships in the area** with organizations such as Metro Mommy Agency and March of Dimes-South Florida to support their health literacy education.

Member REACH facilitates a closed-loop social referral process through our CRD, which includes more than **15,000 Kansas resource listings,** to connect Members with the necessary resources to address the gap. If a Member has four or more SDOH needs, they are warm transferred to our Care Coordination team for immediate assistance and risk stratification.

We recognize the importance of including SDOH-related factors in our risk stratification tool. [redacted] We can map risk down to within one city block and overlay multiple data sets, such as Member addresses, Provider offices, grocery stores, and existing community resources. If we identify a major gap for Members in an area, we initiate community development efforts to partner with community organizations to help close the gap.

[redacted]

We use our **Clinical Documentation System to store risk stratification data and share it among our care teams and with Provider.** We do not share the risk stratification level with Members. However, when engaged with a Member, the Care team highlights that they have been identified as having a need that care coordination could address. A Member can be high risk for a multitude of reasons. **Care coordinators work with Members to understand their needs and help them overcome barriers by creating a comprehensive care plan that fits their needs and addresses the risk factors.** Additionally, care coordinators educate Members on clinical information, such as the importance of having an eye exam in diabetes management, especially if the Member has no vision issues.

Interdisciplinary Case Rounds Used to Advance Integrated, Whole-Person Care

Our person-centered approach to conducting case rounds is a prime example of our commitment to delivering integrated, whole-person care with local Aetna staff. Members benefit from our approach through expedited coordination and delivery of services, increased service options, and access to Providers, including telehealth solutions and out-of-network Providers. Our care coordinators, Community Health Workers (CHWs), and SDOH support staff all collaborate to identify, assess, engage, and coordinate services for PH, BH, and SDOH needs to close gaps in care, and drive Member engagement in their journey to better health. Members meet with their care coordinators as part of the rounds continuum to discuss their goals and care plans.

Members are referred for case rounds by a variety of sources, including the State, hospital transition staff, and internally from Aetna medical directors; staff from UM (including concurrent review nurses), care coordination, and LTSS; and our BH clinicians. We identify Members at-risk through Member interventions, claims review, Prior Authorization (PA) requests, and electronic,

Since initiating case rounds in 2019, we have led over **370 case reviews resulting in positive Member outcomes,** ranging from increased independence, to improved management of disease states such as diabetes. 169a.KS23

Admission, Discharge, and Transfer (ADT) alerts. About **90% of Members reviewed have SDOH needs.**

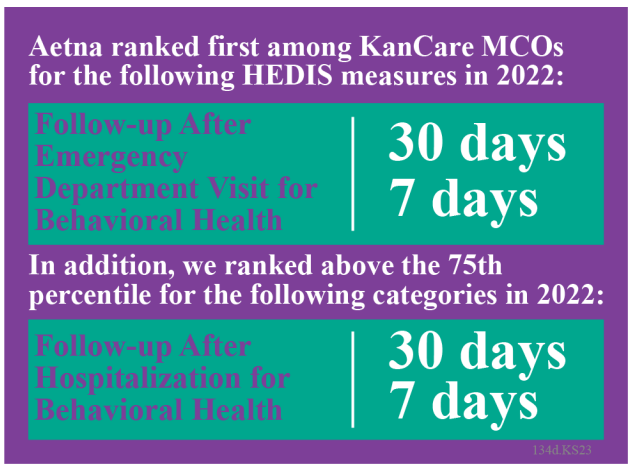
During rounds, we engage an interdisciplinary team with subject matter experts who are familiar with the community and Kansas resources, and we include Providers in Member review discussions when appropriate. Aetna's Transition of Care Specialist, Susie Robinson, facilitates the discussion. These highly integrated, interactive groups number upward of 20 Aetna staff and include PH and BH medical directors, LTSS directors, clinical care coordinators, BH care coordinators, UM clinicians, care advocate specialists, SDOH manager, and CHWs. They comment on cases from their area of expertise while accounting for the Member and family's voice and choice in alignment with our person-centered, culturally responsive approach to care. This interdisciplinary approach to problem-solving provides ideas and service options for Members that care coordinators would otherwise not have access to. We document meeting minutes that can be reviewed securely online by the interdisciplinary team, and care coordinators document next steps, review, and follow-up activities in the Clinical Documentation System.

We continuously review our end-to-end Care Model for improvement and opportunities with a strong commitment to being flexible and testing new strategies to find what works. For example, based on provider feedback, we recognized that we must improve our communication and supports to our hospital partners. As a result, we embedded care coordinators directly in Kansas hospitals (including Ascension Via Christi and the University of Kansas Hospital), and further embedded CHWs in Certified Community Behavioral Health Clinics CCBHCs). This approach provided much needed additional support for Providers through improved communication and data sharing. To keep the momentum, we initiated weekly meetings with 3 additional hospitals to identify Member cases early and address the Member's needs. **We expanded the program to nine hospitals because of strong outcomes and positive feedback from the Providers.** We also initiated **a similar approach with Community Mental Health Centers (CMHCs)** and revised processes for earlier engagement to support them in providing the right care, at the right time to our Members.

Our strategy over the next two years focuses on deploying more CHWs in Kansas communities and increasing the number of embedded care coordinators with support of CHWs to engage the homeless population. By January 2025, **we intend to expand our staff to have 10 CHWs throughout Kansas.** Our data shows that **CHWs have engaged with approximately 450 Members** in multiple Aetna Medicaid plans and saved our organization $1.5 million, with the largest portion of the savings coming from reduced inpatient costs.

Monitoring, Measuring, and Evaluating our Local End-to-End Care Model

We monitor the effectiveness of our model using business intelligence reporting and dashboard capabilities that inform Aetna leaders, the chief medical officer, medical directors, and every area of our Medical Management and Quality Management (QM)



teams. These capabilities support summary-level data details of Key Performance Indicators (KPIs) and drilldown capabilities for more actionable operational information. These dashboards and reports include UM; QM; population health; clinical operations; health equity; maternity; Z Code; and CRD referrals. We track case rounds and transitions of care as part of monitoring.

Our strategic approach to improving health outcomes for Members is based on continuous quality improvement, which is a defined process focusing on activities that are responsive to community needs, population health improvement, and health disparities reduction. We apply the Plan-Do-Study-Act model for focused process and performance improvement activities. This enables us to develop targeted, measurable interventions, including **rapid-cycle improvement,** to quickly evaluate the impact of an activity on our improvement goals and our KPIs. For example, we know that our **embedding model in hospitals is working, because our data has shown a 17% decrease in the average length of stay, while readmission rates have held steady.** Co-location with Providers gives us a unique opportunity to support timely and effective discharge plans and transitions to appropriate levels of care.

We use monitoring tools such as dashboards and reports to review and analyze care coordination outcomes. For example, care coordination enrollment for Members with serious mental illness (SMI) increased by 128.7% from July 2021 to November 2023, and active care coordination engagement (regular two-way in person/telephonic/virtual communications) for Members increased by 112.1% from July 2021 to November 2023.
134g.KS23

Strategy 2: VBP and Provider Incentives

Aetna uses VBP strategies and Provider incentives as key components to advancing integrated, whole-person care by creating clear incentives for Providers to address the holistic needs of Members through targeted financial arrangements, where success is measured by improved Member outcomes. We have been offering VBP arrangements in Kansas since 2019 and we offer both a robust **Pay-for-Quality program, and a more comprehensive shared savings model for Providers interested in expanding their capabilities.** We are continually evolving our VBP models to target priority populations, including Members with long-term needs, and Kansas Department of Health and Environment (KDHE) goals. These include improving health outcomes through integrated, whole-person care and reducing health care disparities, while growing the ability for Providers to take more risk and earn more financially.

Since 2020, we have **paid $1.36 million in value-based payments to Kansas Providers** in various VBP arrangements, and **100% of Kansas PCPs are eligible for our flagship VBP program, Healthier Outcomes, including FQHCs and local health departments.** Our VBP program encompasses PCP, BH, and LTSS Provider types and prioritizes all Members receiving services from those Provider types, inclusive of children, Members receiving LTSS services, individuals in foster care, and those receiving BH services. We link priority populations to anticipated outcomes using standardized quality measure sets and nationally accepted strategies for measuring changes in utilization and overall cost of care. Our VBP measures match KDHE priorities promoting integrated, whole-person care and were approved by KDHE. **One hundred percent of our Members that seek care from a PCP are included in the program.**

In the past three years, we have observed an **exponential increase in the number of Providers advancing from the deemed program to higher level VBP programs** with more accountabilities. As we achieved this quantitative evolution of Providers' involvement, we also

observed that VBP Providers are making significant improvement in key quality measures compared with non-VBP Providers. For example, in 2022, Providers participating in advanced Healthier Outcomes Health Care Provider-Learning Action Network's (HCP-LAN) APM category-3 and above VBP arrangements showed better quality of care results than Providers in the baseline Healthier Outcomes HCP-LAN category-2C VBP arrangements. The table below shows the difference in performance between the baseline and advanced Healthier Outcomes.

Measure	Baseline Healthier Outcomes 2022 Result	Advanced Healthier Outcomes 2022 Result
Attention-Deficit/Hyperactivity Disorder Medication Initiation	37.5%	59.2%
Well-Child Visits	42.5%	44.7%
Follow-Up Care After Emergency Department (ED) Visit for Alcohol Use	16.5%	20.7%
Follow-Up Care After Visit for High-Intensity Care for Substance Use	38.3%	52.5%
Follow-Up Care After ED Visit for a Primary Mental Health Reason	58.6%	82.0%
Breast Cancer Screening	32.3%	37.3%
Timely Prenatal Care	34.2%	39.0%
All-Cause Readmissions	12.1%	11.0%

Healthier Outcomes is an evolving PCP program which addresses the quality side of the value equation, but also addresses Provider practice efficiency through reduced Emergency Department (ED) and inpatient utilization driven by timely preventive and chronic care. We offer the baseline Healthier Outcomes program to all PCPs, and they are deemed eligible for the program by virtue of being part of our network. Advanced versions of Healthier Outcomes program span the continuum of the HCP-LAN APM to include categories 2C-4B. The Healthier Outcomes program offers **additional earning opportunities for Providers when they demonstrate both efficiency and quality** and can advance along the APM continuum. In 2024, we will enter a **new iteration of the baseline Healthier Outcomes program, which will offer more support and structured incentives.** The table below describes our current programs:

Program	Description	Impact on Advancing Whole-Person Care
Healthier Outcomes	Our VBP program designed to incentivize PCPs and offers payment arrangement in various HCP-LAN categories from 2C to 4B.	By promoting preventive care, we drive member engagement in their overall health journey, with engagement leading to increased gap closure in clinical and non-clinical needs that contribute to overall quality of life.
Pediatric Care Network (PCN)	Capitated risk agreement with Children's Mercy Integrated Care Solutions (i.e., PCN) to delegate services, such as medical	As our flagship capitated arrangement, we work with PCN to advance quality outcomes for

Program	Description	Impact on Advancing Whole-Person Care
	management, utilization review, concurrent review, and discharge planning to PCN.	the population they provide services with significant pay-for-performance obligations.
Better Value, Better Care	We engaged KidsTLC, of Olathe, as our partner in this VBP pilot program to open a new avenue of rewards for BH Providers specializing in pediatric BH care. KidsTLC supports children and families who are facing challenges of mental and BH, developmental trauma, and autism spectrum disorder. The objective of the program is to invest in successful transitions for children from inpatient settings back to the community and home.	Targeting the emotional needs of our pediatric population, this program advances whole-person care principles by effectively transitioning children to the least restrictive, therapeutically appropriate settings where they can find pathways to a healthier adulthood.
Employment Support Program for Members with IDD	This 2024 program supports LTSS Providers serving an IDD population with pay-for-performance measures that enhance successful employment opportunities for Members with IDD so they can gain social and economic capability as part of the Employment First State mandate. A secondary objective is to reduce ED and urgent care visits due to improved quality of life.	Recognizing that employment is a key goal of many of Members in the IDD population, we developed a program aimed specifically to addressing this key quality of life need.
CARE/CARE+	We executed a VBP model with Wheat State Healthcare, an Independent Practice Association (IPA) for Kansas CMHCs. The program's objectives include reducing the silos between PH and BH services, increasing the use of Z Codes to capture and act upon health disparities data, and incentivizing the CMHCs for their contributions that move Members to permanent employment and housing.	Z Code reporting further bolsters our understanding of factors related to SDOH increasing our ability to offer comprehensive population health-wide solutions.
Better at Home	We have developed several customized VBP models for HCBS agencies based on population needs and the Provider landscape within Kansas.	By incentivizing focus on the key element of housing, we incentivize Providers to consider holistic Member needs, and goals.
Holistic Health Care Coordination	We have designed a VBP model for Providers offering intensive case management that provides a high capitation payment for case management efforts along with a withhold for achieving performance standards.	Additional targeted case management support at the community levels allows our Members to realize all their goals and objectives on their journey to better health.

Measuring and Monitoring the Effectiveness of VBP Initiatives and Outcomes

We measure and monitor the performance of our VBP programs through the lens of positive Member outcomes and alignment with our goals of advancing holistic, whole-person care. Specifically, we review Provider practices and assess whether they have the right infrastructure in place to support a risk-sharing arrangement, including ability to share data effectively and monitor quality outcomes at the individual Member level. Additionally, as part of our review, we assess their past performance relative to Member outcomes, including the medical loss ratio of Members they service. We also review their overall operational consistency, including timely submission of accurate claims, ability to deploy system changes resulting from regulatory updates, and their submission of records through the HEDIS project process. We closely monitor and measure their performance through HEDIS outcomes and CMS core measures performance, and review whether they effectively and consistently collect SDOH data via Z Codes.

We incentivize the use of Z Codes with Providers by reimbursing $10 for Tier One codes, $5 for Tier Two, and $1 for Tier Three Codes. Providers may bill for a particular Z Code once a year per Member. Tiers and correlating payments are based on the type of SDOH need. We are making changes to our program based on Provider feedback and data analytics, in alignment with the KanCare goal of using cost-effective strategies to improve health outcomes and the service delivery system. 134e.KS23

At the individual arrangement level, Aetna monitors each VBP program for effectiveness and shares information with Providers as part of a dynamic monitoring process so both parties can track progress toward payment goals. The table below describes the standard reports we review and Providers in VBP arrangement receive.

Report	Description	VBP Model	Frequency
Pay-for-Quality Performance	Provider performance profiling at the organizational, group, and individual Provider level. Includes Member-level gaps in care for quality measures.	Baseline Healthier Outcomes, Advanced Healthier Outcomes, Shared Savings, and Shared Risk	Monthly
KPI (Inpatient/ED)	Insights on utilization performance at the organizational, group, and individual Provider level	Advanced Healthier Outcomes, Shared Savings, and Shared Risk	Monthly
Shared Savings Reconciliation Report	Insights on utilization performance at the organizational, group, and individual Provider level, including medical loss ratio	Shared Savings and Shared Risk	Annually

We introduced further enhancements in 2023 that support additional reporting from Stellar Health software and the Availity provider portal. Claims reports allow us to observe overall Provider trends benchmarked to similar Providers in Kansas, as well as Aetna Medicaid's Providers nationally. We do this at both the specialty and Provider-type level.

To support ongoing process improvement, our Quality Practice Liaisons (QPLs) and Provider Relations Representatives (PRRs) check in with practices to share their outcomes relative to their VBP arrangement goals. We monitor the overall pace of improvement and growth in

technological and financial capabilities. Additionally, we **host joint operating committee meetings for Providers** that are in shared risk arrangements to share data, eliminate barriers, and mutually agree on measures and evaluation strategies. Aetna's quarterly **Health Equity Council monitors quality metrics to identify breakdowns by different regional, racial, ethnic, and linguistic categories.** This perspective allows us to monitor the impact on VBP and quality targets and adjust specific VBP contracts as appropriate.

Evaluating the Effectiveness of VBP Initiatives and Outcomes

We monitor the effectiveness of our VBP arrangements in advancing whole-person care by reviewing outcomes measures specific to the program. We perform a formal evaluation before each payment opportunity to calculate earnings against the program measures in the arrangement. For example, we focus the evaluation of the arrangement/program on following aspects (which are all necessary elements in an effective whole-person care strategy):

- **Increased Equity:** HEDIS measures are reported by ethnicity, and we evaluate the Provider's performance across different ethnic groups and share any notable trends directly with the Provider as part of our commitment to closing gaps related to inequities. For example, with the VBP performance monitoring efforts, we have achieved improvement in the chlamydia screening for Black women, who are with the highest needs, in comparison with other ethnicity groups (53.80% for Black versus 40.87% for other ethnicity groups in 2022).
- **Increased Member Engagement:** Through trends in preventive screening and vaccination rates, we evaluate the effectiveness of Providers getting Members to respond to them, and engage in their care journey, which starts at prevention. For example, VBP Providers supporting Members had better HEDIS outcomes than non-VBP Providers in the following measures in 2022:
  - Child and Adolescent Well-Care Visits-Total: 44.7% versus 42.5%
  - Immunizations for Adolescents-Combination 2: 29.1% versus 26.2%
  - Lead Screening in Children: 49.1% versus 46.8%

Overall, program data is used to inform systematic analyses of the strategies included in the prospective KanCare contract, providing valuable insight into future strategies for improved clinical outcomes. As Providers succeed with a VBP arrangement, and with the updated contract requirements that allow KanCare MCOs and Providers opportunities to develop upside and downside VBPs, Aetna is excited to partner with Providers to expand their capabilities to advance to the next categories of the HCP-LAN framework.

Strategy 3: Community Development and Strategic Partnerships

Community development and strategic partnerships are the third key component in our overall strategy to advance integrated, whole-person care for Members across Kansas. Our community development strategy focuses on dedicated staff **identifying and supporting resource expansion for SDOH-related issues;** managing processes for **conducting outreach, hosting community events, and establishing community partnerships;** and making **strategic community investments** that address needs and support the goals of KanCare. We do these things because we believe that stronger, well-resourced communities are more able to support a Member's journey to better health, by helping close many of the SDOH-related factors that lead to severe health disparities. We believe healthy communities result in healthier people.

We work with Community-Based Organizations (CBOs) and other stakeholders recognizing they are an important health and social system partner providing direct services such as employment, food, transportation, utility assistance, housing supports, and other benefits to our Members, all necessary to the advancement of whole-person health. Through an earned understanding and a deep capacity for meeting the needs of Kansas' local communities, we have developed **relationships with over 900 CBOs** across Kansas. Our mission is to continuously deepen our presence in Kansas' 105 counties, with a particular focus on target populations.

We have advanced the people, processes, and technology guiding our community engagement approach since we began serving KanCare Members in 2019. For example, our **Community CARES** team was formed in 2022, taking a grassroots approach to building strong relationships with the leaders, organizations, and systems that support the SDOH needs of our Members.

Figure 9-1 illustrates the process framework for the Community CARES team. Our team augments social care data, helping us implement effective solutions for Kansas communities while also supporting Members with the most urgent social needs. We earn the trust of local partners by listening to and respecting each organization. These organizations have a deep knowledge of the communities, neighborhoods, and individuals they serve. The Community CARES team **attended more than 500 events** and meetings through November 2023 and achieved the following:

Figure 9-1: Community CARES Team Approach. *Our team provides strategic leadership in developing and strengthening community partnerships.*

- Shared vital **information on resource gaps** that we have identified across Kansas, efforts to engage in specific communities to close gaps, and Aetna tools that are available
- Identified **innovative ways to support local social safety nets** through strategic outcomes-based investments
- Worked with State and local leaders, Providers and health care systems, school systems, and other groups serving the community, in addition to CBOs, to **learn about needs and to educate about the KanCare program**

The Community CARES team attends statewide coalition meetings and **Community CARES Manager, Jaclyn Miller, leads the health equity strategic team of the Immunize Kansas Coalition.** The team focuses on expanding languages for communications and using videos to support communities and refugees in understanding vaccines.

In 2023, Aetna introduced **Community Health Councils (CHCs) in Ellis, Reno, and Sedgwick counties** (**Figure 9-2**) to create locally focused task forces of key stakeholders interested in promoting the overall health and well-being of their populations, as well as identifying and closing gaps experienced by Members living in those communities. Our CARES team attends each CHC to develop localized strategies and gain insight. CHC members, facilitated by CARES team staff, develop a project or program to help fill an identified social service gap using public health program planning and evaluation strategies. Together, the group identifies innovative ways to support the social safety net. For example, we have **promoted the use of Z Codes** and shared how they are captured in our claims processing systems. As the use of Z Codes becomes more prevalent, we will be able to analyze data to learn which SDOH needs are the most significant in specific communities. Our Community CARES team will share this data with CHCs, which will help them identify gaps in resources and develop solutions.

Figure 9-2: Ellis County Community Health Council. *The Ellis County CHC met in September 2023 to discuss community priorities and their council objectives. The CHCs typically meet monthly.*

Strategic Community Investments Address SDOH Needs in Communities

We have invested in resource Providers since 2019 and our **2023 budget alone for community investment was over $520,000.** Engaging and collaborating with SDOH resource Providers is crucial for our mission to close SDOH gaps. We have a targeted approach in our engagement strategy in which we network and build community partnerships, share data and information with CBOs, attend community engagement events, support joint funding/grant programs, engage in training opportunities, and provide tools to make informed decisions on resource allocation.

Our investment decisions, which seek to advance positive and holistic Member outcomes, are driven by two elements. The first is that we **employ data in our decision-making about reinvestment and participation** derived in part from the use of Z Codes. The second element is our company's belief that **investments must impact whole communities.** We believe advancement of whole-person care is a foundational bedrock need across the state.

Supporting Housing Initiatives: Since 2021 we have **provided the Kansas Statewide Homeless Coalition (KSHC) and others a $165,000 investment** to assist with housing initiatives. Our investment supports homeless prevention, housing navigation, and rapid rehousing, which includes past due rent, utility payments, housing application costs, deposits and short-term rental assistance, and assistance with applying for state and federal benefits. **Our donation helped almost 900 KanCare Members, including 242 Aetna Members, to navigate the housing and homelessness systems.** This investment was also used to expand KSHC information systems to allow for the capture of data for Aetna Members and the other KanCare MCOs.

Supporting Maternal Health: In 2023, Aetna made a **community investment of $150,000 to the Kansas University Endowment Association for their Baby Talk program,** a pregnancy

and newborn education program administered by the department of pediatrics at the University of Kansas School of Medicine-Wichita. The investment expands the program statewide, making Baby Talk available to all KanCare Members. Baby Talk's goals are to reduce preventable infant death, improve birth outcomes, increase the likelihood of a full-term pregnancies, and increase breastfeeding. **We have agreed to contribute another $150,000 in 2024.**

Baby Talk consists of six, two-hour classes with topics such as how to have a healthy pregnancy, infant care, and postpartum changes and concerns. The program is open to anyone who is pregnant and under 32 weeks of gestation. It was designed for women who may not otherwise have access to prenatal education. **Classes are available in English and Spanish,** and most are taught by labor and delivery nurses. Women who complete all six classes, plus pre- and post-assessments, receive an infant safety item of their choice, such as an infant carrier car seat, portable crib, or breastfeeding kit. Since its launch, Baby Talk has gifted over 1,500 car seats.

Community Events Provide Opportunities for Member Education, Engagement

Aetna participates in many activities statewide as part of our community development approach, including hosting and attending local health and resource fairs, presenting, and exhibiting at conferences, and sponsoring numerous community events where we provide Member outreach and education. These activities align with the KanCare goal of educating, engaging, and empowering Members to personally define their health and wellness goals. We **developed the Kansas Transition Conference** in partnership with Kansas Vocational Rehabilitation, KDADs, Kansas Council Developmental Disabilities, Kansas Youth Empowerment Academy, Families Together, Working Healthy, and other MCOs to address transition over the life span to include all ages and areas such as education, employment, housing, independent living skills, and transportation.

> **Aetna provides wonderful, local support. Even though Aetna is a large organization, I feel like they know the Community of Hope. Because of Aetna, for two winters now, we have had brand-new, heavy-duty coats and gloves for kids and adults to provide on a moment's notice. In addition, this past year we received a grant to support feeding those dealing with food insecurity in Leavenworth County. Aetna stepped up once again to fill the gap.**
> *– Leavenworth Interfaith Community of Hope*
> 056n.KS23

In Kansas, Aetna has a dedicated team of community outreach coordinators who are regionally based. Aetna is an active participant in the communities we serve, and we continuously seek meaningful community collaboration through engagement in events and sponsorships. We develop new relationships and opportunities with CBOs that support Members. We go beyond funding to build relationships that drive improved health outcomes that address SDOH needs.

Aetna's community development director works with community outreach coordinators to identify community events and sponsorships that align with KanCare's goals. The teams meet monthly to review the strategy and opportunities to engage. The community development director is responsible for vetting all events and sponsorships and bringing those of highest impact to Aetna's executive leadership for review and approval. Once approval is given, the Community Outreach team will work with the CBOs to finalize logistics.

We track and communicate with CBOs across Kansas using a customer relationship manager program. We pull email addresses from the system to announce or plan events by type of CBO,

by ZIP code, or by county. This helps us schedule multiple meetings and events around Kansas each month. At community events, we interact with current and prospective Members and provide information. We gain insight from their feedback about the KanCare program and educate them about local SDOH resources.

Measuring, Monitoring, and Evaluating the Effectiveness of our Approach to Community Development

We use a mixed-methods approach gathering qualitative data and using Member and Provider data and feedback to measure the impact of partnerships and community development efforts, as well as community events. When we develop a partnership with a CBO to address a social need we work with the CBO to develop a plan that includes improvement goals, an implementation timeline, data collection methods, and specific measurable outcomes relative to their domain. Following implementation of an initiative with a CBO, we analyze the data and compare the data against our anticipated outcomes. We work with our partner to disseminate learning, scale the initiative, or change the initiative to continually improve integrated, whole-person care outcomes. For example, when we provide investments relative to Member education, we work with the CBO to provide us a monthly report of how many Members they were able to work with, their locations, whether they are Aetna Members, and data indicating whether participants are completing the program 100% or dropping out early. In understanding these outcomes, we can tailor our future investment strategy to CBOs with the most promising outcomes.

The following examples demonstrate Aetna's commitment to Members and Kansas communities through our ongoing support of healthy behavior education programs, and how the programs have changed through monitoring, analysis, and process improvements to meet Member needs:

Weight Management: Aetna offers the University of Kansas Weight Management program as a value-added benefit for Members enrolled in care coordination. Through program monitoring and evaluation, the 12-week Member education class has adapted to better meet Members' needs regarding healthy eating, exercise, and behavior change. The **program changes include having a registered dietitian, with experience in rural areas and food deserts, to lead the class** and providing participants with a scale to gather additional data. From fiscal year 2020 through October 2023, **we supported 225 unique Members** with a total spend of over $33,250.

Nutrition Education: Aetna partners with the Kansas State University Extension services to sponsor the SNAP-Ed nutrition education series, Create Better Health, for individuals who receive SNAP benefits. In the past, we provided $5,000 annually to this program for the purchase of small kitchen equipment for participants who completed all six sessions of the series. In 2023, **we expanded our offering to $10,000 to include individuals from the Expanded Food and Nutrition Education program.** Funding from Aetna and another KanCare MCO **supported 212 participants completing the program,** according to the 2022-2023 Partnership Report.

Aetna is proud of our population-wide approach to improving the overall health of our Members and creating a framework where we gather data and deploy interventions targeting medical and nonmedical needs of our Members. Our strategies are supported by our comprehensive person-centered clinical model that advances Members’ holistic needs and goals. Our approach reflects the State’s goal of partnering together to support KanCare Members in advancing whole-person care strategies and achieving improved health outcomes for our enrolled Members.

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Topic Area 3: Integrated, Whole-Person Care

10. Describe the bidder's methods to identify, track, and address the social needs that impact Members' health Social Determinants of Health (SDOH) for its KanCare Members, for Members in Care Coordination, and those who are not. Include the following in the bidder's response:
    a. The methods, strategies, and tools the bidder will use to identify and track KanCare Members' needs (e.g., Health Screens, Health Risk Assessments, and Z codes).
    b. The individuals (e.g., MCO Care Coordination staff, care coordinators in other Care Coordination models) responsible for following up on identified SDOH needs, and the process for connecting KanCare Members to available resources.
    c. The bidder's approach to making SDOH resource information available to its staff and Providers responsible for addressing Members' SDOH needs.
    d. The methods and tools the bidder will use to track Member access to necessary resources (e.g., geographic information system [GIS], "closed loop referral" platform).
    e. The bidder's efforts to engage, collaborate with, and support SDOH resource Providers.

Aetna has embedded the identification and process to address Members' SDOH needs into its daily business practices. Aetna's experience with KanCare—coupled with best practices acquired through our collective national expertise— positions us to develop innovative solutions. Our approaches to identify, track, and address SDOH needs include:

- A Kansas Member Real Engagement and Community Help Team (REACH) team devoted exclusively to meeting Members' SDOH needs proactively and a Community Collaboration and Real Engagement Solutions (CARES) team that works to close service gaps in Kansas communities.
- A company ethos that dictates we help entire communities—not just our Members.
- The use of a Community Resource Directory (CRD) with a closed-loop referral system.
- Technology and data-driven social risk analytic tools that identify Members proactively and guide community investments to help reduce historically entrenched health disparities.
- Value-Added Benefits (VAB) designed to alleviate SDOH barriers.

a. Methods, Strategies, and Tools to Identify, Track, and Address SDOH

To encourage Member engagement and enhance our ability to address their SDOH needs, Aetna deploys the following:

Dedicated SDOH Member REACH Team

Our Member REACH Team, a proactive SDOH call center, was launched in Kansas in November 2023 and is currently live in six other affiliated plans, including Florida, Illinois, Michigan, Oklahoma, Virginia, and West Virginia. We generate an individual risk score based on SDOH domains including financial strain and unemployment, food insecurity, housing instability, transportation barriers, and health literacy using our proprietary social risk analytics platform. We commit to outreach to 100% of Members annually that are at the highest risk for social care support needs as indicated by their individual risk score. SDOH domains also inform our outreach efforts. We will track our efforts in achieving this 100% goal. While we expand the Team, we have researched and added thousands of Community-Based Organizations (CBOs) into our closed-loop database, described below in Section D.

Member REACH Team staff have lived Medicaid experience; they have received Medicaid benefits or have been a caregiver for a family member enrolled in Medicaid. The Member REACH Team, in addition to outreaching to Members at the highest risk, will:

- Call Members who had a Z Code submitted on a claim.
- Connect a Member with resources. Our staff will ask the Member if they want to contact the resource themselves or have the team make the connection.
- Warm transfer Members to care coordination for immediate assistance and possible change in their risk/care coordination stratification if they identify four SDOH needs.
- Contact lower acuity Members who are not in care coordination, assess their needs, and begin the connection with resources.
- Address gaps in care, including helping Members schedule overdue screenings.

Results as of December 1, 2023, include the following for states that have recently launched a new REACH team. We will track utilization going forward to compare data year over year for Kansas and share our data with our other state teams to learn from each other.

1,350 referrals to resource Providers have been made

144 Members have been warm transferred to care coordination

43% of all requests is for food

158 KS23

Promotion of Z Codes to Provider Network

Because Z Codes are a critical tool in identifying a Member with both clinical conditions and SDOH needs, Aetna is committed to promoting their use to our provider network. We recognize that some Provider practices do not have an on-site claims and billing experts who are comfortable with the requirements of Z Code submissions; therefore, we have developed training modules and provide it proactively and on request. Our network Providers are becoming more familiar with Z Codes as we promote their use, train Provider practices, and obtain feedback. We explain that:

- We continuously review Z Code additions and reimbursement based on Provider feedback, our utilization data, as well as what we learn from the other KanCare MCOs. For example, in our all-MCO, State-approved training for FQHCs earlier this year, we assigned new Z Codes for 2023 and presented them.
- Aetna has assigned Z Codes into three separate tiers. We reimburse $10 for Tier One Codes, $5 for Tier Two Codes, and $1 for Tier Three Codes. Payments are based on the type of SDOH need. Providers may bill for a particular Z Code once a year per Member.
- Providers may use documentation of SDOH information from social workers, CHWs, care coordination, and complex case managers or nurses, if this documentation is included in the Member's medical record.

Technology Solutions

Aetna connects Members with SDOH resources through innovative technology solutions, including:

- [redacted] and is used by our Member REACH team and across the health plan to identify SDOH needs and aid in resource connections. It is a social risk intelligence platform used to analyze Member data and the environment around them, including domain-specific factors such as income, education level, and household size in a community. We use this data to assess the predicted social needs of Members and match that to available services.

- **Pyx Health (Pyx) is a platform that addresses loneliness and social isolation, which is offered as a VAB.** It is also used to both identify SDOH needs and connect individuals with resources. There are two components of the Pyx platform. One is a **mobile application with a chatbot personality** that builds a trusted relationship with Members. The chatbot is compassionate and humorous and focuses on self-management. The **second component is their Compassionate Call Center.** Pyx employees call and onboard Members over the phone. They engage Members by making outbound companionship calls when Members have been identified as being lonely and reach out within one business day. Since the 2022 inception of Pyx in Kansas, **1,924 Members have been onboarded with a total spend of over $238,682.** Aetna Members showed a 42% of improvement in UCLA-3 Loneliness screening from initial to most recent.

> **Two months ago my family started utilizing the over-the-counter catalog through Aetna and it has saved us a ton of money! I've purchased things like ibuprofen, bandaids, and tampons. I'm so glad we have this benefit!**
> ***– Annie M***
>
> 004a.KS23

- [redacted]

Value-Added and Medicare Supplemental Benefits to Address SDOH Needs

As a current MCO, we know Kansans. We know their challenges and their needs, which is why, according to the 2022 KanCare Annual Report, we spend more on VABs than the other MCOs combined. As shown in the table, **since 2020 we have invested nearly $14 million in VABs.** Aetna's VABs that help Members with SDOH needs (in addition to Pyx described above) include:

Year	Total Spend/Year
2020	$2,049,843
2021	$4,280,615
2022	$3,590,904
YTD 2023	$4,070,300
Combined Total Spend	$13,991,662

- **No Place Like Home Grant.** This emergency assistance provides up to $5,000 to help pay to obtain or maintain their residence with initial rent assistance or furnishings. As of Oct. 31, 2023, we supported 36 unique Members with a total spend of over $81,882.
- **Campus Education.** Access to **GED** preparation courses, assistance in scheduling and paying for the GED exam, and other career and educational resources. As of August 2023, Campus Education has 241 enrollees with 50 working on their GED certification and 13 who have successfully completed it.
- **Transportation** to a pharmacy, prenatal classes, job interviews, food banks, and other CBOs that support SDOH needs. Since 2020 through October 2023, we have supported 4,193 unique Members with a total spend of nearly $800,000.
- **A $25 monthly benefit for Over-the-Counter (OTC) drugs and supplies** through CVS Health for Members to order via a website or telephone from an OTC catalog. Items are mailed to the Member's home. From 2020 through October 2023, 11,576 unique Members have used this benefit with a total spend of over $2 million.

b. Staff Responsible for Connecting Members to Resources

In addition to the **Member REACH team** described above, the Aetna staff responsible for connecting and following up when Members have SDOH needs are:

- **The CARES team:** The CARES team currently has three individuals in Kansas, including a manager who help build resources in Kansas' overburdened social safety net system. They support and invest in CBOs that help Kansans get the vital resources they need, including help with maternal and infant health, housing, food insecurity, oral health, and employment.
- **Care coordinators** who identify individual Member needs through assessments and screenings that are reflected in each individual Member's care plan. They identify opportunities to alleviate SDOH barriers that a Member faces by connecting these Members with local resources and health care services to close these gaps during each Member interaction. Care coordinators are trained on the use of our SDOH screening tool and apply it during Member assessments and interactions.
- **Care advocacy specialists** are subject matter experts with state-specific experience including the justice system, recovery and resiliency, children's specialty services, adult specialty services, workforce, housing, and services for Members with IDD. Aetna's care advocacy specialists support care coordinators with individual Member cases when complex needs are identified and assist with connection to services, additional resources, and transition planning. They promote equitable access to all services which are culturally and linguistically appropriate. They are grounded in the demonstration of trauma-informed care and recovery principles.
- **Community Health Workers (CHWs)** engage with Members who present challenges in completing assessments or have gaps in care. Their lived and local experience allows CHWs to better grasp each Member's individual situation. As part of our Advancing Rural Communities initiative, CHWs support rural Members with connectivity to broadband and cellular services to help with their SDOH needs. Because we embrace the criticality of the CHW role within the care continuum, **Aetna will have 10 CHWs by Jan. 1, 2025. We will also have two Community Health Representatives** who will focus on health equity issues by providing culturally appropriate care to our tribal communities.

c. Making Information Available to Staff and Resource Providers

Staff Training and Support

Aetna staff is trained on the importance of supporting Members' SDOH needs and provided tools that they can leverage to close SDOH gaps. We place SDOH conditions on par with clinical needs. We know how SDOH needs affect a person's well-being and that it is critical to meet these nonmedical needs that strongly influence health outcomes overall. The curriculum that we use to train staff is a **REACH team module.** It underscores how REACH functions correlate to member services and care coordination functions including documentation in our

platforms. Training is provided via video, which allows staff to view it post training if they need to have knowledge refreshed. We also provide overviews and explanations on the tools and technology to support Members when SDOH gaps are identified, covered and value-added benefits (VAB), and resources available internally and in the community.

We discuss which type of CBO and resource Provider offer services for a specific SDOH need. REACH team staff take courses to certify in **Motivational Interviewing.** Staff undergo a **deep dive on empathy** and have a practical exercise that provides various scenarios. We also provide a **Mental Health First Aid course.** Once staff complete all required modules and they pass a final test, they move into a "nesting" phase where they will take calls with a mentor to assist.

Our CARES team and REACH team meet monthly to discuss results from the CRD, answer staff questions, and point out new resources added to the CRD. Other department leaders are invited to attend. In turn, our CARES team attends other department meetings to answer questions about SDOH needs and resource Providers and to give a preview about the REACH team being built for Kansas. We discuss feedback from council and coalition meetings that we attend or collaborate with about gaps in specific communities, upcoming community events, and discuss CBOs who have requested support or financial assistance. This connection with community organizations informs our knowledge and fills in details about the neighbors we serve.

Support for Resource Providers

Aetna supports resource Providers through the deployment of knowledgeable teams:

- Our **CARES team** meets with **CBO leaders** on a routine basis. This team attended over 500 events and meetings from January 2023–November 2023. The CARES team engages local people, organizations, and systems that have measurable community impact. Community CARES staff **attend statewide coalition meetings such** as Kanas Nonprofit Chamber, Kansas Power of the Positive, Kansas Birth Equity Network, Kansas Appleseed Statewide Hunger Action Team Meeting, Immunize Kansas Coalition, Kansas Community Health Worker Coalition, Kansas Breastfeeding Coalition, statewide and regional Homeless Coalitions, Sedgwick County Health and Wellness Coalition, Derby Health Collaborative, Healthy Harvey Coalition, Liberal Area Coalition for Families, and multiple other coalitions and councils.
- Our **CARES team** collaborates with **Community Health Councils (CHC)** to develop localized strategies and gain insight. CHCs are community-driven, data-driven, and impactful. For example, Ellis and Sedgwick counties were identified as needing help based on Aetna's data analytics. These counties discussed and are enacting ways to make their communities more aware of resources that are available (e.g., for food insecurity and housing). The CHCs, facilitated by CARES team staff, develop a project or program to help fill an identified social service gap utilizing public health program planning and evaluation strategies. Together, the group identifies innovative ways to support the social safety net.
- **Our Community Development team** uses **Salesforce,** a customer relationship manager tool that tracks and helps communicate with CBOs across Kansas. Email addresses can be pulled with pinpoint accuracy to announce or plan events by type of CBO, by ZIP code or by county. This helps us schedule multiple meetings and events around the State each month. At community events, we interact with prospective Members and share information. We gain insight from their feedback about the KanCare program and educate them about SDOH

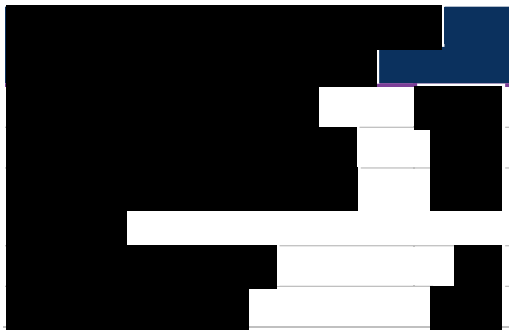
resources available locally. **Since 2019, we have met with over 143,000 Members, prospective Members, and community residents** to obtain feedback, educate about benefits and services, and learn more about CBO capacities, services, and opportunities for community investment. Attendance at events was lower in 2020 through 2022 due to the COVID-19 pandemic. It has since risen, although not yet to the pre-pandemic level of 2019.

Aetna Event Attendance	
2019	87,397
2020	5,532
2021	10,719
2022	18,857
YTD 2023 October	20,512
Total since 2019	**143,017**

- **We embed ourselves in the community** serving on boards of nonprofit agencies, volunteering at CBOs, and attending coalition and council meetings. We keep boards and organizations abreast of updates in the KanCare program and determine ways we can support them. Examples include:
  - Daisy Urbina, senior analyst/business consultant, serves on the board of Salud+Bienestar and supports their mission to "provide information to empower, lead and connect community members to live a healthier life."
  - Jaclyn Miller, Community CARES team manager, serves on the board of Immunize Kansas Coalition.
  - Melissa Lawson, directory health care quality management, and Natalie Stewart, community development analyst, serve on the Barton County Community Needs Assessment Steering Committee.
  - Aetna's managers and directors participate in various community forums and events. For example, our Program Integrity Manager, Lauren Wolf, RN, offers courses in identifying and addressing fraud, waste, and abuse (FWA) at health care conferences, schools of nursing, university classes, law practices, and internal FWA training.

d. Methods and Tools to Track Access—Closed-Loop Referral Platform

[redacted] companywide solution launched in June 2023, the CRD is available to staff in Aetna's Medicaid and Medicare programs. Care coordinators in Kansas are trained on its use and capabilities. Connections to resources are documented in the Member's care plan as well as being tracked in the CRD. The table below summarizes the total number of Kansas-based CRD resources, referrals, and Members served. We view the CRD as a tool open to stakeholders who can help Members and help make connections within the communities we serve. We train CBOs and Providers' offices how to use the CRD and how the platform connects, tracks, and evaluates Member referrals with data being continuously updated on a real time basis.



Our current closed-loop referral rate is 40% with the remainder of Members engaged at some point in the referral process (as of a report pulled in November 2023). We will use these percentages as baselines going forward. Results are dynamic as we educate stakeholders on its use and learn which CBOs have better response times. Previously through an external vendor, we were not able to seamlessly integrate our referral process into our care coordination software, which led to a smaller number of closed-loop referrals. Since implementing the CRD in June

2023, the number of Members that we track for referrals and the corresponding closed-loop referral rate have increased exponentially. We will compare current closure and process rates with national averages and develop performance goals over specific time periods based on evidence-based research. At any time, we can pull data from the CRD tracking to tell us the top categories Members are requesting and the organizations to whom we have made the most referrals over any given time period.

e. Engagement, Collaboration, and Support of Resource Providers

Our Community Investment Strategy aims to build capacity for our CBO partners to close SDOH gaps. We have invested in resource Providers since 2019. Our 2023 budget for community investment was over $520,000. Our investment decisions are driven by two key elements. The first is that we **employ data in our decision-making about investment** with participation derived in part from the use of Z Codes and our social risk analytics. The second is our company's commitment to **investments that impact whole communities** and not only our Members. Two examples of such data-informed investment decisions are described below.

> **We have been able to keep the unhoused of Leavenworth County warm during the winter months as well as fed. Because of Aetna for two winters now, we have had brand-new, heavy-duty coats and gloves for kids and adults. In addition, this past year we received a grant to support feeding those dealing with food insecurity.**
> **–** ***Myranda Agnew,*** *Executive Director*
>
> 119.KS23

Homelessness Data and Community Support

- **Homelessness Data:** We know from our Socially Determined platform that 29.3% of Kansans are at elevated risk of homelessness with even higher concentrations at risk in Sedgwick (39.6%), Wyandotte (43.7%), and Shawnee (35%) counties. Homelessness and housing insecurity oftentimes create new health conditions and exacerbate existing ones. Extreme weather conditions or the spread of communicable diseases in congregated settings can cause illness, while the inability to store medication or maintain proper nutrition oftentimes exacerbates illness. In addition, the stress and transitory nature of housing insecurity negatively impacts an individual's or family's ability to engage with preventative and primary care, leading to excessive and/or inappropriate use of expensive emergency care.
- In 2023 we provided the **Kansas Statewide Homeless Coalition (KSHC) and others a $115,000 investment to assist with housing initiatives.** In 2021 Aetna provided $50,000 to the KSHC for homeless prevention, housing navigation, and rapid rehousing, which includes past due rent utility payments, housing application costs, deposits and short-term rental assistance, and assistance with applying for state and federal benefits. Aetna donations helped 898 KanCare Members navigate the housing and homelessness systems. Of these, 242 were Aetna Members. This investment was also used to expand KSHC's information systems, not only for Aetna Members, but also those with other MCOs. Going forward, in addition to financial investments, we will—in partnership with housing providers—deploy our CHW and care coordination workforce to go into the community and reengage these Members in care.

Maternal and Infant Health Data and Community Support

- **Maternal and Infant Health Data:** The reality of Kansas' maternal statistics highlights the urgency and innovation with which we must tend to our pregnant, postpartum, and infant

Members. We know the pregnancy-related maternal mortality rate for Black women in Kansas is 79 deaths per 100,000 live births, nearly three times the rate of their White counterparts.

- In 2023, Aetna announced a community investment of **$150,000 to the Kansas University Endowment Association for their Baby Talk** program, a pregnancy and newborn education program administered by the department of pediatrics at the University of Kansas School of Medicine-Wichita. The investment expands the program statewide, making Baby Talk available to all Medicaid beneficiaries. Baby Talk's goals are to reduce preventable infant death, improve birth outcomes, increase the likelihood of a full-term pregnancies, and increase breastfeeding. **We have agreed to contribute another $150,000 in 2024 for this important program.**
- Baby Talk consists of six, two-hour classes with topics such as how to have a healthy pregnancy, infant care, and postpartum changes and concerns. The program is open to anyone who is pregnant and under 32 weeks of gestation. It was designed for women who may not otherwise have access to prenatal education. Classes are available in both English and Spanish and most are taught by labor and delivery nurses. Women who complete all six classes, plus pre- and post-assessments, receive a free infant safety item of their choice, such as an infant carrier car seat, portable crib, or breastfeeding kit. Since its launch, Baby Talk has gifted more than 1,500 car seats to Kansas moms. In addition, we sponsor community baby showers in concert with trusted Providers and health departments. Since 2019, Aetna has attended or sponsored **56 baby shower events with over 3,900 attendees** and has provided over $185,000 in community investments for maternal health education.

From Baby Talk Aetna Participants in September 2023 Classes

"I really enjoyed the classes and have passed on the information both to my OB and local WIC office. You are a great instructor, and I benefited a lot from you and the classes."

"I really enjoyed all of the 6 classes provided and appreciated Brandi being able to answer all of my questions! Wishing there were classes available specifically for new fathers."

084.KS23

- **Incentives:** Members receive a $75 incentive card for completing their first prenatal visit with a Provider within the first trimester. Members can receive another $75 for completing further prenatal and postpartum care. Aetna also offers a $10 incentive for completing dental care during pregnancy.
- Going forward, we will further engage these Members by implementing a new strategy through our Community CARES Team. The Kansas Department of Health and Environment (KDHE) supports robust home visiting programs across the State, and we will partner with them to improve maternal and infant health through:
  - **Education and Referral:** We will launch an internal education campaign to bolster the connection between our care coordination teams and on-the-ground home visiting programs.
  - **Home Visiting Partnership:** We will contract with at least two Home Visiting Providers. Through these contracts, we will exchange data on which of our Members are being served and work together in co-facilitated rounds to collaboratively support their needs.

Support of Other Valuable Resource Providers

Other types of SDOH Resource Provider investments and donations include the following organizations based on our data, and our underlying tenet to serve the entire community:

Food Insecurity:

- In 2022, Aetna provided $8,000 to the Unified Government Public Health Department, Wyandotte County Health Equity Task Force, to launch their first culturally preferred box giveaway to Hispanic/Latino and Black communities. The group collaborated with Harvester's Food Bank to provide appropriate food for the County's diverse population.
- In 2022, Aetna contributed $5,000 to the **Division of Extension at Kansas State University (KSU)** to support their Kansas SNAP Education program, which offers classes to SNAP-eligible individuals about cooking on a budget. These dollars purchase incentive and reinforcements items like pots and electric skillets beyond the allowable dollar limit. In 2023, we continued the program and supported the Expanded Food and Nutrition Education Program (EFNEP) offered by KSU with an additional $10,000.
- Investments with **Food Networks** since our entrance as a KanCare MCO: In 2019, we made two investments of $27,500 total. In 2020, one investment for $10,000 total. In 2021, six investments for $37,000 total. In 2022, 11 investments for $53,711 total.

Individuals with Intellectual and Developmental Disabilities

- Since 2021, Aetna has partnered each year with **Heartstrings Community Foundation** to recognize health centers across the State. Aetna delivered in person gift boxes provided by Heartstrings to the various health clinics. The Heartstrings Community Foundation, a local nonprofit, assists adults with IDD to live meaningful, productive, and independent lives through successful employment in the business community.
- In 2023, we contributed $50,000 to **Families Together** to build capacity and promote the adoption of the **Charting the Life Course (CtLC) Framework** to multiple disciplines, rural communities, and bilingual advocates. Since 2018, we have sponsored the CtLC conference, which invites advocates from around the country to Kansas City to learn about the program. We have coordinated trainings to our own staff to learn about the program. Our mutual goals are to encourage a broader adoption of the framework in the person-centered planning process, promote a common language and approach to service planning, and to provide community investments for implementation and sustainability.

Oral Health

- In 2023, Aetna provided $30,000 to **Oral Health Kansas in partnership with the University of Kansas Project ECHO,** the Extension for Community Healthcare Outcomes to help educate dentists about the importance of accepting patients with IDD. The teleconference series includes raising awareness, de-stigmatization, sensory awareness, the importance of teamwork (within the dental team, with care coordinators, and with other health care professionals), and an introduction to existing tools and resources. Oral Health Kansas will also use the funding for "Feeling Good About Your Smile" for Members and their caregivers.
- In 2023, Aetna and our dental subcontractor SKYGEN worked with the **KDHE Bureau of Oral Health** to give toothbrushes and toothpaste at community events. Oral Health Bureau staff attend events with us to provide oral health education.

Financial Support for Kansas Communities

- In 2023, Aetna gave a $5,000 donation to the Salina Family Healthcare for their diabetes education classes to fund printed materials, a meal per session, grocery gift cards, kitchen utensils, and prizes for attendees.

- In 2022, Aetna contributed $25,000 to the **Ronald McDonald House of Kansas City** to renovate family rooms for parents and families of the children who are patients at Children's Mercy Hospital. In 2023, Aetna provided $70,000 to renovate and expand family rooms within the hospital.

> **Aetna has been an exemplary partner in this work of reducing the burden of childhood illness on children and their families.**
> ***Mike Jeffries,*** *Chief Development Officer, Ronald McDonald House Charities of Kansas City*
> 086.KS23

- In 2022, Aetna made a $100,000 investment to the **Kansas Center for Rural Health and the University of Kansas Health System** to launch a community health assessment in Barton County, which will be used as a model for other rural counties to better serve their citizens.
- Aetna was the only KanCare MCO to offer a $25 incentive card to Members who received COVID vaccinations. In 2021, Aetna supported 10 vaccine clinics investing $61,000 with over 1,400 vaccinated. In 2022, Aetna participated in 10 immunization events and invested $21,613 with over 930 vaccinated. In 2022, we provided incentive cards to 7,166 Members.

Aetna CVS Health Foundation Investments That Address SDOH in Kansas

Our national **Aetna CVS Health Foundation** has contributed more than $260 million in corporate grants and other community support to address SDOH including:

- **Affordable Housing investments** of over $1 billion since program inception across the country. **In Kansas in 2023, $15.7 million has been invested in 997 affordable housing units** that were created, preserved, or renovated in Wichita and Great Bend.
- **Workforce Initiatives** programs that provide employment, training, and education opportunities for underserved communities. Nationally, approximately 31,00 individuals transitioned from public assistance to careers with CVS Health in 2022.
  - We support the **Kansas City School District** with work-based learning for high school students through externships at local CVS Pharmacy stores. Students interested in medical careers are invited to apply for the **Workforce Initiatives myCVS Journey pharmacy technician program.**
  - In 2017, Aetna built a retail store training environment on the Johnson County Community College in Overland Park with **pre-employment training to individuals with disabilities.** Currently closed for remodeling, when reopen, we will continue with the mock store initiative. Each semester, we accept up to six students into our two-semester Vocational Training program that trains first in soft and retail-specific skills. In the second semester, we move to higher level skills such as creating resumes and interviewing, and the students complete an internship.

Topic Area 3: Integrated, Whole-Person Care

11. Describe the bidder's approach to identifying and addressing health disparities for KanCare Members. Include the following in the bidder's response:
    a. The bidder's definition of health disparities.
    b. The bidder's approach to monitoring for unintended bias in Utilization Management and service delivery in KanCare. Additionally, provide an example of an identified concern in a program similar to KanCare and the actions that were taken in response.
    c. An example of a specific health disparity in KanCare, the bidder's proposed approach to addressing the disparity, and the anticipated impact on KanCare Members.

As a current KanCare MCO, Aetna has actively engaged with Kansas communities to listen and learn, while providing integrated services, support, and tailored systems of care to identify and address health disparities for KanCare Members. Through these deep-rooted connections and our long-standing tenure in the community, we have unparalleled experience delivering the right care, at the right time, and in the right manner. Our integrated, whole-person approach to identifying and addressing health disparities for KanCare Members includes analysis on geography, race, ethnicity, language, disability, sexual orientation, and gender identity of our population.

Our strategy aligns with the Healthy Kansans 2030 priority of improving inequities in health and health outcomes, including a commitment of inclusion to engage populations that are at a high risk for poor health because of barriers they experience related to social, economic, political, and environmental factors.

We have proudly served KanCare Members since 2019 and use this experience and firsthand knowledge to identify and address the distinctive needs of the diverse KanCare population. For example, understanding that 45% of our membership live in a rural/frontier area, we began early on to confirm that the services provided were equitable. We have and continue to partner with **Project Echo** to provide educational opportunities to rural health PCPs in specialty topic areas where a specialist may not be readily available, such as palliative care related to pain management and those experiencing serious illness. 125b.KS23

Identifying and addressing KanCare Member health disparities begins with cultural competency. We promote diversity, equity, and inclusivity of our Members, Providers, and stakeholders. In order to achieve successful member outcomes, we are committed to providing high-quality, culturally competent services to all cultures, races, ethnicities, sexes, gender expressions, sexual orientations, abilities, and religions. **We strive to honor Members' needs through our long-standing practice of requiring mandatory cultural competency education for all staff, subcontractors, and Contract Providers.** As an organization we have made additional commitments to further enhance identifying and addressing health disparities, such as:

- An Enterprise Strategic Diversity Management Dashboard that tracks workforce representation, inclusion and belonging, talent systems, and diverse marketplace data
- Contributing a $600 Million investment focused on Black and disenfranchised communities
- Executive compensation tied to diversity progress results
- Provider-facing Heath Equity webpage
- Engaging with minority-owned, women-owned, and other small businesses. We are working to create jobs and increase economic opportunities for our communities. **From 2022–2023 we worked with more than 100 qualifying diverse businesses, spending over $9 million.**

Our community-focused approach to identifying health disparities allows us to provide unique, local services to address health disparities at the individual and population level. **Figure 11-1** shows the Social Impact Team and how they engage in our Kansas communities.

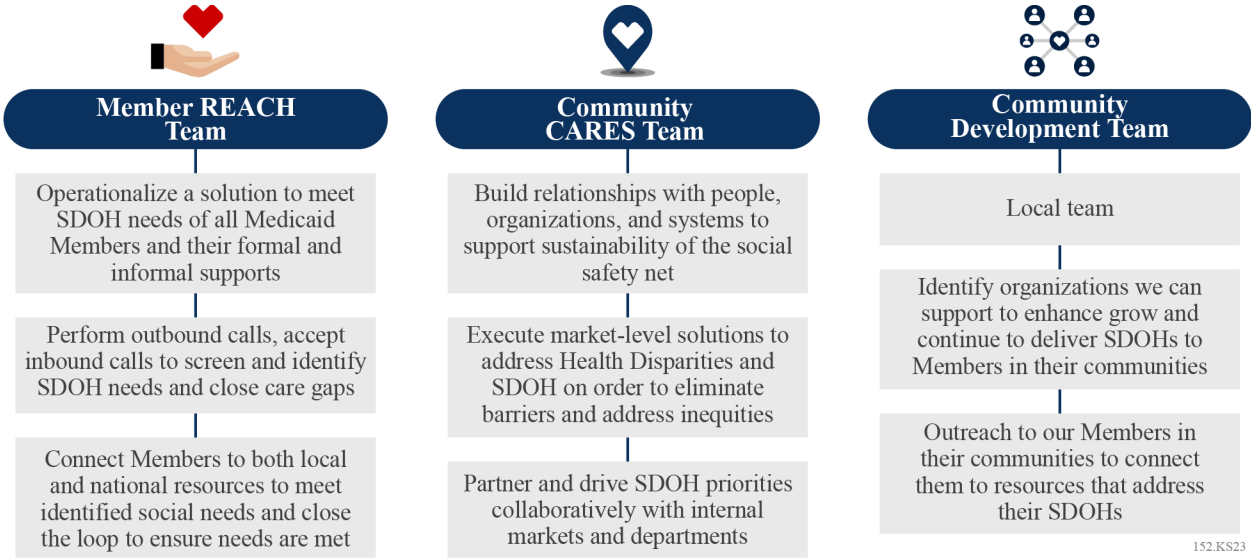


Figure 11-1: Our Social Impact Team engages members and organizations in the communities we serve across Kansas. *Team members live in the communities they serve, helping them build trust and gain understanding of community issues and the resources needed to address them.*

Our tenure in Kansas has given us resources to identify health disparities at the zip code level, allowing us to aggregate multiple data points and, upon identification of health disparities, quickly support Members in the identified location. We know there are noticeable disparities in conditions such as diabetes, with a higher prevalence among Hispanic populations (36%) compared to non-Hispanic white populations (23.7%). Similarly, our data shows infant mortality rates are higher for Black, non-Hispanic populations (13.5 deaths per 1,000 live births) compared to non-Hispanic, white populations (5.5 deaths per 1,000 live births). Our health disparity approach to address these gaps includes:

- Socially Determined (predictive modeling) platform
- Use of Z Codes
- Member Feedback
- Kansas-Specific Community Resource Centers (CRC)
- Health Equity Dashboard

We are a leader in driving an enhanced focus on health disparities to improve the health of KanCare Members. We proudly link arms to **"help with heart"** and share in the State's vision of confirming Kansans in every community have access to quality health care that meets their individual needs. We work with community stakeholders, like Wyandotte

Aetna Expands Colonoscopy Coverage to Age 45

Black Americans have a markedly increased colon cancer death rate in comparison to Whites. Aware that disparities that occur in colorectal cancer outcomes based on race and SES may be lessened by improving access to and uptake of colorectal cancer screening Aetna adjusted our colonoscopy screening guidelines to coverage beginning at 45 and became the first insurer to implement this policy across all plans. Aetna now considers a colonoscopy as a colorectal cancer screening test as medically necessary for preventive services for average-risk Members aged 45 years and older when recommended by their physician. 125m.KS23

County Health Equity Task Force. Together, in 2023, we connected Members with 500 food boxes and provided education on relationship between food and diabetes. We did this as one intervention to address the 36% diabetes rate in Hispanic communities in Kansas, which is more than 20% higher compared to white people in that same community.

a. Definition of Health Disparities

Health disparities are the differences in health outcomes and access to health care services that exist among specific population groups. These disparities are influenced by social, economic, and environmental factors that significantly impact the quality of life and longevity of individuals in the affected groups. Specifically, Aetna defines health disparities as **differences in the incidence, prevalence, mortality, and other adverse health conditions or outcomes that exist among specific population groups in Kansas.** Factors that contribute to health disparities affect populations based on race, ethnicity, language, disability, sexual orientation and gender identity, geography, religion, income, and special health care needs.

Aetna achieved **National Committee for Quality Assurance (NCQA)** in Health Equity accreditation in 2022, Meeting all standards at 100%. This accreditation guides our development of a culture to support health equity initiatives; data collection and network development supporting Kansans' cultural and linguistic needs; and processes to identify opportunities for reducing health disparities and improving care. Our Health Equity Director is a key member of our leadership team and will be responsible for managing and maintaining our NCQA Health Equity accreditation. This leader will be responsible for confirming that we continue to embed health equity in everything we do, and advance health equity for our Members, Providers, and communities by improving trust, access, and quality of health.

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Because we believe that everyone should have a **fair and just opportunity** to attain their full health potential and well-being, we offer comprehensive care to all Members. Aetna has a deep-rooted philosophy relative to how we can achieve health equity and it is grounded in the following principles:

- **Being fair and just** regardless of race, ethnicity, language, disability, sexual orientation, gender identity, geography, income, religion, geography, income, and disability. Aetna further understands that equal is not always equitable and emphasizes "fair and just" as means of creating equitable health care.
- **Addressing all aspects of health** by understanding that healthy means a complete state of physical, mental, and social well-being impacted by clinical and Social Determinants of Health (SDOH) including access to quality health care, education, housing, transportation, and jobs.
- **Recognizing the impact of racism and discrimination** (implicit or otherwise) as key drivers of health outcomes, and the importance of working with communities to remove barriers to health.

b. Monitoring for Unintended Bias in Utilization Management (UM) and Service Delivery

We monitor for unintended bias in KanCare's UM and service delivery internally and externally and emphasize program oversight, colleague, and Provider training, and developing and maintaining a diverse, multicultural network. Aetna takes an enterprise-wide, agnostic, and data-driven approach to monitoring for unintended bias in all States it operates in and across business

lines. This includes reviewing UM patterns, de-aggregating race, and ethnicity data to identify trends, and taking corrective action when identified.

Recognizing that health equity requires a robust and systemic approach, we conducted a global analysis of our UM Program in 2021. The evaluation occurred across all Aetna lines of business, including Medicaid. We used gender, race, ethnicity and specific SDOH data elements, such as urban, suburban, and rural geo-mapping. The data was evaluated within each line of business for authorizations and appeal trends with the intention of identifying health equity gaps. **The national data profile contained 782,000 authorizations matched to currently eligible Medicaid Members from our Race/Ethnicity data set.** The period studied occurred during the COVID-19 pandemic, which may result in fewer authorization requests for services not deemed medically necessary. From this data set, we noticed a lower approval rate for Black and Asian populations. Aetna is now working on solutions to address this bias. A further opportunity was identified to **analyze procedure codes for both Medicaid Authorizations and Medicare Appeals which shed further light on utilization patterns by race and exposed the key driver of approval variations.**

Our UM program also studied the impact of race and SDOH for inequitable access to medications, with consideration of UM policies and processes. The study was conditional on having a prescription written that required Prior Authorization (PA). **We found that PAs are less likely to be initiated for Members living in census-tracts with a high fraction of minority residents.** As PA initiation is a bottleneck, we educate our clinical teams to identify these gaps in our joint UM rounds with our Provider partners. We currently engage with nine different hospitals across the State and are directly embedding our clinical coordinators into these settings. We are modeling a conscious inclusion approach that addresses the impact of race by providing information and data points to our Providers on what the disparity gaps are in their population. By 2025, we plan to further enhance our value-based purchasing strategies to intentionally close gaps in outcomes by race. Our teams will regularly evaluate the impact of change to identify further areas of improvement.

The results identified authorizations in **Medicaid showing the highest racial variation for authorization approval where Asian and Black communities are adversely affected.** In the appeals process, we identified that inpatient authorizations appear to drive variations between Asian, Black, and White for Medicaid compared to outpatient.

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Addressing Unintended Bias in Service Delivery

We know some Members face challenges directly impacting their ability to receive the health care services they require. The challenges may be due to English language barriers, a hearing or visual impairment, cultural and social barriers, Behavioral Health (BH) concerns and physical or mental limitations. All Aetna colleagues are required to complete health equity training, including cultural competence and humility, biases that may exist, as well as how to overcome the historical barriers to equitable care and treatment of historically under-served and marginalized populations. Additionally, we offer Providers specialized training and support, emphasizing Member accommodations, health equity and cultural competency. Our cultural competency Provider trainings enhance patient care, reduce barriers to quality care and bolster the patient/Provider relationship. We recognize these relationships' key role in patient adherence to treatment and follow-up visits. **From January 2021 through third quarter 2023, we provided 171 training encounters, inclusive of all-MCO trainings, cultural competency trainings, town halls, billing trainings, EPSDT**

trainings, website trainings, and presentations at Provider association conferences. A sampling of our expert led required courses include:

- **Culturally Respectful Care:** Foundational Principles for Self and Practice Evaluation. A series on culturally respectful care addressing health care disparities equips learners to identify root causes, integrate cultural humility into clinical interactions and incorporates bias self-assessments into practice for improved clinical outcomes.
- **For BH Teams:** Actionable strategies for BH Teams in Inclusive Patient Management and Respectful Care. BH teams learn about systemic racism, bias, discrimination, barriers to care, SDOH and cultural humility. The action steps needed to achieve inclusive and equitable care through cultural sensitivity are provided.
- **For Physicians:** Actionable Strategies in Your Role as a Physician in Inclusive Patient Management and Respectful Care. Physicians learn about systemic racism, bias, discrimination, barriers to care, SDOH and cultural humility. The actions needed to achieve inclusive and equitable care through cultural sensitivity are provided.

Developing and Maintaining a Diverse and Multicultural Network

In addition to education, we evaluate the robustness of our Provider networks regularly to determine how reflective they are of our Members. Realizing racially discordant care is a real phenomenon, education and network analyses are critical to confirming our Providers are as empowered as possible. In order to maintain a robust Provider network, we collect demographic data from our Providers, which allows us to analyze continuing education content and track completion.

Example of an Identified Concern and the Actions Taken in Response for KanCare

As a current KanCare MCO, we are familiar with existing concerns related to unintended bias which affects KanCare Member health outcomes and quality of life. **Through direct member feedback, we learned that potential unintended bias in our staff could create barriers to service delivery and care.**

We acted, and in the beginning of January 2021, **our leaders participated in the successful Heart of Inclusion learning experience.** Our national training includes two courses, **Conscious Inclusion** and **INCLUDE.** Conscious Inclusion training focuses on awareness of the types of workplace biases that impact decision-making and how we interact with our stakeholders, Providers, Members, and colleagues. It provides guidance on how to mitigate those biases by using six traits of inclusive leadership (cognizance of bias, curiosity, courage, cultural intelligence, commitment, and collaboration.). INCLUDE training is a three-part, research-based course, featuring easy-to-digest tools to help colleagues activate new habits essential to creating a more inclusive workplace. The training focuses on how the status, certainty, autonomy, relatedness, and fairness model can provide a way of bridging the gap between intention and impact in interactions through lifting people up, finding common ground, and creating clarity.

We benchmark these trainings based on the leadership level and role to make sure we have a top-down and bottom-up approach to engagement**. Due to the success of this learning experience, today as a standard practice, we require all staff to attend our Heart of Inclusion learning experience. Nationally, over 200,000 colleagues have completed one or both of our trainings.**

Various indicators have shown that the execution of this learning experience, in Kansas, had a positive effect on interactions with Members, leading to the improvement in utilization of services **provided in the KanCare benefit plan.** Positive effects on service included:

- Engagement of Black Members enrolled in care management **increased by 24 percentage points from 47.6% in June 2022 to 59.1% in June 2023.**
- Hispanic experience with our member services team treating Members with courtesy and respect **improved from 93.3% in 2021 to 100% in 2022, an increase of 7.29 percentage points.**
- Establishing a substance use disorder telehealth project with CKF Addiction Treatment to expand access to services and provide coordination of care where acute Providers may have been ineffective due to bias, staff, etc.

These areas of growth in the KanCare plan led to the following improvements in utilization management of care services:

- Insufficient Prenatal Care for Black Member engagement with Case Management (CM) **decreased 6.3 percentage points from 14.9% in 2022 to 8.6% year-to-date in 2023.**
- Access to Ambulatory Care for Black Members engaged in CM **increased 7.7 percentage points from 84.2% in 2022 to 91.9% year-to-date in 2023.**
- Well-Child Visit in First 30 Months of Life for Hispanic Children **increased 2.55% from 67.68% in 2021 to 70.23% in 2022.**
- Follow-up after Emergency Department (ED) Visit for substance use Hispanic **increased 14.49 percentage points from 13.95% in 2022 to 28.44% year-to-date in 2023, a 104% jump.**
- Follow-up after ED Visit for substance use Black Members **increased 11.06 percentage points from 11.76% in 2022 to 22.82% year-to-date in 2023, a 94% jump.**

c. Example of Specific Health Disparities in KanCare, our Approach to Addressing the Disparity, and the Anticipated Impact on Members

Kansas is ranked 26th for maternal mortality rate in the United States, with Black women affected disproportionately. The pregnancy-related maternal mortality rate for Black women in Kansas is nearly 79 deaths per 100,000 live births, almost three times the rate of their White counterparts. Additionally, about 1 in 10 (9.8%) Kansas babies are born with low birth weight, compared to the national average of 8.3%. Low birth weight and prematurity are the leading causes of infant mortality and morbidity.

For maternal health, we have Aetna team members based in Kansas on both the **Fetal and Infant Mortality Review Board (FIMR)** and who are directly involved with the **Kansas Birth Equity Network** of the University of Kansas Medical Center.

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It is because of these realities that we must care for our pregnant, postpartum, and infant Members with urgency and innovation. Short gestation, low birth weight and maternal factors were causal factors of infant deaths in Kansas between 2015 - 2019. Health disparities were significant in the infant mortality rate related to the Black population. According to the 2022 March of Dimes Preterm Birth Report Card, Sedgwick County received a D scoring due to their 11% pre-term delivery rate, which had worsened from the previous year.

Since 2019, Aetna has made improvements to maternal health rates through multiple interventions and initiatives reaching both the Member, the Provider, and the community. We are proud of our progress in improving maternal health rates related to pre and postpartum care and continue to reduce the disparity between race/ethnicities. **Between 2020 and 2023 to date, Black Members have shown a 13.68 percentage point improvement in postpartum care; however, these rates continue to lag behind Asian and White cohorts.** Prenatal care declined during the COVID-19 pandemic and is slowly returning to early rates. As with postpartum rates, while improvement is noted in all races, Black Members continue to experience disparate results. To address poor outcomes, Aetna executed a multi-modal approach to address the barriers, concerns and special needs of both Members, Providers, and community stakeholders.

Improving Outcomes of Maternal and Infant Aetna Members in Kansas

Improved outcomes for Rural Members:

- Low Birth Weight Deliveries down 42.6%
- Deliveries with PCP visit within 90 days up 30.4%
- NICU admissions per 1,000 deliveries down 54.1%
- Rural Members in CM had an 18% higher rate for following up after delivering than Rural Members not in CM. They also increased 97% from the prior year

Improved outcomes for Black/African American Members:

- C-Section Deliveries/1000 Members down 22%
- NICU admissions per 1,000 deliveries down 77.3%
- Postpartum care is up 26.9%
- Pre-term births per 1000 Members is down 62%

Timeframe is rolling 12 months (6/1/22-6/30/23) compared to 7/1/21-6/30/23

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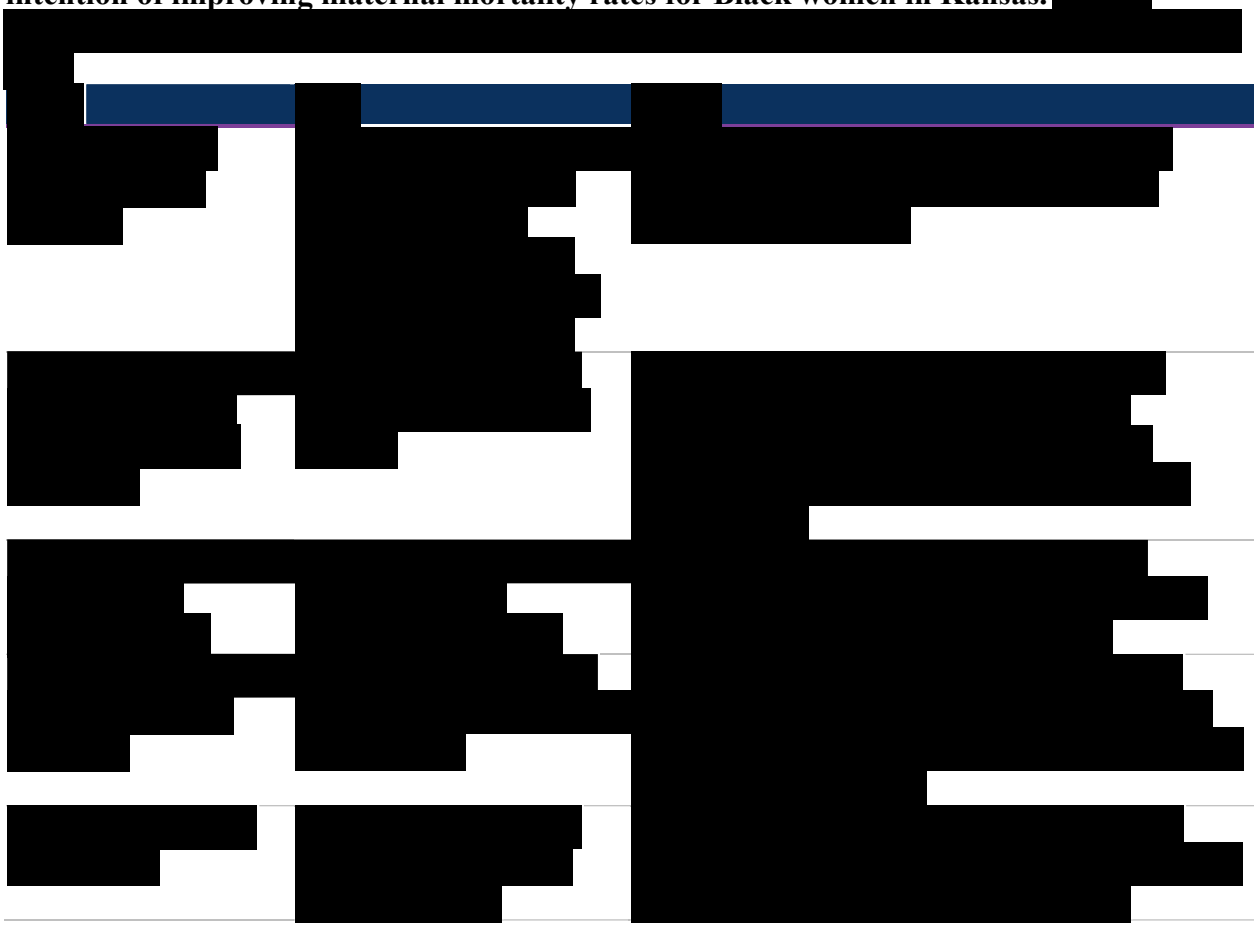
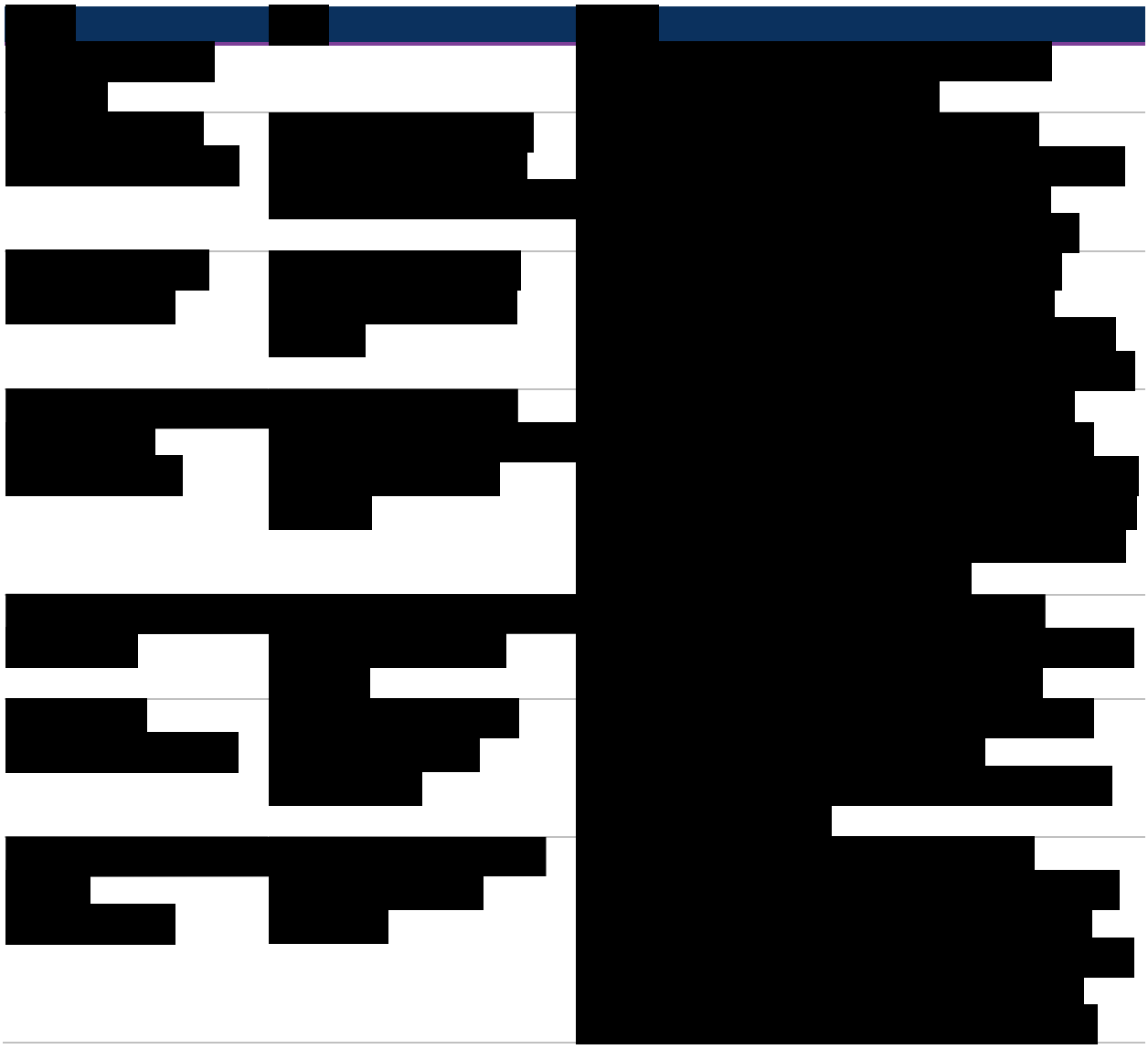
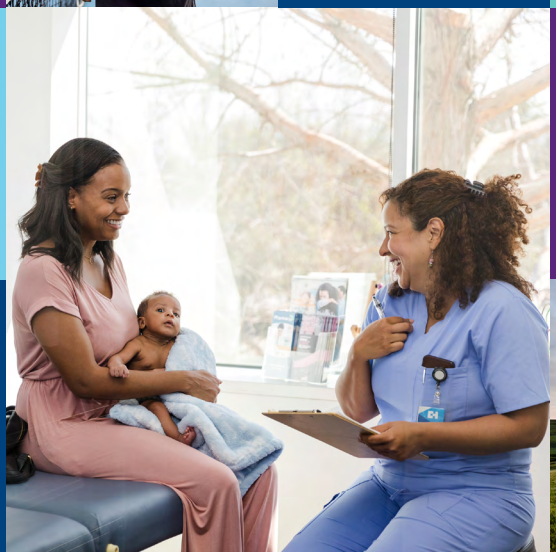
In 2025 and beyond, Aetna plans to deploy additional targeted interventions with the clear intention of improving maternal mortality rates for Black women in Kansas. [redacted]





Building on Our Current Foundation and Structure

Aetna will continue to reduce disparities and eliminate bias for Members by completing a business unit assessment, enhancing our network of Providers, expanding colleague learning opportunities, monitoring health equity indicators, and continuing to engage with the State and community resources to understand needs. As part of our health equity infrastructure, we will continue to grow a culture of fair and just treatment for our Members in 2024 and beyond, offer holistic care that addresses all aspects of well-being, and employ tools to identify racism and recognize bias within the health care system.


Topic Area 4: Utilization Management and Services

Tab 7d

Topic Area 4: Utilization Management and Services

12. Describe the bidder's strategies and approaches to ensuring appropriate utilization of services while reducing Provider administrative burdens.

Aetna Better Health of Kansas Inc. (Aetna) uses well-coordinated, integrated, and cost-effective strategies and approaches to achieve appropriate utilization of services while reducing Provider administrative burdens. We have proudly served Kansans since 2019 and have day-to-day experience and working knowledge of Kansas' diverse populations, Providers, community resources, and health care system. For example, Aetna is currently the **only KanCare MCO with embedded care coordinators at multiple Kansas hospitals** as well as embedded Community Health Workers (CHWs) at Certified Behavioral Health Clinics (CCBHCs) in Johnson County (Johnson County Mental Health Center) and Wichita (COMCARE). These high-touch services have shown to increase Member engagement, enhance care coordination, and provide additional support for Providers through improved communication and data sharing. We are excited about the impact on Members and Providers of future program expansion and have discussed with the Kansas Department for Aging and Disability Services (KDADS) embedding care coordinators in state hospitals beginning in 2025.

To improve the Provider experience by listening to their feedback, we host **four specific Provider Advisory Committees** quarterly to address the unique needs and solutions of each Provider type and have representation from Providers and key stakeholders on the Quality Management (QM)/Utilization Management (UM) Committee.

In alignment with the KanCare goal of leveraging data to promote continuous quality improvement, our approach centers on a comprehensive data ecosystem that informs all aspects of our services. This includes UM, QM, member services, network development, provider services, and claims processing. In addition, we are **expanding our data interoperability capabilities** as a Health Information Service Provider (HISP)-enabled MCO to directly address the basic Provider need for timely access to the most complete, up-to-date, relevant, and actionable Member record available to facilitate delivery of the highest level of care, while reducing Provider administrative burdens.

Aetna's Medicaid Medical Policy Committee **removed PA requirements for a total of 319 services in Kansas in 2022 and 2023,** enhancing the Member and Provider experience and reducing administrative burdens. 042.KS23

In this section, we describe how we effectively use data, a proven UM approach, advanced technology, provider services, and expert Aetna staff with Kansas experience and knowledge to manage appropriate utilization of services and reduce Provider administrative burdens.

How We Use Data to Measure Appropriate Utilization of Services

We invest in advanced reporting and data analytics technology, Aetnalytics Hub, to support our care coordination, population health, and QM efforts, to provide a person-centered care experience, and to support Providers to continuously improve care and reduce their administrative burden. Any service that is delivered to a Member, or should have been delivered to a Member, under the Member's benefit package is subject to review for over and under-utilization by our Medical Management team with the Chief Medical Officer (CMO). Aetna uses

many sources of data to identify potential over and under-utilization of services as part of our comprehensive Quality Assessment and Performance Improvement (QAPI) program, as described in the table.

Services	Data Source
UM	• Prior authorization (PA) and claim reviews • Emergency Department (ED) utilization reports • Inpatient admissions • Outpatient utilization of services • Readmissions and avoidable readmissions • Average Length of Stay (ALOS) for acute services and ALOS per thousand • Bed days per thousand Members • Laboratory and diagnostic utilization
State Collaboration	• Notifications from state regulators • State regulator performance indicators
Others	• Value-Based Purchasing (VBP) quality report • Practitioner audits (e.g., ambulatory medical record review) • Grievances • Pharmacy reports

We maintain extensive business intelligence reporting and dashboard capabilities and related training materials. These capabilities support numerous summary-level data details of key performance indicators and drill-down capabilities for more actionable operational information. The following list is an excerpt of the dashboards and reports we offer.

- **Trend and UM dashboard:** Summarizes plan-level UM trends such as readmissions, ED utilization, service authorization, and claims trends.
- **Population Health dashboard:** Provides a 360-degree Member view including eligibility trends, Member conditions, predictive analytics, and adjustments for risk stratification.
- **Clinical operations dashboards:** Includes UM, claims key indicators, care coordination, HEDIS trends in care coordination, and call tracking.
- **Maternity dashboard:** Provides information and childbirth delivery events, including pre-term deliveries, low birthweight deliveries, and Caesarean deliveries. These insights guide strategy to improve maternal health.
- **Quality Performance Management System:** Incorporates clinical and administrative data including medical records, Consumer Assessment of Healthcare Providers and Systems, claims, appeals, grievances, encounters, authorizations, quality of care incidents, pharmacy data, and SDOH from administrative and supplemental resources. With this data, we can quickly assess the quality and appropriateness of care, supporting our community, Providers, and Members.
- **Provider Analytics Reporting Suite (PARS):** A companion platform within the Availity provider portal that allows easier access to review and download VBP and HEDIS-related performance dashboards. PARS shows Providers their gaps in care, and cost, utilization data, and clinical data, such as a daily census, quality performance.
- **Z Code dashboard:** Provides an overview of the Z Codes submitted by our Providers, and enables us to analyze these codes based on Provider type, geography, and SDOH domain/Z Code type.

- **Community Resource Directory dashboard:** Displays community resource data that is used to analyze and provide detailed information on individual Members and their social service referrals, and community and state-level referral information regarding most referred resource categories and organizations.
- **Pharmacy dashboard:** Prescription claims summary, pharmacy summary, pharmacy high-utilizer, and pharmacy market share.

QM/UM Committee Develops Strategies Addressing Utilization of Services

The QM/UM Committee directs oversight of the KanCare UM program. Our CMO works directly with the QM/UM Committee, which reviews and monitors UM activities of Aetna staff and network Providers. The **QM/UM Committee integrates intervention strategies to address both over and under-utilization of health care services.** The committee collects, monitors, analyzes, and evaluates utilization data working with Aetna medical directors and leaders from Behavioral Health (BH), care coordination, HCBS Waivers, pharmacy, and network. The committee, including Providers and key stakeholders, interprets variances, establishes outcomes for reporting interventions, and conducts analysis to determine the effectiveness of the interventions.

Using Data to Reduce Health Care Disparities and Provide Appropriate Utilization

Aetna collects and uses Member-identified race, ethnicity, language, and SDOH data to identify and reduce disparities in health care access, services, and outcomes. We make investments in data, infrastructure, and staffing to support our equity efforts by addressing SDOH and detecting disparities from inequities at the community (e.g., urban and rural) and individual levels. Our approach aligns with the KanCare goal of reducing health disparities and the Healthy Kansans 2030 priority of improving inequities in health/health outcomes. To support a thorough and NCQA-aligned focus on equity throughout our organization, we:

- Use **health equity reports and dashboard,** which stratify the Member population by race and ethnicity, rurality, gender, and other factors. Our QM team monitors data on an ongoing basis so we can quickly identify and address disparities. Population analytics drill into leading measures such as PCP activity, pharmacy utilization, and care coordination outreach, enrollment, and engagement as well as lagging measures such as inpatient admissions, ED visits, cardiology, and mental health services.
- Use **Member-specific and population-based health-related data throughout our VBP models and population health programs** to reduce disparities
- **Monitor for unintended bias** in UM and service delivery through program governance and oversight, staff and Provider training, and development and maintenance of a diverse, multicultural Provider network

Social Impact Solutions to Provide Appropriate Utilization

We use our Better Together: Social Impact Solutions product in Kansas to close social care gaps, mobilize partnerships to accelerate health equity, empower Providers, and improve health outcomes for Members. Better Together: Social Impact Solutions is a proprietary suite of products and programs aimed at creating healthier Members and communities. We connect Members to needed services and build community capacity to address SDOH needs.

An analysis of our **Z Code and Community Resource Directory data showed that food insecurity was both a top Z Code submission and the most frequent referral request in our Community Resource Directory for the Wichita area.** As a result, we hosted a Community Health Council in Wichita to learn more about the strengths and needs of the community. Community feedback validated what was gleaned from our analysis, as stakeholders highlighted limited access to food as a significant barrier for many Members. **The Community Health Council worked together to manage the sustainability of community refrigeration systems to provide access to perishable items for those facing food insecurity.** We addressed Member needs with a secondary benefit of decreasing other more intensive, restrictive, and costly services like ED visits, inpatient hospitalization, long-term residential treatment, and other long-term institutional placements.

We develop solutions to address different SDOH needs, including:

- Using our **Community Resource Directory** to identify and coordinate services. The directory launched in June 2023 and offers more than **15,000 referral resources in Kansas,** as well as advanced reporting capabilities. Referrals to food resources are the most common in Kansas. **Our current closed-loop referral rate is 40%.**
- Supporting Providers and community-based organizations holistically in addressing **Member SDOH needs, including incentivizing Providers for the use of Z Codes.**
- Building community partnerships and making data-driven financial investments through the **Community Collaboration and Real Engagement Solutions (CARES) team.** The CARES team attended over 500 events and meetings through Nov. 2023.
- Addressing gaps in the social safety net through facilitating **Community Health Councils,** which develop projects to fill an identified social service gap using public health program planning and evaluation strategies.
- Outreaching Members with SDOH needs as identified by Provider Z Codes and our social risk analytics tools. For example, our **Member Real Engagement and Community Help (REACH) team** is an SDOH call center implemented in Kansas November 2023. The Member REACH team proactively contacts Members at-risk for SDOH needs, such as food, housing assistance, transportation, and financial assistance locally in their community.

Aetna develops SDOH, Z Code training for Kansas Providers

Aetna partnered with the Mid-America Mental Health Technology Transfer Center of the University of Nebraska Medical Center to develop a webinar series around SDOH and Z codes. Kansas Providers can access the training on KDHE's Kansas TRAIN website. The webinars follow a case study family and, for each topic, educate on how the issue might present in clinical settings, which Z codes would be relevant, and the effect we might see on the family, as well as a link to community resources.

Based on a list of codes we identified as being related to SDOH, we requested and funded an appendix on Z Code usage in the KDHE Billing and Coding Resource Guide, which is distributed to public health agencies.

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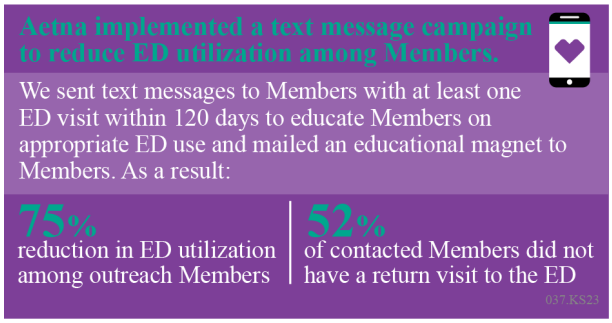
How We Use Data to Drive Outreach and Engagement Campaigns

Aetna Advice: Our Aetna Advice campaigns are an innovative way to focus on individuals using claims and HEDIS data to target Members encouraging them to change behaviors, improve health, and achieve wellness goals. Through predictive analytics and artificial intelligence, Aetna Advice connects Members with the right message through the right channel (e.g., mailer, email, telephone call) at the right time. Aetna Advice identifies barriers and opportunities for behavior

change and delivers relevant and personalized messages via physical and digital channels. Some examples include asthma/inhaler education, prescription adherence, and opioid use disorder prevention.

Outreach campaign example: We partner with mPulse for outreach campaigns to Members to improve health outcomes using text messages, interactive voice response, email, direct mail, and NanoSites. mPulse combines behavioral science, analytics, and industry expertise to deliver tailored conversations that drive results and help Members adopt healthy behaviors.



Dual Eligibles campaign: Our D-SNP manages a telephonic outreach campaign for Members who are not fully using their benefits. We call Members to educate them on the scope of their benefits and encourage their use. Every D-SNP Member can work with a Care team, which can help Members access and understand their benefits.

Comprehensive, Integrated UM Program

Our UM program integrates systems for managing, monitoring, evaluating, and improving the utilization of care and services Aetna Members receive and reducing health disparities. The program spans all clinical aspects of health, including:

- **Physical Health (PH),** including preventive, diagnostic, oral health, vision, and treatment services in inpatient, outpatient, and home-based treatment settings
- **BH,** including preventive, screening, inpatient, outpatient, medication-assisted treatment, and other community-based services
- **HCBS Waivers,** serving a variety of targeted populations groups with seven 1915(c) waivers and administered by the State-authorized electronic visit verification system
- **Pharmacy** network services to Members and Providers and a leading pharmacy claims adjudication and payment system
- Full set of **socioeconomic factors and related social support services** that affect health

Our fully integrated Management Information System (MIS) supports a Member's personalized care experience in which the Member record is one record, housed in **one documentation system.** The MIS anchors our program transparency and accountability.

Integrated services: We fully integrate the PH and BH care services rendered by contracted Providers and use a biopsychosocial clinical model to evaluate the individual needs of each Member as they relate to PH and BH. The model incorporates UM decision-making criteria that fully integrates behavioral and physical co-occurring disorders, as per NCQA HP 2023 UM1 A2, and in compliance with the Mental Health Parity and Addiction Equity Act. Our program protocols consider individual Member characteristics, unmet health care and social needs, and demographics.

Program components: We incorporate nationally recognized, evidence-based medical necessity guidelines; use of appropriate clinical professionals; integrated technology; risk management; appropriate handling of service authorizations; and Member and Provider appeal rights.

Integration with QM, UM, and care coordination: The UM program is integrated with our QM program and pursues the common principle of providing optimal clinical practices in all settings by balancing PH/BH management, operations, and finance components. Our Care Coordination team also supports the UM process in cases where more information is needed to make an informed PA decision, eliminating the need for a call to the Provider. Aetna's concurrent review clinicians from the UM team, along with our embedded care coordinators, collaborate with facilities to identify Members' potential continuing care needs required for a safe transition to the next level of care. The concurrent review clinician works with the Member's care coordinator or a transition of care coordinator to make sure the Member's discharge plan transitions into the Member's care plan.

UM Program Oversight

Our **CMO,** who is a board-certified licensed Kansas physician, has **complete oversight of the UM program** and activities. The CMO is accountable for supervising program operations and directing the development and implementation of the UM program within the health plan. The CMO directs and actively participates in QM/UM Committee meetings and, with the assistance of the QM team and medical committees, oversees performance improvement activities to assure that health plan goals and objectives are met.

> **It's clear that Susie (Robinson, Aetna transition of care coordinator) and her team care about the patients and try to help progress them out of the acute care setting. And Susie and her team work to influence post-acute Providers, agencies, and State of Kansas agencies to cooperate and coordinate care. I'm appreciative of Susie and her team.**
> ***Jill Hagel,*** *Director of Case Management*
> *University of Kansas Hospital* 041.KS23

Kansas UM Staff Streamlines Processes to Reduce Administrative Burden

Qualifications: Aetna employs and trains highly qualified, licensed clinical staff with expertise to apply clinical criteria and evidence-based guidelines to different aspects of our UM activities. Our staff employ subject matter expertise, combined with our expert training programs, in key areas such as physical and mental health, substance use, pharmacy services, LTSS, and social support services that address SDOH. Our staff are also trained in HCBS Waiver program requirements and Aetna's service delivery strategies for waiver clients. Additionally, we have **specialized UM staff dedicated to post-acute recovery facilities, neonatal intensive care units, and spinal injuries for added efficiencies and expertise.**

Medical directors and directors of clinical health services: Our medical directors are licensed and board-certified physicians, our LTSS director is board-certified, and our directors of clinical health services are licensed clinicians. Directors of clinical health services are responsible for developing and implementing programs and policies and providing ongoing assessment of clinical and non-clinical operations to help support the delivery of high-quality care. Our medical directors, LTSS director, and directors of clinical health services participate in a variety of rounds (e.g., brain injury transition, BH, complex care, concurrent review, LTSS, psychiatric residential treatment facility) and support discharge plans and coordination of services.

Key positions: The UM team consists of clinical staff members including concurrent review clinicians (registered nurses and licensed BH professionals), PA clinicians (including registered nurses, licensed practical nurse, licensed vocational nurses, and licensed BH professionals), and non-clinical inbound/outbound queue associates. Pharmacy UM is managed by a separate Aetna Medicaid team, coordinated by Aetna's dedicated pharmacy director/manager.

Training: UM staff receive four weeks of role-specific training upon hire, which includes live classroom instruction by our UM experts, a "day in the life" observation of senior UM staff, and technology-based training. The training culminates with IRR testing to make certain staff have retained what they have learned. **We updated our training approach to apply Brain-Centric Design™, a proven neuroscience method for presenting information for deep understanding and complete comprehension.** We conduct ongoing UM training to roll out new benefits, Kansas Medicaid changes, policies and procedures, or refresh UM staff knowledge and skills. Audit findings, new policies and procedures, appeals data, and feedback from Providers guide selection of ongoing training topics.

In 2022, the clinical staff in Kansas (not including the medical directors) had an average Inter-Rater Reliability (IRR) score of 98.5% across all the criteria sets, **exceeding the 95% standard.** The Aetna medical directors had an average score of 99.2%. IRR assessments measure the consistency with which Aetna staff applies medical necessity criteria. 038.KS23

Medical Necessity Guidelines

Medical necessity guidelines/clinical criteria facilitate consistency and integrity in the process of making clinical determinations. Aetna Medicaid uses nationally recognized, evidence-based criteria that is compliant with the Mental Health Parity and Addiction Equity Act, and applies the criteria based on the clinical presentation and needs of individual Members and characteristics of the local delivery system. We review clinical criteria sets for adoption per award, and then review and update them annually or as applicable when national, state, or community evidence-based clinical criteria guidelines are released or revised.

The annual review process involves a broad range of specialties and subspecialties such as emergency medicine, psychiatry, pediatrics, surgery, family medicine, internal medicine, psychiatry, pharmacy, and subspecialties, in developing, adopting, and reviewing criteria. We customize our clinical criteria, utilization review, and approval practices by adopting state of Kansas-defined criteria when required. The established hierarchy of referenced criteria is described below.

Resource	Description
Kansas Medical Assistance Program (KMAP) and CMS Guidelines	Applicable KMAP and CMS coverage determination guidelines as well as other criteria as required by contract.
MCG™	National, evidence-based clinical guidelines, best practices, and care planning tools across the continuum of care to support clinical decision-making for all clinical services except SUD services.
Level of Care Utilization System (LOCUS) and Children and Adolescent Level (CALOCUS)	LOCUS for adult mental health services and CALOCUS for children and adolescent services. Provides mental health and co-occurring SUD Providers with a standardized tool to support health care resources being consistently used in the most effective and efficient manner.
American Society of Addiction Medicine (ASAM)	Guidelines for placement, continued stay, and discharge of patients with SUD and co-occurring disorders including sole use of criteria for treatment provided in community BH centers, authorizing at the next highest level when a needed level of SUD treatment is not available.

Resource	Description
Aetna Clinical Policy Bulletins (CPBs)	Our CPBs are based on evidence in peer-reviewed published medical literature, technology assessments and structured evidence reviews, evidence-based consensus statements, expert opinions of health care providers, and evidence-based guidelines from nationally recognized professional health care organizations and public health agencies.

Prior Authorization Process

Our experienced and qualified UM staff complete PA requests timely and efficiently in compliance with contractual requirements and with established NCQA turnaround times. Our PA process includes receipt of request and approval or denial of coverage decisions. As part of the PA requirements, Providers submit a request for a PA. If the service requires PA, UM clinical staff review the request, apply the hierarchy of appropriate medical necessity criteria, and evaluate the individual Member's circumstances. Staff review the Member information in the UM and claims business application and contact the requesting Provider or care coordinator for additional information if needed to support the request. A medical director under the direction of the Aetna CMO, with appropriate clinical expertise in treating the applicable Member's medical or BH condition, is the only staff within UM with the authority to deny or reduce a service request based on medical necessity.

We processed PAs for KanCare Members within 99.57% of timeliness standards from January 2022 to October 2023. 040.KS23

We enter HCBS initial authorizations into the **Electronic Visit Verification (EVV)** system and use EVV-generated reports to assist in reviewing service utilization. EVV system reporting makes it easy for the Providers to manage and monitor Member care.

We offer special program opportunities for network practice engagement such as our **Preferred Provider program.** Selected, high-quality BH network facility Providers can participate, and traditional authorizations and clinical review processes are bypassed for administrative simplification.

Aetna is prepared to work with the other KanCare MCOs, the State, and Providers to develop and use a standardized PA form for PA requests. **Aetna collaborated with the KanCare MCOs to develop a standardized PA form for BH services to improve the Provider experience and reduce administrative burdens.** Led by the Kansas Hospital Association, the initiative was prompted by Providers' feedback that they had to adapt to unique PA processes for each Provider.

Strategies and Approaches for Reducing Provider Administrative Burdens

Our comprehensive approach includes a continual, structured review of PA code requirements, advanced technology supporting PA submissions and automation capabilities to enhance processing, and Aetna staff providing Provider support.

Structured Process to Review and Remove PA Code Requirements

We reduce Provider administrative burdens and deliver an enhanced Member experience using a structured and collaborative approach for reviewing and revising PA requirements throughout the calendar year. Aetna's CMO and medical directors listen to and solicit feedback from Providers in working with the Aetna Medicaid Medical Policy Committee (MMPC), which establishes the

standard PA requirements. **Aetna's MMPC removed PA requirements for a total of 319 codes in Kansas in 2022 and 2023.**

The MMPC is composed of physicians and other clinical representatives from each of our Medicaid health plans as well as staff from National Medical Management UM. The MMPC meets monthly and reviews data from multiple sources (i.e., utilization patterns, medical necessity criteria, evidence-based practice guidelines, new technology assessments, current similar code authorization requirements) and receives recommendations from us and other Aetna Medicaid health plans when making a recommendation on potential authorization requirements for a specific service code. Aetna's QM/UM Committee provides feedback on PA requirements based on local population trends and data analysis. We notify Providers of all changes to PA requirements using bulletins that are approved by the State.

To further reduce administrative burden, evidence-based preventive services such as **vaccines and cancer screenings never require PA, nor do occupational, physical, or speech therapies for participating Providers, as well as NEMT. In addition, we automate approval for all DME requests for $500 or less.**

To improve health outcomes and the Member and Provider experience in alignment with KanCare goals, we make exceptions to PA requirements like during the COVID-19 public health emergency, when we removed some PA requirements with skilled nursing facilities to enable more seamless transitions of care. **During state or federally declared emergencies,** we adhere to the CMS requirements for Members. This includes the **suspension of PA requirements for medical care and allowing Members to use out-of-network Providers.** We can also **remove drug PA requirements and pharmacy network restrictions, and lift the "Refill Too Soon" edit** within 24 hours of an emergency declaration.

Electronic Submission Through the Provider Portal

We accept the electronic submission of PA requests from a Member's Provider through the HIPAA-compliant, web-based Availity provider portal. Our UM system's integration with Availity allows Providers to conduct business with multiple health plans and all Aetna lines of business (i.e., Medicaid, Medicare, commercial) through a single sign-on. **Availity offers automated features for authorization submission, expedited approval for certain specified codes, PA status inquiry, and electronic response.** Providers can also submit additional information using electronic attachments without peer-to-peer consults in response to non-authorization or reduction of services. Additionally, we are developing automated processes for concurrent review for D-SNP Members.

Availity also features key information for Providers, such as PA requirements, how to request a copy of medical necessity criteria, and how to access the Provider Prior Authorization Tool (ProPAT). ProPAT allows Providers to look up procedure codes to determine if the services require authorization. In 2024, **Providers will benefit from no-cost, streamlined functionality to locate their remittances as an enhanced solution to using the Claim Status Inquiry.** We also accept PA requests via fax and telephonically through our toll-free provider services line.

Use of Electronic Medical Records (EMRs)

The availability of Member information through EMRs supports the timeliness and completeness of the authorization process and reduces administrative burden on hospitals to share data manually. **We currently have access to Provider EMRs to use for concurrent reviews and collection of HEDIS data through agreements with hospital systems,** including AdventHealth, Ascension Via Christi, Children's Mercy Hospital, Stormont Vail Health/Cotton O'Neil Clinic, and The University of Kansas Health System. We speak to hospitals about the importance of access to EMRs and comprehensive Member data, and their potential effect on reducing coverage denials.

Automation Capabilities

Approval of Specific Authorization Requests

Our UM documentation system automates approval of specific authorization requests. These requests include a subset of codes within groups such as rehabilitation and physical therapy, mental health therapy, home care, neurological procedures, sleep studies, and chemistry studies. **Providers can receive near real-time determinations, eliminating the need to monitor request status and avoiding delays in Member care.** The system evaluates each request using predictive modeling and/or applies rules engine logic based on our clinical criteria. The system either expedites approval of the request or refers it for traditional clinical review by UM staff. The system never automatically denies a request.

Digital Processing Solutions Expedite PA Turnaround Times

We use innovative ideas and advanced technologies such as **Robotic Process Automation (RPA/digital worker), artificial intelligence/machine learning, and cognitive solutions to enable faster turnaround time per transaction, reducing Provider administrative burden.** While we receive approximately 70% of PAs by fax, we use Intelligent Character Recognition (ICR) to help intake staff process the fax images. The RPA automatically extracts Provider fax authorizations and sends them to the ICR engine, from where electronic data is mined. The verify panel module then starts for manual review and corrections of select low confidence fields. The fully validated data is then automatically ingested into the UM book of record and electronic authorization is created. Once a UM clinician reviews the PA, it is either approved or denied.

Embedded Aetna Staff in Hospitals

To improve the Member and Provider experience, Aetna is currently the **only MCO with embedded care coordinators at multiple Kansas hospitals** as well as embedded CHWs at CCBHCs in Johnson County (Johnson County Mental Health Center) and Wichita (COMCARE). This approach enhances communication among Members, Providers, and Aetna for discharge planning and care coordination. Additionally, Aetna conducts discharge collaboration meetings with several facilities in which we include Aetna Medicare and commercial plans to effectively bridge the gap in communication and discussion for Members that have either both insurances (Aetna and Aetna Medicare or commercial Aetna plans). This allows for a broader spectrum partnership for our community partners and our health plans.

Provider Support

Provider Relations Representatives (PRRs): PRRs are the single point of contact and trusted partners for all Provider interests and concerns. They are in the field delivering training, orienting new Providers, and resolving and escalating issues as needed. We have dedicated PRRs to address claims issues and other needs specific to BH, HCBS, medical and ancillary Providers, and skilled nursing facilities.

Quality Practice Liaisons (QPLs): Our field-based QPLs support Providers to achieve success in closing quality measure gaps and earning value-based payments. We provide trainings and information on HEDIS measures, best practices, and provider incentive programs. In addition, we help Providers sign up for the Vaccines for Children (VFC) program; submit HEDIS data electronically to supplement claims data; and answer questions and remove barriers to promote better health outcomes.

Support for Providers treating Members with IDD
Our Extraordinary Funding (EF) Committee works closely with Providers treating Members with complex medical needs and/or BH needs through all steps of the EF process. For example, we successfully placed a Member within a children's residential home with EF, which prevented the Member from being admitted to a psychiatric residential treatment facility and entering State custody. Our service coordinators communicate with Providers to make sure they have access to the EF paperwork and understand the guidelines for completing the paperwork. We meet with Providers to review the paperwork to make certain it is completed and the process is understood. In addition, we include these Members in complex case rounds as needed and provide additional supports.

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Support, training, and materials: We provide support, training, and materials to Providers and comply with all requirements in **Section 7.6.6 of the RFP.** All Providers have an assigned PRR, who performs individual training in-person or virtually, including PA requirements, medical necessity, clinical practice guidelines, technical assistance, prescriber education, and claims support. For example, our **Provider Relations and UM teams collaborated to increase training for the University of Kansas Medical Center.** We reviewed appropriate revenue codes use, which resulted in a decrease in claim denials and fewer grievances and appeals.

Provider collaboration: We have **four specific Provider Advisory Committees** quarterly to address the unique needs and solutions of each Provider type: PCPs, specialists and hospitals, BH, and HCBS, ancillary services, and DME. This model offers a venue through which we hear firsthand from our network Providers on what they need from us to assist in serving Members. We incorporate this input into the quality improvement programs, strategies, and initiatives we develop to support improved health outcomes and Provider experience.

Clear denial rationale and peer-to-peer consults: Aetna provides Member-focused, transparent, written Notices of Action (NOA) to Providers and Members of any health care decision to deny, defer, or modify requests for PA within the stated timeframes. We compose the written NOA with language that is at or below a sixth grade reading level and provide translation services when the Member requires. The written notice communicates in easily understandable language the outcome, rationale, and recourse available including the Member's appeal rights.

Aetna medical directors that participate in the UM process and conduct clinical reviews are available to discuss review determinations with attending physicians or other ordering Providers. Providers are notified in the NOA, or in verbal notification if provided before the written that they may request a peer-to-peer consultation to discuss denied, or potential denial of, medical necessity authorizations with the medical director reviewer by contacting the centralized or designated peer-to-peer review line. The NOA letter informs the Provider and Member of the right to initiate an appeal and the procedure for doing so.

Pharmacy

We use the following practices and technology to reduce Provider administrative burdens:

- **Step-therapy/step-edits and SmartPA:** System coding edits process claims at the point of sale if prerequisite drugs and/or diagnoses are found in a specified look-back period. When the prerequisite requirements are met, a PA is not needed from the prescriber. Currently, **80% of the drugs with step-therapy or SmartPA are processed without a PA needing to be submitted.** This reduces the burden of work for Providers while ensuring prerequisite requirements are met.
- **Electronic PA (ePA):** Allows Providers to transmit PA requests electronically and eliminate the need for handwritten PA fax forms and phone calls. Providers use a secure web portal to submit ePA requests and monitor PA status. ePA streamlines the PA submission process and improves provider administrative efficiencies.
- **Provider Report Cards (PRC):** Our Pharmacy Operations team created PRCs to educate prescribers on drug coverage and share prescribing profiles. Our pharmacists provide education promoting responsible prescribing of controlled substance and opioid prescriptions and utilization, and equipping Providers with tools to effectively manage Members and their workload demands. **In 2024, we will be implementing PRCs for Kansas Providers with a high PA submission rate,** and Providers prescribing targeted medication classes based on health plan program needs. The **program achieved a 40% reduction in PA requests** from targeted Providers in our affiliated Illinois plan in 2023.

Strategies and Approaches for Reducing ED Utilization

Our approach to identifying and proactively preventing inappropriate ED use includes attention to SDOH and BH needs, strengthening our network of Providers to improve access, team-based care coordination, and planned transitions between facilities and Providers. We work closely with Members, Providers, facilities, and social supports to make sure both medical and nonmedical issues, which lead to ED usage, are addressed for Members with high utilization. The table below describes components of our

Aetna's cost per ED visit **decreased 13.3%** to $142.05 for the reporting period beginning April 2022 and ending March 2023.
The per member per month ED utilization cost **decreased 9.5%** to $7.50 for the same reporting period.
036.KS23

multifaceted approach to decreasing ED use, improving the quality of care, and containing costs. We are continually reviewing our processes and developing solutions to address Member needs and ED utilization trends.

Approach	Description
Data Analysis and Management	• Use data analytics and management to support **early identification of Members with high ED utilization** and perform continuous ED utilization monitoring and analyses, including the use of ED visit admission, discharge, and transfer alerts for immediate intervention. • Conduct **Member risk stratification and refer Members to care coordination,** as appropriate. • Collaborate with hospitals on **data collection for BH-related ED visits** and develop remediation plans for hospitals with high rates of BH ED stays greater than 23 hours.
Provider Support	• Partner with community-based LTSS Providers, who describe scenarios where Members use ED services because a Provider in the home recognizes a change in condition, but a PCP or specialist is not available to quickly assess and treat that condition. **We work with Providers to help fill this need for clinical consultation when conditions change,** including in-home urgent care services, telehealth for physical and BH concerns, and more comprehensive services for ongoing telehealth support for Members with complex health conditions. • **Embed care coordinators in hospitals,** enabling them to go to the ED if we are informed that a high-utilizing Member is in the ED. • Implement Provider enhancement strategies, such as VBP, which **incentivize Providers to expand access to care through extended and weekend office hours,** offer virtual care partnerships and telehealth consultations, and employ service extenders, such as CHWs.
Member Support	• Aetna registered nurses make **calls to Members on HCBS Waivers following ED visits.** • We outreach and educate Members through **text message campaigns, newsletters, mailings, our website, and the 24-hour nurse line,** describing alternative sources of care. • Aetna's **Passport To Health** journal is a personal aid to help Members document their health information, guide discussions with their Providers, and better understand covered and value-added benefits. • **Hospital Companion Program value-added benefit** enables Members on the Frail and Elderly, Physical Disability, Brain Injury, and IDD Waivers to receive up to 16 hours of hospital companionship per year provided by their personal care service worker while the Member is in the hospital. • We provide **in-person education** during community events, Member-specific health events, and by phone, including health education (e.g., flu, COVID-19, nutrition), information on value-added benefits, support for navigating and renewing benefits, accessing telehealth services, and how to use the Community Resource Directory and other supports to locate resources for SDOH needs. It also includes support from care coordinators to mitigate needs leading to repeated utilization.

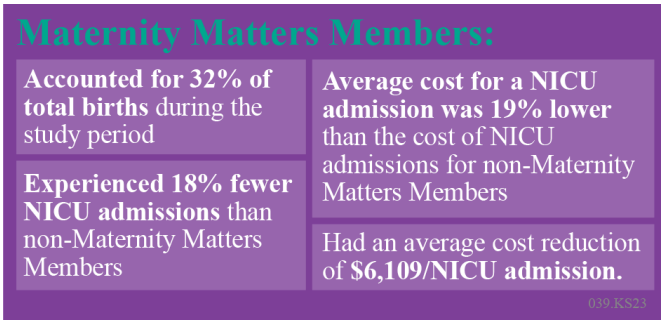
Strategies and Approaches for Reducing Hospital Utilization

Our comprehensive strategy begins with identifying Members at risk for increased hospital utilization through the initial health screen, health risk assessment, and needs assessment, the predictive modeling of claims, and utilization review. We prioritize integrating PH, mental health, SUD services, SDOH needs, and pharmacy to prevent Member readmissions and address emergent urgent needs before immediate unscheduled hospital admissions are required.

To address the needs of Members with high hospital utilization, we use our robust, continuously monitored UM program and our Care Coordination team, making sure Members get the care and services they need in the right setting. Our UM review routinely considers the expected utilization of services and the characteristics and health care needs of the Member population. We use PA data and claims data to identify those Members who will benefit from a higher level of engagement from care coordination. We also have **UM and Care Coordination teams review processes to identify, intervene, and reduce disproportionate utilization of services using a comprehensive suite of PA and claim-based UM reports, along with the screenings and assessments conducted by our Care Coordination team.** Together, our UM, and Care Coordination team support Members in avoiding the risks associated with overuse, underuse, and misuse of health care interventions.

Real-time data from the Kansas Health Information Network (KHIN)—which enables health care stakeholders to share data for coordinating patient care—also identifies Members with the highest need of support and intervention. **We incorporate inpatient admission, discharge, and transfer data from the KHIN feed in our Aetnalytics Hub daily.** Data is sent to our population health platform and will trigger alerts to the Member's Care team to begin specialized outreach and engagement efforts. Member and caregiver requests as well as Provider referrals are processed within seven days and are another mechanism for the Care Coordination team to support Members in accessing the right services at the right time. Additional successful strategies for reducing hospital admissions and readmissions in Kansas include:

Addressing Maternal Health



Our **Maternity Matters: Together with You** program is a preventive health program for pregnant Members and new mothers that aims to support healthy prenatal and postnatal behaviors while reducing the incidence of premature births. The program supports all Members and their unique pregnancy journey. We offer Members a Value-Added Benefit (VAB) including **a $75 redeemable reward for the first prenatal visit** within the first trimester or within 42 days of plan enrollment and a **$75 redeemable reward for completing a postpartum visit** within 84 days of delivery. The VAB also includes $10 for a dental checkup during pregnancy. Analysis of our Maternity Matters: Together with You program study in 12 states demonstrates improved birth outcomes, fewer NICU inpatient days, and cost reductions. The table describes examples of our services:

Program	Description
Baby Talk	Baby Talk is available to anyone who is pregnant and under 32 weeks of gestation. Baby Talk consists of **six, two-hour classes with topics such as how to have a healthy pregnancy, infant care, and postpartum changes and concerns.** Women who complete all six classes, plus pre- and post-assessments receive an infant safety item of their choice, such as an infant carrier car seat, portable crib, or breastfeeding kit, at no charge. Since its launch, Baby Talk has gifted more than 1,500 car seats to Kansas mothers.
Vheda Health	Vheda Health provides **remote monitoring for chronic conditions, including high-risk maternity.** Members receive a cellphone customized for their needs, and Vheda outreaches to the Member and care coordinator if there are readings out of normal range. In its other Medicaid markets, Vheda has been successful and has realized a **2.4-point A1C decrease in Members with diabetes** from start to end in the program.
Maven	Maven is a platform focused on **reducing neonatal intensive care unit admissions.** Maven connects families to a nationwide network of OB/GYNs, Maternal Fetal Medicine, doulas, 24/7 lactation consultants, registered nurses, and BH clinicians. The service provider has shown the capability of identifying pregnancy before receipt of the 834 eligibility file.
Mae Health	In-person and virtual support offering culturally sensitive maternity support for Black expectant mothers. In-person doulas and lactation specialists. Addresses the health disparities in maternity care.
Ouma	Telemedicine Providers for high-risk pregnancies. Maternal Fetal Medicine physicians, obstetricians, and certified midwives. Partnerships with current rural health clinics in Kansas.

Our comprehensive maternal health program achieved the following outcomes for KanCare Members in 2023 year-over-year, as described in the table below:

Metric	Outcome
NICU admissions per 1,000 deliveries	59.8% decrease
Pre-term births per 1,000 Members	32.4% decrease
Deliveries with primary care follow-up within 90 days	25.7% increase
Low-birthweight deliveries	18.6% decrease

Psychotropic Polypharmacy Program for Foster Care Members

In response to risks that medically inappropriate poly-psychotropic pharmacy poses for the foster care population, Aetna implemented in Kansas the Children's Healthy Administration of Medication and Monitoring Program™ (CHAMMP™) in March 2023. CHAMMP™ is a multidisciplinary collaborative approach to review the prescribing of psychotropic medications, improve health outcomes, and support Member safety. We identify Members through a monthly internal report, which includes pharmacy claim data indicating one or more of the following scenarios: under the age 6 with prescription(s) for psychotropic medications; ages 6–12 with prescription(s) for atypical antipsychotics, antidepressants, or mood stabilizers; and under the age 18 with 2 or more psychotropic medications, prescribed psychotropic medication(s) with no

documented BH service visits, and filling prescription(s) for psychotropics for 3 or more months without a BH visit.

During CHAMMP™ case rounds, we develop a care plan with the Member and determine the best interventions to meet their BH needs. The care coordinator engages the Member/caregivers and the medical director and/or pharmacist consult with prescribers to address concerns and meet health outcome goals. Depending on the number of identification criteria met, we stratify the Member into low, moderate, or high-risk with corresponding engagement and interventions. The Member's case is reviewed by a committee of the BH medical director, clinical pharmacist, and Care Coordination team in case rounds upon identification and again in 90 and 180 days. The clinical pharmacist outreaches the Provider for metabolic monitoring and a drug utilization review, as recommended by the committee.

CHAMMP™ data from the initial 90 and 180-day reviews of program Members reveal **100% are engaged with a care plan and 94% are engaged with a BH Provider.** In addition, 47% made changes on their medication regimen and 35% improved their level of functioning. In Kansas, we are modeling CHAMMP™ after the program administered by our affiliated health plan in Kentucky, which has yielded **a 62% reduction in psychotropic utilization and an 800% increase in metabolic monitoring for foster care Members receiving antipsychotic treatment.**

Readmission Avoidance Program (RAP)

Our program includes a standardized "end-to-end" coordinated workflow among the UM, Care Coordination, and Pharmacy teams; BH specialists; and other key partners to facilitate a seamless transition of care for Members identified as high-risk for readmission via our proprietary risk stratification algorithm. Care coordinators support these Members for at least 30 days post-discharge to make sure they have the knowledge and resources needed to safely recover from their hospitalization. We refer all high-risk Members to our Pharmacy Medication Management program, which educates Members to take medications as prescribed as compliance is crucial for Member self-management.

Administrative Lock-In

Chronic condition pharmacy adherence **improved 13.1%** for Aetna Members engaged in the Readmission Avoidance Program from September 2021 to October 2023, comparing 6-month pre-admission versus 6-month post-admission outcomes. 136.KS23

Aetna's Member Restriction program **supports Members' whole-person needs,** assists Members to improve appropriate pharmacy and medical benefit utilization for their health care needs, and coordinates care with Members' PCP and other Providers as needed. The program identifies Members who may be misusing, abusing, and/or diverting controlled substances and limits their access to these medications. We regularly **monitor pharmacy and medical utilization data to identify potential abuse, misuse, or fraud.** We **educate Members** regarding their behavior before placing a Member in administrative lock-in.

We are compliant with state and federal regulations and notify the State at a frequency defined by the Kansas Department of Health and Environment when a Member has been placed in administrative lock-in/Member Restriction program and if a Member in lock-in transfers to fee-for-service or another MCO. At least annually, Aetna's CMO, BH medical officer, care coordination director, and pharmaceutical director **analyze data on the performance and**

outcomes of the Member Restriction program. They present a summary of the results of this analysis, which incorporates feedback from the four Provider Advisory Committees, as well as any identified areas of concern in the program's performance and recommendations for action planning to the QM/UM Committee.

UM Program Evaluation

Aetna's director of clinical health services prepares a written annual evaluation of the UM program and submits it to the State for review after receiving approval from the QM/UM Committee and Quality Management Oversight Committee. The evaluation is completed in collaboration with the CMO or designee, and/or designated BH practitioner, and includes an assessment of completed and ongoing activities and evaluation of data trends over time, and identifies opportunities for changes to the UM program for the coming year. Aetna's IRR administrator prepares and reports a summary report of the plan's annual IRR activity to the CEO, CMO, and the QM/UM Committee.

The evaluation process includes reassessment of program structure, scope, processes, and sources used to determine benefit coverage and medical necessity. The UM program description and work plan developed for the subsequent year incorporate recommended changes and goals based on assessment of objective data and program effectiveness. Monthly, the CMO and director of clinical health services analyze utilization data, evaluate plan performance, and identify any variances in the standard of care. We use established methodologies to measure performance, comparing data against benchmarks or goals and historical information. At a minimum, the CMO or designee presents utilization reports to the QM/UM Committee monthly. The QM/UM Committee provides feedback to the CMO and approves action plans.

In Summary

We are proud of the comprehensive, integrated UM program that we have developed as a KanCare MCO since 2019. Led with complete oversight by our CMO, we manage our UM program using an **experienced and expert Kansas staff, comprehensive data ecosystem, and evidence-based practices, and continue to advance our data-sharing capabilities for an improved Member and Provider experience.** We monitor and update our strategies and approaches for reducing Provider administrative burdens by listening to Provider feedback and offering support services; **reducing requirements for PA** through a structured approach; **embedding staff** in hospitals to improve care coordination; using **automated processes** for increased efficiency; and implementing programs to improve outcomes for key areas such as health disparities, SDOH, and maternal health. Our UM program demonstrates how we provide the expertise, experience, innovative strategies, methods of approach, and capabilities necessary to advance the KanCare vision and goals.

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Topic Area 4: Utilization Management and Services

13. Describe the bidder's approach to developing and monitoring its Utilization Management program, in writing (e.g., policy, guidelines) and in operation, to ensure compliance with Mental Health Parity and Addiction Equity Act (MHPAEA).

Aetna's multifaceted approach to facilitate ongoing compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) derives from our experience with integrated Behavioral Health (BH) teams, Medicaid managed care experience in Kansas since 2019, and national experience where we provide services in accordance with state and federal law. Through our initiation of activities to comply with these laws in 2008 as an early advocate of the MHPAEA, we conduct legal reviews and comprehensive actuarial analyses resulting in fully compliant MHPAEA processes and systems that support Members' access to integrated, well-coordinated services.

As per State requirements, Aetna Medicaid health plans have submitted and successfully completed annual parity reviews in Maryland, Pennsylvania, Virginia, and West Virginia since 2017. In Kansas, we will use that organizational experience to meet new State compliance reporting requirements. We will comply with Section 7.1.6 of the RFP and new contract requirements for MHPAEA.

Collaboration simplifies Prior Authorization (PA) process for BH Providers

Aetna collaborated with the KanCare MCOs to develop a standardized PA form for BH services to improve the Provider experience and reduce administrative burdens. Led by the Kansas Hospital Association, the initiative was prompted by Providers' feedback that they had to adapt to unique PA processes for each Provider. The collaborative effort is an example of Aetna and the MCOs achieving the State's vision of, "Partnering together to support Medicaid Members in achieving health, wellness, and independence for a healthier Kansas."

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Aetna supports the principles of parity and incorporates them as a foundation to **our holistic model of care—One Team, One Member—and overall philosophy of an integrated, biopsychosocial approach to whole-person health care that does not separate mental health and SUD treatment from medical/surgical care.** We recognize that issues of mental health parity often disproportionately impact racial and ethnic groups, pregnant and postpartum women experiencing mental health and SUD diagnoses, LGBTQ individuals, and people living in rural areas, highlighting the need for improved access to mental health and SUD treatment and why mental health parity is an Aetna priority.

We focus on seeking out the care Members need, regardless of the type it may be or if Medicaid covers the services, to build a comprehensive system of care for each Member. Our integrated care coordination and network development facilitates access to medical/surgical, mental health, SUD, dental, vision, pharmacy, and SDOH services with equal importance. This approach aligns with the KanCare goal of improving health outcomes by providing holistic care to Members that is integrated, evidence-based, and well-coordinated.

As an established KanCare MCO, we are focused on making sure Members receive the best care and services, have their needs addressed, and improve their health outcomes. We recognize stakeholders in Kansas believe opportunities for improvement related to MHPAEA exist. During our tenure serving KanCare Members, **we have demonstrated our commitment to always**

listening to Kansans and engaging in collaborative discussions with organizations to understand their concerns as we strive to best serve Kansans.

We address common parity challenges of Member awareness and Provider network challenges by responding to Member feedback, providing Member and Provider education, monitoring service denial and appeal rates, and continually engaging in network development, single-case agreements, and telehealth solutions. Aetna care coordinators and Community-Based Organizations (CBOs) actively outreach Members to inform them and provide support to make sure they are receiving equal consideration of their treatment needs, whether for medical/surgical, mental health, or SUD care.

Approach to Developing UM Program to Confirm MHPAEA Compliance

Since 2019, we have developed our Kansas program to maintain compliance with MHPAEA using a comprehensive set of internal policies and guidelines. These include Aetna's "Compliance with Mental Health Parity and Addiction Equity Act of 2008" policy; our "Mental Health Parity and Addiction Equity Act (MHPAEA)" white paper, in compliance with State requirements; Standards in Health Equity Policy and Procedure; the UM program description; PA utilization service grids; our annual Quality Assessment and Performance Improvement (QAPI) plan; and a variety of policies covering all aspects of our operations including UM, pharmacy, claims processing, network development, Provider credentialing, grievances and appeals, and more.

Our UM staff have Kansas experience/expertise and maintain MHPAEA compliance through adherence with the following Medical Management policies in addition to other policies that can impact parity, such as credentialing and committee structures.

Focus Area	Policy Coverage
UM	• Approving and applying medical necessity criteria • Concurrent review-observation care • Decision-making criteria notification • Discharge planning • Elective referrals • Hours of operation and after-hours call • Member transition • Prior authorization • Practitioner and Member over and under-utilization of services • Process for review and approval of Aetna clinical policy bulletins • UM system controls • UM timeliness standards and decision notification
Review Processes	• Benefit exception • Denial of coverage • Identification and referral of potential quality of care concerns • Internal quality review • Medical claims review • Medical review • Member rights regarding protected health information following initial denial

Focus Area	Policy Coverage
	• On-site review • Peer-to-peer review • Readmissions • Reviewing additional information • Use of board-certified specialty reviewer
Staff	• Clinical personnel license requirements • Roles and responsibilities

Medical necessity guidelines

Aetna uses nationally recognized, evidence-based criteria that is MHPAEA-compliant, and applies the criteria based on the clinical presentation and needs of individual Members and characteristics of the local delivery system. Medical necessity guidelines/clinical criteria facilitate consistency and integrity in the process of making clinical determinations. We review clinical criteria sets for adoption per award in each state market, and then review and update them annually or as applicable when national, state, or community evidence-based clinical criteria guidelines are released or revised.

The **annual review process involves a broad range of specialties and subspecialties,** such as emergency medicine, family medicine, internal medicine, mental health, pediatrics, pharmacy, psychiatry, and surgery in developing, adopting, and reviewing criteria. We make sure the clinical criteria sets are sufficient to address the services necessary for diagnosis or treatment of illness or injury, to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth and development.

We customize our clinical criteria, utilization review, and approval practices by adopting state of Kansas-defined criteria when required. The clinical criteria do not differentiate by age, sex, race, and ethnicity. The established hierarchy of referenced criteria is described in the table.

Resource	Description
Kansas Medical Assistance Program (KMAP) and Centers for Medicare and Medicaid Services (CMS) Guidelines	Applicable KMAP and CMS coverage determination guidelines and other criteria as required by contract
MCG™	National, evidence-based clinical guidelines, best practices, and care planning tools across the continuum of care to support clinical decision-making for all clinical services except SUD services.
Level of Care Utilization System (LOCUS) and Children and Adolescent Level (CALOCUS)	LOCUS for adult BH services and CALOCUS for children and adolescent services. Provides mental health and co-occurring SUD. Provides a standardized tool to support health care resources being consistently used in the most effective and efficient manner.
American Society of Addiction Medicine (ASAM)	Guidelines for placement, continued stay, and discharge of patients with SUD and co-occurring disorders including sole use of criteria for treatment provided in community BH centers, authorizing at the

Resource	Description
	next highest level when a needed level of SUD treatment is not available.
Aetna Clinical Policy Bulletins	Our proprietary medical necessity guidelines follow objective and credible sources, such as evaluated, peer-reviewed scientific literature, valid and reliable clinical evidence, consensus of health care professionals, and expert opinions on industry standards. This set of clinical policy bulletins is available on our website.

We have multiple secure, user-friendly approaches, such as dedicated websites, as well as mailers, to disseminate the Kansas medical necessity criteria, authorization policies, procedures, and our practice guidelines to Providers and Members.

Program Operations

The table below describes how our program operations are guided by the following parity compliance processes and principles, confirming equitable treatment of medical/surgical, mental health, and SUD benefits.

Focus Area	Description
MHPAEA Program Priorities	• We maintain medical management techniques, such as the UM process, applied to mental health or SUD benefits are comparable to and applied no more stringently than the medical management techniques applied to medical/surgical benefits. • We maintain **compliance with MHPAEA for any benefits we offer beyond those otherwise specified in the contract** (e.g., in lieu of services, EPSDT). • We provide **out-of-network coverage** for mental health and SUD services, when needed, as we do for medical services. • We use a **standardized credentialing process** for mental health, SUD, and medical/surgical Providers. We will assist the State with the transition and implementation of centralized credentialing and re-credentialing and comply with the State's requirements. • We use the Kansas Medicaid formulary. All medications are added to the formulary through the Kansas Mental Health Medication Advisory Committee along with the Kansas Drug Utilization Review and Preferred Drug List committees. • We analyze any proposed changes to mental health or SUD benefits 30 days before implementation of changes to manage compliance with MHPAEA; we will provide additional information upon Kansas Department of Health and Environment request.
UM	• We integrate MHPAEA compliance into our UM program, from how we authorize services to how we evaluate and monitor compliance. • We make mental health medical necessity criteria available to any Member, potential Member, or contracting Provider upon request, using nationally established criteria, such as ASAM.

Focus Area	Description
	• We communicate adverse benefit determinations, including the reason for any denial of reimbursement or payment, with respect to medical/surgical, mental health, or SUD benefits to Members. • We **require our PA utilization service grids to be compliant with national and state mental health parity laws** and regulations.
Financial Requirements	• We **do not impose an aggregate lifetime or annual dollar limits on mental health or SUD benefits,** in accordance with 42 C.F.R. § 438.905. • We make sure any financial requirement or treatment limitation to mental health or SUD benefits in any classification (inpatient, outpatient, emergency care, or prescription drugs) is not more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification, in accordance with 42 C.F.R. § 438.910(b)(1). • We make sure any **cumulative financial requirements for mental health or SUD benefits in a classification are not accumulating separately from any established medical/surgical benefits** in the same classification, in accordance with 42 C.F.R. § 438.910(c)(3); i. • We make sure **mental health or SUD benefits are provided in every classification of benefits in which medical/surgical benefits are provided,** in accordance with 42 C.F.R. § 438.910(b)(2).
Non-Quantitative Treatment Limits (NQTLs)	• We make sure no NQTLs are imposed for mental health or SUD benefits in any classification, unless any factors used in applying the NQTLs to mental health or SUD benefits in a classification are comparable to and applied no more stringently than factors used in applying the NQTLs for medical or surgical benefits in the classification, in accordance with 42 C.F.R. § 438.910(d).
Quantitative Treatment Limits (QTLs)	• Our QM and UM staff annually review PA policies and requirements to make sure that quantitative treatment limitations applied to mental health or SUD benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical/surgical benefits.

Aetna Staff Training

We require all Aetna staff, including non-clinical and non-UM staff, to complete mental health parity training upon hire and annually. This training includes:

- A comprehensive overview of the MHPAEA
- How parity affects Members
- The role Aetna Medicaid employees, including clinical leadership, have in supporting and upholding the principles of MHPAEA
- Overview of QTLs (e.g., visit/day limits) and NQTLs (e.g., limitations or exclusions based on medical necessity, facility type, PA, or standards for admission to a provider network)

In 2022, the clinical staff in Kansas (not including the medical directors) had an average Inter-Rater Reliability (IRR) score of 98.5% across all the criteria sets, **exceeding the 95% standard.**
The Aetna medical directors had an average score of 99.2%. IRR assessments measure the consistency with which Aetna staff applies medical necessity criteria. 038.KS23

- Mental Health First Aid training, which teaches compassion and skills for supporting those with mental health conditions and SUD
- Annual IRR testing, regular in-service trainings on SUD, daily rounds, and weekly meetings related to SUD services.

Member Education and Parity Awareness

Parity awareness is a key factor in health literacy but may often be overlooked in Member education efforts. Education regarding parity is more than simply providing an annual notification outlining Member rights under the MHPAEA. Aetna strives to provide comprehensive information and health education to Members regarding parity. We do this through the Member website; in written Member materials, including the annual notification to Members; and inclusion of Member's rights information in care plans.

If a Member believes they are not receiving equitable treatment, they can appeal a denial of services; contact their care coordinator, a community health worker, member advocate, or member services; or respond on the health risk assessment they are not receiving adequate treatment. We also partner with CBOs, such as the National Alliance on Mental Illness and Mental Health America, which educate and advocate for Members regarding parity rights.

Provider Network's Higher Parity Standard

Although a Provider network may meet adequacy standards, it may not be sufficient to offer parity. Parity sets a higher standard than network adequacy. Rural and frontier areas, for example, have a lack of mental health and SUD Providers, which makes it difficult for Members to receive needed care. We continually outreach and monitor our network for potential mental health and SUD Provider additions. Our strategies for addressing mental health, SUD, and Medication-Assisted Treatment (MAT) Provider shortages include:

- Contracting with **all 20 Certified Community Behavioral Health Centers (CCBHCs) for SUD treatment.** We are contracted with the remaining six CMHCs, which will attain CCBHC certification in 2024 integrating SUD treatment.
- Contracting with all willing MAT Providers
- Providing **multiple telehealth options** for a range of ages for mental health through Flourish Health, MDLIVE, and OneTelemed, as well as SUD through an outpatient substance use treatment center, CKF Addiction Treatment
- Contracting with **Providers in the border states** of Colorado, Missouri, and Oklahoma

In instances when Aetna is unable to offer medically necessary services covered in the contractual agreement within our network of Providers, we coordinate with out-of-network Providers to procure these services. In cases where inclusion is not possible, we expedite single-case agreements that require the Provider to deliver the same high standard of quality care and expertise to Members as they provide to non-Medicaid patients.

Monitoring Compliance with MHPAEA

Aetna is prepared to provide documentation and reporting to establish and demonstrate compliance with 42 CFR Part 438, subpart K regarding parity in mental health and SUD benefits in a format and frequency as specified by the State. Aetna Medicaid health plans in Maryland, Pennsylvania, Virginia, and West Virginia submit MHPAEA reporting on an annual (State fiscal

year) basis as dictated by formal templates provided to us by the state. This gives us the **opportunity to use other states' requirements to develop and customize a Kansas-specific MHPAEA report.** We use this as a best practice opportunity to build off each parity analysis that we submit. We are also able to create MHPAEA data monitoring and template formats that can be used in each state. It gives us the opportunity to see where we need to proactively make changes or set up monitoring in other states.

How We Monitor MHPAEA compliance

One component of our comprehensive mental health parity monitoring is monthly reviewing of reports that include volume of authorization requests received for medical/surgical versus mental health/SUD benefits. We **monitor the percentage of approvals, denials, and appeals within each benefit classification to confirm oversight of trends over time.** Both our Aetna health plan leaders in Kansas and national Aetna Medicaid leaders review and discuss this data to promote compliance with MHPAEA and prioritize parity across the benefits that our Members receive.

In Kansas, our Compliance, Legal, UM, and QM teams currently monitor MHPAEA compliance in many ways, including:

- **Reviews of Member access and service provision data** through a suite of near real-time dashboards and monthly (or ad hoc upon request) quality, network, and care coordination reports.
- QM and UM staff **annually review PA policies** and requirements to make sure that quantitative treatment limits applied to mental health or SUD benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical/surgical benefits.
- Aetna Medicaid Medical Policy Committee evaluates and measures compliance by **reviewing our list of services that require authorization,** at least annually. Our chief medical officer oversees this process and reports results to our Quality Management Oversight Committee (QMOC). The QMOC annually reviews and approves policies on UM practices, pharmacy, appeals, and peer reviews.
- We promote strict **adherence to the drug formulary** and monitor for step therapy.
- We provide **out-of-network coverage** for mental health, SUD, and medical/surgical services.
- We **monitor adherence to communication requirements to alert Members of mental health and SUD service denials and reasons for denials.** Our BH medical director, a board-certified psychiatrist, reviews all mental health and SUD denials of service.

Aetna reports utilization data for mental health/SUD monthly to the Grievance and Appeal (G&A) Committee under the umbrella of the Quality Management/Utilization Management (QM/UM) Committee. This includes the number of PAs requested; denied; denied with Member appeal; denied with Member appeal upheld; denied with Member appeal reversed; and complaints by NCQA category. The G&A Committee identifies utilization trends and collaborates with the QM/UM Committee to implement process improvements.

MHPAEA Compliance Plan

Our internal **compliance plan promotes the prevention, detection, and avoidance of potential MHPAEA violations** and provides continuing guidance to maintain compliance with the law.

Our compliance and monitoring program includes conducting IRR testing for application of medical necessity criteria; responding promptly to identified offenses and developing corrective action plans; conducting internal monitoring and compliance reviews; monitoring subcontractor compliance; conducting effective training and education; and retaining records and information.

We respond to the State promptly for requested meetings, information requests, resolution of compliance risks, and notification of changes to benefits or limitations that impact compliance. Our formal response is provided by our Legal and BH Compliance teams specific to Kansas.

Our **Member Advisory Committees** (MAC) also provide valuable insight regarding our parity compliance. MAC feedback regarding access to Providers and services informs our MHPAEA compliance analysis. We follow up on the input from these Member groups, promptly addressing any noncompliance issues. In addition, our **member advocates** and **Health Equity subcommittee** help confirm MHPAEA compliance through Member and stakeholder engagement and data trends analysis. Member advocates directly interact with our Members when advocacy is requested. Hearing concerns directly from Members and Providers allows our member advocates to be aware and monitor the types of service concerns, frequency, and report to the Health Equity (HE) subcommittee. The HE subcommittee monitors MHPAEA compliance through Member and stakeholder engagement and data sets trend analysis. The HE subcommittee makes recommendations to the QM/UM committee on matters pertaining to equitable and culturally competent services provided to Members.

The **Aetna Medicaid Integrated Mental Health Parity Committee** meets monthly and includes representatives from Legal, BH Operations, Medical Operations, Claims, and Network departments. The committee addresses potential issues that are presented by Member and Provider complaints, and regulators. This information drives a comprehensive comparative analysis completed for UM, medical necessity, benefits, and network. When disparities are discovered, we take action to make corrections.

Topic Area 4: Utilization Management and Services

14. Describe the bidder's ability and approach to collaborating with the State to design, implement, and evaluate pharmaceutical initiatives and best practices. In addition, describe in detail at least one data driven, innovative clinical initiative that the bidder implemented within the past thirty-six (36) months that led to improvement in clinical care, including how improvement was measured, for a population comparable to the ones described in the RFP.

Since 2019, Aetna has demonstrated our commitment to partnering with the State and collaborating on designing, implementing, and evaluating pharmaceutical initiatives and best practices. We are well-qualified to work on innovations with the State based on our understanding of the KanCare population, Providers, community resources, and health care system, as well as the exceptional depth of pharmaceutical and clinical knowledge in our organization with our parent company, CVS Health, being a leader in retail pharmacy and PBM services. We are committed to continuing to enhance consistency for pharmaceuticals in response to feedback from Members, Providers, advocacy organizations, and associations to support KanCare improvement.

Aetna has had a contractually required pharmaceutical director supporting KanCare since 2019 and our relationship with the Kansas Department of Health and Environment's (KDHE) Pharmacy program leaders has strengthened under the leadership of our current Pharmaceutical Director, Mark Demary, and the Chief Medical Officer, Dr. Muna Enshiwat.

Aetna's behavioral health clinical leaders participate in the statewide Psychotropic Medication Workgroup facilitated by the Kansas Department for Children and Families Medicaid and Children's Health Unit. As a result, Aetna revised our psychotropic medication utilization review guidelines in foster care, addressing non-medication interventions for behavioral health concerns.

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If the State elects to contract with a single PBM, as referenced in **Scope of Services Section 7.3.1,** we will be prepared to assist the State with the transition and implementation of the new care model. We will leverage the experience and expertise of our affiliate health plans in Kentucky and West Virginia, which collaborated with the State on successfully transitioning to a single PBM model.

Aetna collaborates with the State in a variety of ways, including introducing, receiving approvals for, and implementing new programs; serving on committees; and meeting weekly to discuss pharmacy-related issues and specific pharmaceutical management. The following examples align with the State's vision of collaboration and partnership to realize program excellence and optimal health outcomes for Members.

Drug Utilization Review (DUR) Programs

Aetna Medicaid has been working with states to make Preferred Drug Lists (PDL) more functional for 37 years. Our National DUR Board analyzes Member and Provider drug utilization patterns to identify intervention and education opportunities, improve safe and appropriate use of drugs, monitor outcomes and review cost-effective therapy.

In Kansas, the Aetna DUR Board leverages our local Kansas expertise and Aetna Medicaid's national experience to collaborate with the State on opportunities for improvement. For example, we develop outreach campaigns unique to Aetna and with approval from KDHE, to educate Providers about potential gaps in care or unsafe drug regimens based on retrospective review of pharmacy claims. These communications are actionable for identified Providers. These campaigns help improve patient outcomes by making sure Providers are updated on the latest evidence-based guidelines and are aware of any potential safety risks associated with certain drugs. For example, our program to educate the prescribers of chronic benzodiazepines to risks associated with them in Members also taking opioids resulted in **31% of Members discontinuing concurrent therapy.**

Additionally, our Pharmacy Joint Operating Committee advises the Quality Management Oversight Committee and Aetna leaders on quality and Member needs, including review of contract performance and metrics.

Readmission Avoidance Program Provides Integrated, Whole-Person Care

Our Readmission Avoidance Program provides holistic care using a standardized end-to-end coordinated workflow among the Pharmacy, Utilization Management, Care Coordination and Behavioral Health (BH) teams, as well as other key partners, to facilitate a seamless transition of care for Members identified as high-risk for readmission via our risk stratification algorithm. Our care coordinators embedded in Kansas hospitals enhance communication between the Member and Providers in supporting the discharge planning process.

In Kansas, chronic condition pharmacy adherence **improved 13.1%** for Aetna Members engaged in the Readmission Avoidance Program from September 2021 to October 2023, comparing 6-month pre-admission vs. 6-month post-admission outcomes.
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We engage all high-risk Members with our Pharmacy Medication Management team, which conducts medication reconciliation and educates Members to take medications as prescribed as compliance is crucial for Member self-management. Care coordinators contact Members within 48 hours after discharge, which improves medication adherence, and support these Members for at least 30 days post-discharge to make sure they have the knowledge and resources needed to safely recover from their hospitalization.

DUR Program Interventions Achieve Outcomes for Members

Our DUR program identifies suboptimal utilization patterns and develops interventions to improve prescribing or dispensing practices, Member safety, and pharmacy-related quality measures, including HEDIS measures. Our specialized pharmacy services offer medication reviews and integrated, interdisciplinary case rounds for complex Members. We achieved the following outcomes in Kansas from October 2021–September 2022, as reported to the CMS:

- Educated Providers on **Members receiving duplicative chronic obstructive pulmonary disease medications,** resulting in **67% of Members not being on duplicate therapy three months post-outreach**
- Educated Providers on the **risks of valproic acid in persons of childbearing potential** and increased the use of contraceptives in this group, resulting in **30% of Members discontinuing valproic acid**

Aetna continually evaluates opportunities to partner with our PBM affiliate, CaremarkPCS Health L.L.C. (CVS Caremark), to integrate the pharmacy claims data into clinical program solutions that meet the health needs of our Members, support our Providers, and deliver value and stewardship of Medicaid resources to our KanCare partners. We currently use the following standardized clinical programs to identify opportunities to improve drug outcomes and prevent inappropriate prescribing of medications. If the State elects to contract with a single PBM, we will adopt comparable programs and practices with the new service Provider to improve health outcomes.

- **Point-of-Sale DUR:** Provides a frontline safety review to prevent medication issues at the point of dispensing.
- **Retrospective Safety Review:** Acts as a safety net for situations that may have a negative clinical impact on a Member. The program helps to reduce safety concerns such as drug-drug interactions, which were not identified at point-of-sale.
- **Safety and Monitoring:** Reduces instances of fraud, waste, and abuse of controlled substances through claims monitoring and prescriber outreach.
- **Gaps in Care:** Identifies and helps close gaps in evidence-based medication therapy, targeting six chronic conditions, via retrospective claims review that are best managed with combination therapy.
- **Adherence to Drug Therapy:** Encourages timely refill and renewal of prescriptions.
- **Medicaid Medication Therapy Management:** Includes both comprehensive medication reviews and targeted medication reviews to confirm the appropriate use of medications and improve clinical outcomes.

Aetna Members and Kansas communities have access to care through **52 CVS Health retail pharmacies in Kansas, including 10 HealthHUBs™ and MinuteClinics®,** for annual wellness visits; preventive health screenings; depression screenings; vaccinations; and services to close HEDIS measure gaps such as Controlling High Blood Pressure and Hemoglobin A1c Control for Members with Diabetes. **KanCare Members made 769 visits to MinuteClinics® in Kansas in the past year.** CVS pharmacists receive system alerts and provide in-store medication counseling for Aetna Members who have recently been discharged from inpatient admissions. Additionally, in partnership with Pursuant Health, we will be offering Members the option to **complete their health screen at self-service kiosks in targeted CVS retail stores in Kansas.** This provides an additional option for KanCare Members to complete their health screen and receive a $25 incentive.

Aetna Advice Engagement Campaigns Increase Prescription Adherence

Our Member outreach and engagement campaigns in Kansas aim to increase prescription adherence among Members on specific maintenance medications for managing asthma, diabetes, heart health, and mental health conditions, with an objective of decreasing Emergency Department (ED) visits and inpatient stays associated with poor adherence. We implement Aetna Advice campaigns to align with KanCare goals and with approval from the State.

The campaigns primarily rely on timely text messages and automated phone calls three days before a fill date as well as three days after the expected fill date for Members who missed a refill opportunity. Additionally, we have built a predictive model to identify Members most unlikely to fill on time (based on Member demographics and prior claims experience). These

Members receive an additional direct mail highlighting the importance of medication maintenance.

Through predictive analytics and artificial intelligence, Aetna Advice connects Members with the right message through the right channel (e.g., mailer, email, telephone call) at the right time. Aetna Advice identifies barriers and opportunities for behavior change and delivers relevant and personalized messages via physical and digital channels.

Aetna Members in Kansas improved the following health outcomes with the support Aetna Advice campaigns:

- **32.3% improvement in adherence to anti-asthmatic medications** pre- versus post-initial outreach in 2022 and **26.3% improvement** in Q1 2023
- **7.1% improvement in adherence to anti-diabetic medications** pre- versus post-initial outreach in 2022 and **43.6% improvement** in Q1 2023
- **4.3% improvement in overall adherence for treating asthma, diabetes, high blood pressure and hyperlipidemia** pre- versus post-initial outreach in 2022 and **8.4% improvement** in Q1 2023
- **1.3% improvement in overall adherence for treating attention-deficit/hyperactivity disorder, anxiety, bipolar disorder, depression and schizophrenia** pre- versus post-initial outreach in 2022 and **4.9% improvement** in Q1 2023

Collaborating with the State to Achieve KanCare Goals

Aetna Pharmaceutical Director, Mark Demary, is actively engaged as a nonvoting member of the following state entities:

- **Preferred Drug List Advisory Committee:** Promotes clinically appropriate utilization of pharmaceuticals in a cost-effective manner without compromising the quality of care.
- **Drug Utilization Review Board:** Establishes a DUR program for outpatient drugs.
- **Mental Health Medication Advisory Committee (MHMAC):** Provides recommendations to the DUR Board for developing guidelines.

Additionally, Aetna and the KanCare MCOs, state representatives, and the KanCare fiscal agent representatives meet weekly to discuss pharmacy-related issues and collaborate on specific pharmaceutical management. Their initiatives include:

- Aetna collaborates with the State to decide on what, if any, **Advanced Medical Hold Manual Review (AMHMR) Prior Authorization (PA)** might be in effect from the time a new-to-market drug is placed on AMHR until its reviewed by the Kansas Medicaid DUR Board, at which time, formal permanent PA criteria will be established. **The initiative has achieved cost savings for Aetna membership of more than $220,500 through Oct. 31, 2023.**
- Aetna collaborates with the State to propose **medications requiring step-therapy guidelines** to the PDL Advisory Committee and/or DUR Board. **The initiative achieved cost savings for Aetna membership of more than $2.35 million for 2022** and more than $410,400 through Oct. 31, 2023.
- Aetna collaborated with the State to implement **eight custom concurrent therapy edits around antidepressants and antipsychotics** that also incorporated age-specific logic. Since implementation in May 2023, these safety check edits have resulted in **191 reviews for medical appropriateness for 144 Members on duplicate therapies.** These reviews **reduced**

duplication by 13% and assured the remaining cases were medically necessary situations for each individual Member's needs.

Examples of Data-Driven, Innovative Clinical Initiatives that Lead to Improvement in Clinical Care

Aetna's polypharmacy initiative for the foster care population and Independent Community Pharmacy program are examples of data-driven, clinical initiatives that align with the **Healthy Kansans 2030 priorities of improving access to care and reducing inequities in health and health outcomes.**

Integrating pharmacy data into clinical programs is vital to the care of our Members. Prescription drug claims provide invaluable real-time insight into Members' medical needs. Pharmacy data is directly accessible to our Pharmacy and Care Coordination teams, allowing for shared information regarding Members' medications and supporting the provision of appropriate levels of person and family-centered care coordination. Aetna's clinical teams within pharmacy, informatics, medical affairs, population health, quality, care coordination, and utilization management all collaborate on clinical programs to determine the most optimal way to integrate pharmacy data.

Polypharmacy Management Improves Outcomes for Foster Care Members

In response to risks that medically inappropriate poly-psychotropic pharmacy poses for the foster care population, Aetna implemented the Children's Healthy Administration of Medication and Monitoring Program™ (CHAMMP™) in March 2023. CHAMMP™ is a **multidisciplinary collaborative approach to review the prescribing of psychotropic medications, improve health outcomes, and support Member safety.**

We **identify Members through a monthly internal report,** which includes pharmacy claim data indicating one or more of the following scenarios: under age 6 with prescription(s) for psychotropic medications; ages 6-12 with prescription(s) for atypical antipsychotics, antidepressants, or mood stabilizers; and under age 18 with 2 or more psychotropic medications, prescribed psychotropic medication(s) with no documented BH service visits and filling prescription(s) for psychotropics for 3 or more months without a BH visit.

During CHAMMP™ case rounds, we **develop a care plan with the Member and determine the best interventions to meet their BH needs.** Our care coordinator engages the Member/caregivers and the Aetna BH medical director and/or clinical pharmacist consult with prescribers to address concerns and meet health outcome goals. Depending on the number of identification criteria met, we stratify the Member into low-, moderate-, or high-risk with corresponding engagement and interventions. The BH medical director, clinical pharmacist, and Care Coordination team review the Member's case in rounds upon identification and again in 90 and 180 days. The clinical pharmacist outreaches the Provider for metabolic monitoring and a drug utilization review, as needed.

CHAMMP™ data from the initial 90- and 180-day reviews of KanCare Members reveal **100% are engaged with a care plan and 94% are engaged with a BH Provider.** In addition, 47%

made changes on their medication regimen and 35% improved their level of functioning, which contributed to an 18.7% reduction in BH admissions for foster care Members.

Aetna's affiliated Kentucky plan has achieved strong outcomes with CHAMMP™ supporting the Supporting Kentucky Youth (SKY) foster care program. We are using their experience and expertise to develop the Kansas CHAMMP™ program and anticipate delivering similar positive outcomes. Our Kentucky plan has achieved the following:

- The plan has conducted more than **330 individualized psychotropic polypharmacy Member case rounds and consults** since Jan. 1, 2021.
- At 90 days post-rounds/consult, **47% of Members reviewed have generally successful clinical outcomes.** We define successful outcomes as an improvement in level of functioning, decrease in placement disruptions, and/or decrease in ED visits or inpatient admits.
- At 180 days post-rounds/consult, **60% of Members reviewed have generally successful clinical outcomes.**
- Members with an individualized psychotropic polypharmacy case round or consult completed in 2021 had a **23% reduction in pharmacy costs.**
- Members showed **improvement in the following HEDIS measures** in measurement year 2022, surpassing the Quality Compass national average: Metabolic Monitoring for Children and Adolescents on Antipsychotics, Follow-Up Care for Children Prescribed ADHD Medication (continuation and maintenance phase), and Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics.

In Kansas, we are implementing identical or comparable resources, processes, and systems as the Kentucky plan to enable our foster care Members to achieve their personal goals.

Independent Community Pharmacies Increase Access to Care for Members

Community Pharmacy Enhanced Services Network (CPESN) launched in July 2020 in Kansas with the recognition that **Members' pharmacy and health needs are best met when resources are provided in their own communities.** We know pharmacists often have a real-time view into Members' evolving needs and the local challenges Members face due to frequent interactions. CPESN USA is a clinically integrated network of independent community pharmacies that coordinates patient care with broader care teams to provide medication optimization activities and enhanced services for high-risk patients.

Aetna has engaged with 25 independent pharmacies in Kansas since 2020, the majority in rural areas in the southeastern part of the state. **We are the only KanCare MCO with a CPESN partnership, serving as a touchpoint for hard-to-reach Members as well as CPESN pharmacists serving as a family medical adviser by referring Members with complex needs for Aetna care coordination services.** Aetna identifies high-risk Members for CPESN engagement through the health screen and assessment process, claims data, care coordination, and Provider referrals. We share a list of Members identified for CPESN engagement. **CPESN pharmacists engage identified Members during pharmacy visits** and, with the Member's consent, provide education on the following: closing gaps in care; improving medication adherence; decreasing polypharmacy; addressing SDOH needs; and reducing medication safety risks. The program includes monthly reporting from CPESN on pharmacy engagement and quarterly quality reports tracking utilization and has plans for reporting that focuses on HEDIS

gap closure for approximately 25 measures, including Asthma Medication Ratio and Hemoglobin A1c Control for Patients with Diabetes.

CPESN pharmacist and Aetna care coordinator support grieving father with transitioning of child's care

Henry is an 11-year-old boy with no known drug allergy, high-functioning autism spectrum disorders, and a past medical history of asthma. Henry's mother recently passed away in a car accident. His father is supportive and caring, but is stressed with all of Henry's medical and personal care needs as his wife normally took care of these things.

Henry's father calls a CPESN pharmacy, Graves Drug in Winfield, requesting assistance and explanation of medications to ensure he is providing Henry his medications as appropriate. Henry's father expresses no SDOH needs and is secure with transportation, housing, and food. He inquires about mileage reimbursement (they live in a rural community) and other value-added benefits (VABs) that are provided through Aetna.

The pharmacist assists Henry's father in understanding his son's medications and ensuring the father understands the importance of administration and dosage of medications. An Aetna care coordinator calls the father to provide VABs information and explain mileage reimbursement, over-the-counter catalog information, and verifies no other resources for food or housing are needed.

Henry's father states no additional needs and thanks the pharmacist and the care coordinator for their assistance. Henry is at optimum level.

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We measure clinical improvement for the CPESN program by tracking pharmacist engagement with participating Members and the improved use of care (e.g., Member visits to their PCP instead of the ED). In the past full program year of CPESN in Kansas, **170 unique Members engaged with pharmacists through activities such as SDOH referrals, vaccinations, medication reviews, closure of HEDIS gaps in care and medication education. An Aetna analysis shows a reduction in ED visits per 1000 of 24% and a reduction in inpatient admissions per 1000 of 12% among Members engaged in the CPESN program.** A cost savings analysis of the same period shows **savings of more than $145,000.** The CPESN program is a key component of our access to care strategy for rural Members, offering essential services for a targeted population that otherwise might not be available. We measured outcomes by comparing Members engaged in the CPESN program to a control population of unengaged Members who filled prescriptions at participating CPESN pharmacies but were not part of the CPESN program. A propensity score matching algorithm was used to significantly reduce bias in the comparison group by selecting one unengaged Member per engaged Member who most 'resembled' each other based on 180+ factors, including demographics, utilization, and prescription data.

Aetna has effectively collaborated with the State on pharmaceutical initiatives as a KanCare MCO since 2019. We make important contributions to State committees and weekly meetings and, programmatically, have helped achieve KanCare goals through DUR and member engagement programs. In addition, we have improved Members' access to care and care coordination through our partnerships with independent pharmacies in rural communities as part of the CPESN program. We will be prepared to support the State on a successful and seamless implementation of a single PBM model using our organizational experience. As a KanCare MCO, our Pharmacy program has demonstrated the expertise, experience, innovative strategies, methods of approach, and capabilities necessary to advance the KanCare vision and goals.

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Topic Area 4: Utilization Management and Services

15. Describe the bidder's approach to ensuring KanCare Members, including Members residing in Rural and frontier areas of the State, receive non-emergency medical transportation (NEMT) services in accordance with the Access standards in Section 7.5.5.5 of the RFP.

Since 2019, Access2Care has provided more than 21,000 Aetna KanCare unique Members with a total of 700,870 trips. About one-third of the trips originated in rural and frontier areas of Kansas. 168a.KS23

Our approach to NEMT services plays a vital role in making sure Members can access health care and leads to improved health outcomes and decreased health care costs. At Aetna Better Health of Kansas Inc. (Aetna), we partner with our subcontractor, Access2Care, for all Member NEMT needs. **We chose to partner with Access2Care in part due to their high Member satisfaction rate and their low transportation request complaint percentages of 0.1%.** As part of our NEMT approach, we integrate Access2Care's Kansas NEMT expertise with our experience as a KanCare MCO to identify and meet Members' needs; educate all stakeholders, including Members, Providers, and community-based organizations; set expectations on our transportation benefits; and use data analytics to develop a flexible statewide transportation solution. As a result, we currently meet all NEMT access standard requirements and support KanCare's goal to improve rural and frontier Member access to NEMT services.

With newborn in NICU, transportation benefits support mother and family

Maria's newborn, an Aetna Member, was in the NICU at a Kansas City hospital following a premature birth at 23 weeks. Maria requested a Spanish-speaking Aetna care coordinator and worked with her to arrange lodging, transportation, and meal benefits (through our Access2Care partnership) so her husband could travel from their home near Topeka to visit the baby. Maria also used the mileage reimbursement benefit to drive home to be with the rest of her family. Our care coordinator worked with the hospital and Maria to make certain the newborn had services in place at discharge for durable medical equipment and medication. The support we provided through benefits education and a Spanish-speaking care coordinator provided relief to Maria during a stressful time in her family's life. 103.KS23

Approach to Ensuring KanCare Members Receive NEMT Services

As a current KanCare MCO, Aetna and our partner, Access2Care, already have an established network in place to meet the transportation needs of all KanCare Members. To make certain we continue to meet KanCare Members' transportation needs, we use data analytics to continually analyze utilization across our statewide transportation network. Access2Care's adequacy evaluation tool tracks post-trip data and new membership count to determine service level need in each Kansas county. We match this information to make certain the network offers a 10% buffer to cover additional requests. To best meet the needs of KanCare Members, we offer several tools, partnerships, and programs, such as the Preferred Provider program, the Priority Experience program, and dedicated network specialists—all of which are described in full detail later in this response.

> **They are always there for me. They picked me up on time. While traveling long distances, they are attentive to my needs. Sometimes, it's even the same company that comes back and picks me up the next day when I have to stay overnight. It is such a blessing.**
> ***– Linda B.,*** *who frequently travels long distances for care* 168c.KS23

We use transportation provider education, the transportation provider manual, contractual agreement, and monitoring to confirm access standard compliance. The table that follows describes our approach to making sure all Members receive NEMT services in accordance with the Access standards in **Section 7.5.5.5 of the RFP.**

Access Standard	
Arrive at a Member's pickup location no later than 15 minutes after the scheduled pickup time (Section 7.5.5.5.A)	In the event of noncompliance, we speak with the driver and the Member in real time. If the Member still wants transportation despite the delay, we advise the driver to complete the trip, however, we document late pickup/no-show for performance monitoring purposes. If the Member no longer wants transportation due to driver tardiness, we reschedule transportation and document "Vendor No Show." We review and investigate each trip that does not comply with this standard.
Wait at least 15 minutes after the scheduled pickup time (Section 7.5.5.5.B)	If a driver is running late, they must contact the Access2Care call center so they can help the Member reschedule their appointment. If a driver is late and causes the Member to miss a scheduled appointment time, it is counted against their performance.
Arrive at the office/facility at least 15 minutes before the Member's appointment, but no sooner than one hour before the Member's appointment. NEMT Providers will not leave an office/facility before opening (Section 7.5.5.5.C.1-2)	We manage on-time performance relative to scheduled appointment time at the trip level. We review all late appointments to understand the reason for untimeliness, mitigate future occurrences, and confirm standing appointment arrival times are correct per Member request.
The Member shall not wait for more than one (1) hour after the appointment for return Transportation that has not been pre-arranged. (Section 7.5.5.5.D)	Unless prescheduled, Members typically call us when they are ready for their return ride. In the event the estimated time of arrival is over one hour, we locate a nearby transportation provider who can accommodate the Member. If we identify those providers who consistently do not meet required standards, we facilitate corrective action.
Communicate with Members regarding the approximate arrival time and notifying Members when the NEMT Provider will be late (Section 7.5.5.5.E)	The Access2Care call center calls the Member the night before to finalize the pickup time. Should the driver run late the day of the trip due to unforeseen circumstances, we require them to notify Access2Care, so the Access2Care call center can outreach the Member to inform them of the delay and help them schedule a new appointment, if necessary. This process also allows Access2Care to update their scheduled pickup time records to confirm trip clearing data matches up-to-date Member request.
Use efficient return routes that do not result in unnecessary delay or include schedule or	Our policy states that drivers should only transport Members to the addresses indicated on the trips assigned to them. Drivers are also informed, through policy, that a Member

Access Standard	
unscheduled stop during the return trip (Section 7.5.5.5.F)	should not be in the vehicle for more than an hour unless it is a long-distance transport, or the Member agrees to the extended return time. Access2Care uses MapQuest integration with their trip booking platform to determine mileage of a transport based on the most efficient route. This route mileage determines payable amount for mileage reimbursement and the rate paid to transportation partners for NEMT trips. While Access2Care does not directly set specified routes for their transportation providers, they make certain trips are built and paid only to the most efficient route.
Evaluate NEMT by conducting a quarterly performance audit (Section 7.5.5.5.G)	We capture performance metrics and underlying data in real time. We produce and share raw data, calculation methodology, and metric results through internal quality committees at least quarterly. We conduct quarterly internal audits and review processes to confirm compliance with our standards. We document, research, and identify the root cause of noncompliance. In the event of unexplained noncompliance, we issue a corrective action to address the gap at a more systemic level.
Provide an exception to the three-day transportation scheduling requirement for Members needing same day NEMT (Section 7.5.5.5.H)	We allow for a designated set of trip reasons, such as urgent care and facility discharge, to bypass any days' notice restrictions in place. For additional exceptions, we authorize short notice transports as needed.
Arrange pickup within three hours for urgent care, facility discharges and inter-facility transfers (Section 7.5.5.5.I)	All trips requiring pickup within three hours are marked for urgent securement. We call the facility to confirm the Member is ready, a valid contact number, the facility entrance for pickup, and any special needs the Member may have upon discharge to confirm a smooth pickup. We use our list of known transportation Providers who are committed to immediate availability to secure trips for immediate transport.
Provide guidelines to NEMT Providers regarding coordinating Member pickups at facilities, which includes who to notify regarding arrival, the method of notification, and how long the Provider is to wait for the Member (Section 7.5.5.5.J)	When a Member is ready for pickup at a facility, we can immediately dispatch a driver to the confirmed pickup location. We encourage drivers to communicate directly with Members (upon Member consent). If a driver cannot contact a Member for any reason or if they are running late for a trip, they call the Access2Care call center for further attempted communication and to document the situation so that it can be reviewed later.
A process for implementing requests for prescheduled transportation to recurring appointment at the same location for the same treatment	We have specially trained personnel dedicated to serving at-risk populations. They schedule transportation on a standing order basis for trips such as dialysis appointments. For additional information, see the **Preferred Provider program** description after the table.

Access Standard	
or condition for up to six months. (Section 7.5.5.5.K)	
Submit a report on transportation Provider no-show and remediation activities. (Section 7.5.5.5.L)	As a current KanCare MCO, we provide a report of transportation provider no-shows and will continue to do so. We record and monitor all transportation provider no-shows, action plans, and provider corrective steps for quality improvement. For additional information, please see the **Addressing Provider Performance** below.

Preferred Provider Program

We connect Members, particularly those with recurring or high needs, with a **dedicated Preferred Provider** who services all the Member's trips. For example, rural trips are time-consuming and typically not as cost-effective, which increases the need to find the right transportation provider that will commit to these needs even if an upward adjustment in price is necessary. We put the Member's needs first as it is often the only option in remote areas with no transportation companies operating within a reasonable radius. Once the arrangements are set, we avoid the need to search for a willing transportation provider each time the Member books a trip. We have a **reliable "short list" of transportation providers that are consistently willing to travel outside of their typical service areas to fulfill needs.**

The Trip Locker program incentivizes reliable transportation providers and helps maintain a strong network across Kansas. We make available in the Trip Locker platform any trip that is not secured within 7 days of the appointment date. All participating providers can view PHI-restricted trip information including time, location, and level of service. The program enables providers to select upcoming transports that may not have been offered to them through the traditional method.
168b.KS23

Dedicated Network Specialist

We have a dedicated network specialist in Kansas to oversee transportation provider management and serve as the point of contact. The network specialist works closely with providers to expand service areas as needed. Aetna is increasing communication between our provider relations representatives and Access2Care's network specialists for an improved transportation provider and Member experience.

Priority Experience Program

The **Priority Experience Program** serves to bolster network adequacy because it is a specialized solution to outlier challenges. Members with high needs, communication barriers, or in particularly rural areas could be more likely to have transportation concerns through the broadly established and applied means of securement. Less than 1% of Members require us to go outside the standard scope of operations, leverage transportation providers willing to go outside their normal hours/geographic range of coverage in special circumstances and establish customized communication processes to provide successful transport. We assign

> **A bonus that we've found is that we can schedule appointments using email. This is great for my daughter. Part of her disability includes verbal delays; she is a lot better at writing. We've gone from spending an hour or more on the phone with an agent each week to spending 5 or 10 minutes composing an email.**
> – ***Dakota Z's mother,*** *in reference to the accommodations made for her daughter's special needs*
> 170.KS23

Members to a coordinator, who identifies any special needs, expectations, or challenges. The coordinator will monitor for upcoming trips, contact the Member regarding pickup times, and return trip pickup times. The coordinator works with the network and Member to establish a Preferred Provider, if appropriate, and contact that provider to discuss the Member's special needs.

Partnerships and Solutions

Local Transit Authorities

We recognize that in some rural areas the local transit authority can be a valued partner. For example, **Wichita Transit provides accessible van service to people with physical or cognitive disabilities that prevent them from using the fixed route bus system.** A Specialty Services team manages the full scope of integrating Members to use transit authority services. They can **accompany a Member on their first trip** and guide them through the process. We work with the following transit authorities in Kansas: City of Salina-Saline and Ellis counties; Coffey County Transit-Coffey County; Dodge City Transit-Ford County; Nemaha County Transit-Nemeha, Brown, Jackson, Marshall, Pottawatomie counties; Northeast Kansas Area on Aging-Atchinson, Brown, Doniphan, Jackson, Nemaha counties; Reno County Area Transit-Reno County; and Wichita Transit-Sedgwick County.

Aetna's D-SNP in Kansas also contracts with Access2Care, which simplifies the NEMT process for dually eligible Members. Because of the common service Provider, these Members do not have to contact separate NEMT companies for their needs and become familiar with one set of NEMT rules. In addition, D-SNP Members receive a $250 monthly incentive card that can be used to pay for transportation (e.g., rideshare, public transportation, gas) to any destination they choose or other everyday living expenses.

046.KS23

Rideshare Companies

We will begin deploying rideshare services in 2024. In other states Access2Care serves, rideshare companies such as Lyft are effective in mid to high-population urban centers. In turn, longer distance transports and those with pickup locations in rural or frontier areas, are a viable option for traditional transportation providers.

"Leased Vehicle" Options

Access2Care has a leased vehicle model that is advantageous in difficult-to-serve areas where traditional transportation providers may be sparse or reluctant to operate. This service secures the use of a network vehicle for a daily/weekly/monthly period to be delegated to any NEMT services necessary rather than securing transports on a per-trip basis.

Mileage Reimbursement

Aetna has processes to reimburse Members or caregivers for mileage. Currently, our Members submit these requests and receive a reimbursement via a paper check. Based on Member feedback, we would like to **collaborate with the State on allowing Members to sign up for electronic fund transfers** for mileage reimbursement.

Addressing Provider Performance

We continuously monitor trips that go unsecured, and their location, to take action to serve those Members. In situations where we identify a performance issue, the network specialist meets with

the transportation provider to understand why this is occurring. In many cases, transportation providers do not have the same performance visibility and are unaware that key performance indicators have declined, in which case a simple notification can restore that metric back into compliance.

When necessary, we deploy a progressive corrective action process that provides a structured approach to addressing deficiencies and improving/preventing a recurrence of performance issues. Each step represents an escalation in corrective measures:

1. Verbal warning
2. Written warning and potential increase in number of trips audited
3. Suspension and final written warning
4. Termination

Throughout each of these steps, volume is progressively removed from the transportation provider until improvement is made. **We retrain on policies and procedures, require review of transportation manuals, and reiterate the terms of provider agreements as solutions.** Access2Care reports performance monitoring and corrective action steps to Aetna timely, including during monthly Joint Operation Committee (JOC) meetings.

Oversight and Performance Monitoring

Aetna takes a collaborative approach to promoting subcontractor responsiveness and accountability. **We integrate subcontractor oversight for Access2Care into our organizational structure,** with clear lines of responsibility and oversight to confirm a streamlined experience for Members, providers, the Kansas Department of Health and Environment (KDHE), and the Kansas Department for Aging and Disability Services (KDADS). We perform monitoring and evaluation of service-level agreements between our organization and subcontractors on a monthly and/or quarterly basis, in compliance with performance monitoring standards in **Section 7.5.14 of the RFP.**

Aetna's **Delegation Oversight Committee** reviews reporting to identify areas that are substandard. Routine monitoring affords collaboration between our organization and Access2Care to address deficiencies and to implement corrective action. Aetna and Access2Care conduct a monthly JOC meeting with reporting on trips by mode with total claims in each, and program financials. Aetna is represented by a cross-functional group including clinical, operations, provider, and grievance and appeal representatives. The JOC covers a variety of key topics including access to services; contact center performance; encounter timeliness and accuracy; modes of transportation utilization; operational questions or concerns; new processes or initiatives; missed trips; Member no-shows; complaints; abandon rate; and average mileage. In addition, Aetna submits a quarterly NEMT utilization report to the State. We perform a comprehensive annual review to measure performance efforts that address KDHE-KDADS concerns. If we identify deficiencies or areas for improvement, we take corrective action.

Measuring On-Time Performance for KanCare Services

We monitor on-time performance metrics for KanCare services, tracking on three time points:

- Member's actual time of pickup versus scheduled time of pickup
- Member's actual drop-off time to appointment versus scheduled appointment time

- Member's actual return ride pickup time versus scheduled return ride pickup time or notification time of ready for pickup

Using these timestamps, we calculate whether each trip met the compliance requirements for timeliness. Network specialists use Microsoft Power BI, directly connected into their live database, to obtain detailed information on every trip that is determined to be late on any of the above metrics. The Network team can rapidly identify trends or outliers and mitigate the issue. We also use data on missed appointments to track geographic areas of concern, monitor and manage transportation providers, and troubleshoot Member issues. Network specialists track real-time reporting to identify and address developing service issues.

Provider Scorecard

Detailed provider performance reporting allows Access2Care to make data-based decisions related to network adequacy and any disciplinary action needed for their network partners. The Provider Scorecard (**Figure 15-1**) is a full-service reporting tool that allows network specialists to focus on improving performance. Aetna and Access2Care review and discuss KPIs during their monthly JOC meetings. We share Member grievance information as part of a complete program overview. The JOC makes recommendations to the Quality Management Oversight Committee and contributes to the annual program evaluation.

TranProvider	On Time %	Provider Missed Trips %	Complaints %	CPM	Missed Trips	Complaints	Vendor No Shows	Avg. Response Hrs
Courtesy Carriers LLC (KS)	85.3%	0.1%	0.0%	$2.2	2		1	207
Express Medic - BUTL,DOUG,HARV,LEAV,MIA,WYD	99.7%	0.2%	0.0%	$9.1	3		3	222
Gordon Transportation (KS)	97.8%	0.0%	0.0%	$3.6	0			173
Medex Transportation Services, LLC (KS)	99.7%	0.0%	0.0%	$4.4	0			362
Sunflower Taxi- West (KS)	99.4%	0.2%	0.0%	$5.3	3		1	277
Gman LLC (KS)	99.3%	0.0%	0.0%	$5.8	0			209
Kantrek -Extended	98.0%	0.0%	0.0%	$4.9	0			159
Valis LLC (KS)	100.0%	0.0%	0.0%	$3.9	0			1
Best Transport LLC (KS)	100.0%	0.5%	0.0%	$2.0	4		4	130
United Transportation, LLC (KS)	97.6%	0.0%	0.0%	$9.9	0			246
Wildcat Transport (KS)	99.1%	0.1%	0.0%	$5.6	1		1	192
OCCK, Inc. - Saline Co (KS)	93.0%	0.0%	0.0%	$1.9	0			278
Sunflower Taxi- East (KS)	100.0%	0.0%	0.0%	$7.0	0			206
Wellness Transportation LLC (KS)	100.0%	0.0%	0.0%	$5.0	0			46
G & B Enterprises Inc (KS)	99.0%	0.5%	0.0%	$2.9	2		2	196
(SS) Elizabeth Layton Center (KS)	100.0%	0.0%	0.0%	$6.1	0			1
DROP OF A HAT TRANSPORTATION(KS)	88.1%	0.0%	0.0%	$2.2	0			87
AVA Transportation Inc.(KS)	100.0%	0.0%	0.0%	$2.6	0			1
(SS) Arrowhead West, Inc. Ford & Edwards Co (KS)	100.0%	0.0%	0.0%	$2.0	0			3
KanTrek, LLC (KS) -Central	100.0%	0.0%	0.0%	$4.4	0			437
Purpose Driven Medical Transportation, LLC (KS)	100.0%	0.0%	0.0%	$3.8	0			70
(SS) COE Training Services, INC. (KS)	94.4%	0.0%	0.0%	$1.5	0			1
Total	**96.9%**	**0.2%**	**0.0%**	**$4.1**	**42**	**3**	**32**	**132**

Figure 15-1. Access2Care Provider Scorecard. *Provider Scorecard is a full-service reporting tool that allows network specialists to focus on improving performance.*

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Topic Area 4: Utilization Management and Services

16. Describe the bidder's proposed array of Behavioral Health crisis services and how those services will interface with 988 and other crisis resources within Kansas. Include the following in the bidder's response:
   a. The bidder's approach to collaborating with its Behavioral Health crisis Providers, first responders, and other crisis resources to create a comprehensive, well-coordinated, Behavioral Health crisis continuum for all Members.
   b. The bidder's approach to collecting data, measuring, and evaluating the effectiveness of its Behavioral Health crisis services, and implementing improvements based on its evaluation findings.
   c. The bidder's plan for evaluating and meeting network adequacy with Behavioral Health crisis services, like mobile crisis services and crisis stabilization services.
   d. The bidder's plan for promoting awareness of 988 and how to access local crisis services to Members.

Aetna has been managing Behavioral Health (BH) crisis services in Kansas since 2019. In that time, we have prioritized prevention of Member BH crises while focusing on the safety of our Members in crisis and strengthening care and service coordination for our Members after a crisis. This experience informs our deep understanding of the Kansas crisis delivery system and the challenges and risks facing the diverse member populations we serve. We focus on developing and strengthening relationships within the crisis continuum of service Providers across Kansas as part of a coordinated system that interfaces with the 988 Suicide and Crisis Lifeline, Family Crisis Response Helpline, mobile crisis teams, crisis receiving and stabilization facilities, first responders, and more. As a tenured KanCare MCO, we are committed to **supporting the goals and objectives of the Kansas Suicide Prevention Plan 2021-2025,** in recognition the **suicide death rate increased 44.5%** from 2011 to 2021, according to the Kansas Department of Health and Environment.

Aetna continually advances our Provider network, community partnerships, coordination protocols, and staffing to meet Member and community needs. An indicator of today's environment, the number of calls from Aetna Members to the Family Crisis Response Helpline increased 200% from 2021 to 2023—14 to 42. Our Care Coordination team coordinates follow-up with the Member within 72 hours of receiving the crisis call information.

128.KS23

Our multifaceted approach aligns with the Substance Abuse and Mental Health Services Association's (SAMHSA) service and support philosophy: **Anyone, Anywhere, and Anytime.** We currently **contract with all 26 Community Mental Health Centers (CMHCs),** most of which have 24-hour crisis lines and include Spanish-speaking BH clinicians that we coordinate with for Member crisis interventions and referrals. Within the CMHC system of care, Aetna coordinates referrals and services with the 20 CMHCs that are **Certified Behavioral Health Clinics (CCBHCs).**

Our comprehensive continuum of services also includes contracts with **100% of the Providers of crisis stabilization services** and 10 community-based facilities including Guiding Lights Crisis Stabilization Center in Leavenworth and Pawnee Mental Health Center in Manhattan. In

addition, we have **all the State's Federally Qualified Health Centers (FQHCs)** in our network and coordinate with law enforcement agencies and first responders to support Members at-risk.

Our comprehensive approach in Kansas is supported and informed by the experience and expertise of Aetna Medicaid, which manages the BH and crisis services benefits of over 2.6 million Medicaid Members across 15 states. We will be enhancing our services in 2025 with the addition of a **dedicated, Kansas-based crisis system specialist,** who will be a Kansas-licensed mental health professional with expertise and demonstrated experience working in the Kansas crisis services continuum. This key position will focus on providing education, training, resources, and consultation to our internal Member-facing staff to maintain a safe and holistic response for our Members' BH crises. In addition, this role will be engaged in collaborating and building partnerships with community stakeholders and entities to continue to strengthen the Kansas BH crisis system.

Members in need of immediate assistance can access our **Member services line 24/7** through a toll-free number and receive the **support of licensed BH clinicians who assess, triage, and address emergencies.** When appropriate, BH clinicians will engage a Member's care coordinator to reassure and further support the Member through a warm handoff or three-way call.

We support our Kansas Members, including vulnerable subpopulations related to BH crises, as part of our **One Team, One Member** model of care: through dedicated staff for foster care children and youth; specialists supporting the needs of Members with IDD; Spanish-speaking staff and community resources, and interpretation services for equitable and culturally competent support; and training on the LGBTQ population. We also understand the needs of other vulnerable subpopulations including children and adolescents, veterans, justice-involved, and the intersection of SMI and SUD increasing the risk of suicidality. We help **coordinate access to services that reflect SAMHSA's key components of a BH continuum of care:** access to prevention and early intervention services, crisis services, and treatment and recovery support services.

Practicing Crisis Prevention

Aetna believes the first approach to supporting Members in crisis is to work to prevent crisis from occurring, when possible. Members and families are best served through our proactive approach of intentionally developing genuine, trusting relationships with Members and their circle of support. Having an extensive, proactive local system of care that is integrated into the community, partnering with us to wrap around our Members is imperative.

Our commitment to supporting the Family Crisis Response Helpline

We are able to better serve our Members and demonstrate our commitment to improving health outcomes by being the only KanCare MCO that participates in biweekly meetings with the Kansas Department for Aging and Disability Services (KDADS) and Carelon Behavioral Health, the crisis services Provider for the Family Crisis Helpline for ages 20 and younger. Through this collaboration we stay up to date on the State's crisis response system and have access to program data for enhancing our crisis services. The 988 Suicide and Crisis Lifeline is integrated with the Family Crisis Response Helpline so that individuals who call 988 can be connected with the Family Crisis Response Helpline. 047.KS23

Training and Approach. Working from a trauma-informed perspective and using Motivational Interviewing techniques, our Member-facing staff are positioned to support Members to improve their communication skills, reduce frustration, and enhance the quality of important relationships, such as the Provider/Member

relationship. **Mental Health First Aid training** reviews the unique risk factors and warning signs of mental health problems and emphasizes the importance of early intervention.

Our Crisis Services. Aetna is fully engaged in the crisis continuum and has developed relationships and assisted and/or supported initiatives and strategic campaigns to facilitate and grow crisis response services in Kansas with the Providers and community organizations such as Carelon Behavioral Health, which manages the Family Crisis Response Helpline; COMCARE; Johnson County Mental Health Center; Kansas Suicide Prevention HQ; Mental Health Association; Sedgwick County; and Valeo.

Assessing Members' Risk: Our risk stratification process integrates multiple sources of internal and external data to assess Members' physical, behavioral, and SDOH risks. This includes Utilization Management (UM) and claims data on BH crisis services utilization and BH inpatient admissions, including suicide attempts. The **initial risk stratification is based on quantitative data from our predictive modeling tool,** [redacted] The final risk stratification considers qualitative data, such as Member preferences, source of referrals to care coordination (e.g., Providers, self-referrals, Aetna staff, and others knowledgeable about the Members' condition), and information gleaned through follow-up health risk and needs assessments. Our Clinical Documentation System integrates Emergency Department (ED) and hospital/treatment facility admission alerts and updates care coordinators with notifications and information on Member needs. We also **incentivize PCPs to conduct BH screenings** to identify Members' risks.

Monitoring for Members' Risk Factors: Our Care Coordination team uses the **Clinical Engagement Console (CEC) "Snapshot"** technology to identify a Member's risk factors; inform the care coordinator of the Member's current status, needs, and opportunities for use in discussions with the Member and Care team; and support prioritization of care coordination goals, actions, and interventions. Our CEC Snapshot serves as a quick visual aid that displays multiple health risk factors and levels in a color-coded format to show high, medium, or low risk.

Children's Healthy Administration of Medication and Monitoring Program™ (CHAMMP™): CHAMMP™ is a comprehensive program aimed at preventing overprescribing psychotropic medications in Members under the age of 18. CHAMMP™ monitors Members' medication management through regular Care Coordination team reviews. The polypharmacy rounds are an input into the care coordination system, as Members who are at high risk of crisis are often identified through these reviews and the care coordinator follows up to facilitate access to services and support for the Member. The care coordinator contacts the Member's Provider to discuss metabolic testing and learn more about the Member's medication regimen.

Member Outreach and Engagement: Through our partnership with **Pyx Health, a platform that solves loneliness and social isolation for the most vulnerable Members,** Pyx escalates Member concerns using an electronic alert to our Care Coordination team for Member outreach. The Pyx platform is available to all Aetna Members. The Care Coordination team notifies a Member's Provider if there are concerns as a result of a Pyx intervention. Pyx connects directly to 988 in crisis situations. In addition, we are implementing an **Aetna Advice** initiative that focuses on reducing self-injurious behaviors and suicidality for Members identified as high-risk

children and adults. The program uses an omnichannel approach (i.e., mailings, text messaging, email) and provides education, support, and resources to this vulnerable Member cohort.

Working with Members to Develop Crisis Safety Plans: We collaborate with our Members to develop crisis safety plans using their own language to promote awareness of triggers that are indicative of BH decompensation, as well as situations and people that may exacerbate a crisis. If the Member already has a crisis safety plan through their BH Provider, we use the active plan as the Member's record. This plan lists coping strategies to manage a crisis, names and phone numbers of familial and social supports to contact, local and State crisis hotlines, and locations and contact information for Providers to access in the event of a worsening BH/SUD crisis.

Supporting Members with Comorbid BH/SUD: We train all UM and Care Coordination staff on the regional availability and program descriptions for SUD services, including virtual SUD and BH Providers and the times in which a Member with SUD in crisis should be connected to the 988 Suicide and Crisis Lifeline. **We assign Members receiving Level II or III care coordination with a primary SUD diagnosis to a care coordinator who specializes in BH/SUD.** Our dedicated Care Coordination staff serve as the single point of contact for our Members' care coordination while providing education on SUD; identifying community recovery supports; consulting with our Kansas-based recovery and resiliency specialist to better inform active linkage of our Members to needed SUD services; and supporting our Members' engagement to their local recovery system. In addition, our Member-facing staff receive training in Mental Health First Aid, Motivational Interviewing, trauma-informed care, and evidence-based practices, as well as ongoing supervision and education.

Aetna demonstrates our commitment to Member safety and suicide prevention by training all Member-facing staff in Mental Health First Aid (MHFA). MHFA training teaches individuals how to identify, understand, and respond to signs of mental illnesses and substance use disorders.

166b.KS23

We coordinate care across settings, such as community-based crisis services, CMHCs/CCBHCs, hospitals and EDs, outpatient facilities and FQHCs. We also include SUD peer support specialists in the Interdisciplinary Care Team, with Member permission, to offer Members insight and support from individuals with lived SUD experiences. This includes **peer support specialists with lived experience in the foster care system** who understand that youth in foster care are at significant risk for using substances. In addition, we work with **parent peer support specialists** through CCBHCs for Members to offer parents support and connection from parents with lived experience.

Supporting Members with Opioid Use Disorder (OUD): Our Opioid Management program identifies Members with potential OUD to provide Medication-Assisted Treatment (MAT) and other interventions specific to the disorder and provides care coordination to address the root cause that led to the initial use of opioids such as uncontrolled pain or history of trauma. **Our approach recognizes Members with OUD might be at elevated risk for suicidality.** Care coordinators provide education on opioid use, assist with SDOH and treatment needs by connecting to resources and Providers for evidence-based care such as MAT or pain management, and manage interventions to limit use through our Administrative Lock-In program. Aetna Members in Kansas with **OUD and a subsequent opioid prescription decreased 34.6%** from June 2021 to September 2023.

a. Approach to Collaborating with BH Crisis Providers, First Responders, and Other Crisis Resources to Create a Well-Coordinated BH Crisis Continuum

Our approach focuses on Members having multiple points of entry into BH crisis services, in alignment with the Healthy Kansans 2030 priority of improving access to care by developing seamless collaborative systems that remove barriers to access and support. We have developed a comprehensive, well-coordinated BH crisis response continuum for our Members in Kansas since 2019 by providing BH crisis services with licensed Aetna BH clinicians 24/7; developing and enhancing a coordinated referral system with BH crisis Providers such as the Family Crisis Response Helpline for ages 20 and younger and CMHCs/CCBHCs; collaborating with the four contact centers of the 988 Suicide and Crisis Lifeline; and engaging with first responders, such as crisis intervention teams, on crisis intervention training and strategies.

Aetna Member Services Line**:** Our member services line, supporting telephone crisis intervention, is available to Members needing immediate assistance 24/7 through a toll-free number, in alignment with **Scope of Services Section 7.3.1.** Our Kansas-based team with licensed BH clinicians **assess, triage, and address emergencies and link Members to the appropriate level of services in the highest-quality, least restrictive manner.** During the call, the BH clinician checks our system to verify if the Member has a BH Provider. We remain on every call for as long as necessary to address all needs and confirm the Member is safe. Depending on severity, Aetna staff will verbally provide information to 988 through a warm transfer, attempt a three-way call with a local mental health center or crisis center to provide a warm transfer to a clinician. If 988 is requested, Aetna staff will stay on the line as those are accessed as well to complete a warm transfer.

Our BH clinicians refer all Members who call to the Care Coordination team for follow-up within 24 hours. The Member's Provider becomes part of the Interdisciplinary Care Team with bidirectional communication. We recognize that our internal Member BH crisis line is one of several valuable inputs to better inform our overall care planning and service coordination for our Kansas Members.

Our Kansas call center serves Members Monday-Friday, 8 a.m. to 5 p.m. CT. Licensed BH clinicians in a centralized Aetna Medicaid call center—fully trained on the Kansas integrated crisis system—support Members after weekday business hours, weekends, and major holidays for 24/7 coverage in compliance with **Scope of Services Section 7.3.1.** Members can find the toll-free number on the back of their member identification card, in the member handbook, and on the Aetna Better Health website.

We **do not require pre-authorizations for emergency services or treatment for a BH crisis,** so there are no barriers placed on Members and their caregivers in their most critical times of need, in compliance with **Scope of Services Section 7.10.11.** In addition, we are developing a **training program for Member-facing staff to build awareness and understand risk factors for LGBTQ Members** and to rapidly connect LGBTQ Members to resources such as The Trevor Project and Providers in their Kansas communities.

Linking Members to BH Crisis Providers, First Responders and Crisis Resources

We train Member-facing staff, including BH clinicians, member services and care coordination, on the continuum of community resources for BH crisis services, including use of crisis lines, appropriate crisis services available within each region and the process for linking Members to the appropriate crisis services as needed. Through the member services line we make referrals to mental health and BH services such as CMHCs or CCBHCs, Regional Alcohol and Drug Assessment Centers (RADAC), social detoxification units, and certified gambling counselors, in compliance with **Scope of Services Section 7.10.11.** Aetna contracts with Heartland RADAC, serving Members in 13 locations.

We work with law enforcement agencies to support Members in addressing their BH issues through referrals to Providers and community resources, and to keep them from going to jail. We support law enforcement by sharing HIPAA-compliant information about Members and request welfare checks on our Members. In some instances, our BH clinicians support law enforcement and mobile crisis teams by phone during a Member crisis.

We are **working with Sedgwick County's Crisis Intervention Team (CIT), Homeless Outreach Team, and Sedgwick County Offender Assessment Program** to identify ways to share resources to improve public safety and divert individuals with mental health conditions from the criminal justice system and into treatment. In addition, we are meeting with **law enforcement agencies in Topeka and Wichita** about developing partnerships for training and crisis coordination protocols.

We are learning from the experiences of affiliate Aetna Medicaid health plans in other states to expand our CIT program. For example, Mercy Care, an Arizona health plan administered by Aetna Medicaid, established a program, in collaboration with Solari Crisis and Human Services, to train the staff at Phoenix Police Department (PPD) dispatch centers to divert calls related to mental health crisis to Solari's crisis center. As a result, 911 **dispatchers relay calls to a Solari specialist instead of first dispatching an officer for the many calls that do not require police intervention,** where safety is not a concern, and an on-scene response may not be needed. We also understand learnings from Mercy Care's provision of **Applied Suicide Intervention Skills Training** to tribal community caregivers and crisis intervention training to tribal police can be applied to our partnerships with law enforcement in Kansas. These trainings improve caregiver and police responses to crisis situations; disseminate information about available outpatient BH services; and increase the likelihood of Member access to timely and appropriate services without involving criminal justice.

Aetna recognizes that our Members with justice involvement are a vulnerable subpopulation that often struggle with physical health, BH and SDOH needs. We will have a **dedicated, Kansas-based justice system of care specialist** to improve our engagement, in-reach and collaboration with Kansas jails, prisons, courts and probation/parole. Further, a key focus will be providing information, resources and consultation to our Care Coordination staff to promote holistic, person-centered transitions, and prevent decompensation, for our Members integrating back into the community. Our comprehensive approach will improve our BH safety planning component for justice-involved Members and reduce the risk of recidivism.

We are committed to improving crisis prevention and services for Members. The following initiatives are integral to our approach to increasing Member engagement, monitoring for improvement or exacerbation in symptoms, and intervening before a Member has a crisis or needs ED or acute care services:

- We are continually enhancing our relationship with the Kansas Department for Aging and Disability Services and State partners **to improve nursing facilities for mental health transitions** with the understanding these Members often have significant BH concerns.
- We are the **only MCO with embedded care coordinators at hospitals in Kansas,** which enhances communication and increases access to Members receiving services. Additionally, we have CHWs embedded with two CMHCs/CCBHCs in Wichita (COMCARE) and one in Johnson County (Johnson County Mental Health Center), to meet with Members on their medication management, treatment compliance, health care engagement, and SDOH needs.
- We **meet weekly with Mental Health Association (MHA) and Valeo community health centers to address Members' needs and address gaps in care.** Many of these Members have had recent BH crisis episodes that place them in an inpatient admission or ED visit. We work with MHA and Valeo to wrap the Member in services as timely as possible.
- We conduct **weekly rounds with Members in psychiatric residential treatment facilities.** Our interdisciplinary teams make sure each Member is fully wrapped in services to meet all their needs upon discharge. Care coordinators support Members with crisis awareness and prevention education and services as appropriate.
- Two Aetna Care Advocate specialists are on the State's leadership team focused on **diverting Members with IDD away from crisis services and incarceration** using the Sequential Intercept Model.
- .We actively **engage with organizations such as Kansas Suicide Prevention HQ, Association of Community Mental Health Centers of Kansas and CKF Addiction Treatment,** as well as meet weekly with CMHC Providers with Members transitioning from inpatient or crisis services. In 2023, we participated in and made a financial investment to the Kansas Suicide Prevention Coalition meeting and attended the Kansas Suicide Prevention HQ Coalition and the 988 Breakfast Celebration as examples of our commitment to developing and enhancing crisis solutions.

Supporting Members After a Crisis:
Following a crisis, the care coordinator contacts the Member to confirm their ongoing safety and review and/or revise their crisis safety plan (if they have one). The crisis safety plan is part of the Member's care plan, plan of service, or Person-Centered Service Plan developed in collaboration with the Member and their natural support system. The care coordinator and an Interdisciplinary Care Team support the Member to prevent another crisis by eliminating gaps of care, building supports, and lowering readmission possibilities, as well as assisting with SDOH and treatment needs by connecting to resources and Providers for evidence-based care. These services include recovery support, outpatient, intensive outpatient/day services, residential, and hospital/intensive inpatient. As the single point of contact for the

Leading BH HEDIS Measures
Aetna ranked first among KanCare MCOs in the following categories in 2022:

- Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: **7 Days**
- Follow-up After Emergency Department Visit for Mental Illness: **30 days (above 90th percentile)**

105.KS23

Member, the care coordinator works with our dedicated care advocate specialists with system of care expertise to address needs that are critical to maintaining community tenure.

When receive crisis notifications in a variety of ways, including admission, discharge, and transfer alerts for emergency services, daily reports from Carelon, which manages the Family Crisis Response Helpline, and alerts from Providers through the BH crisis mailbox. **If the Member is not participating in care coordination,** we outreach to the Member, offer care coordination services, and make sure the Member has community supports and follow-up appointments in place. When Members receive emergency services but not inpatient care, we contact them within 72 hours of crisis resolution. For Members receiving inpatient care such as a BH psychiatric admission, we coordinate with the inpatient facility on discharge planning upon admission and support Members to attend follow-up Provider appointments. We notify the Member's Provider(s) following a crisis and include the Provider on the interdisciplinary care team.

b. Approach to Collecting Data, Measuring, and Evaluating the Effectiveness of BH Crisis Services, and Implementing Improvements Based on Findings

Our approach focuses on collecting data from a variety of sources, using the data to inform our crisis response activities, measuring, and evaluating the effectiveness of our BH crisis services and implementing improvements. As technology and crisis-related programming have advanced during our five years as a KanCare MCO, we have continually reviewed opportunities to expand our data information resources to improve health outcomes.

How We Collect and Use BH Crisis Services Data

We receive **external daily utilization** reports on the Family Crisis Response Helpline from Carelon and Provider notifications through the BH crisis mailbox. We use the data to deliver timely services and conduct analysis for improvements in the following ways:

UM: We **collect monthly UM data of crisis services received by our Members,** including Member demographics, date of service, service received and primary diagnosis. We **analyze the UM data for quantitative indicators of performance and relevant process metrics** including trends for identification of Member-specific crisis recurrences. We extract gaps in care insights to implement improvements, including engagement with care coordination and Member crisis prevention initiatives and to aid in decision-making for service improvement including service or network expansion.

Family Crisis Response Helpline: We review daily reports from Carelon, which **identify our Members who had contact with the Family Crisis Response Helpline** and/or a follow-up crisis service the previous day. We follow up on all crisis contacts identified in daily reports within 72 hours of crisis resolution to determine the Member’s need for further services or make referrals to any services. We collaborate with the Member’s Interdisciplinary Care Team to manage the crisis, facilitating same-day follow-up appointments, when necessary. Carelon reports that the **Family Crisis Response Helpline has received 353 crisis calls** from Kansans ages 20 and younger over a rolling 12-month period, supporting 288 individuals and facilitating 38 mobile crisis interventions.

Clinical Documentation System: We analyze data from the Clinical Documentation System to **measure the timeliness of crisis referrals,** confirming care coordinators are making follow-up calls within 24 hours of the event to address Members' post-crisis needs. **In 2022 and 2023, Aetna care coordinators completed 100% of calls within 24 hours.** We would address any timeliness gaps with 1:1 meetings and additional training for care coordinators.

BH Crisis Mailbox: We receive and respond to **crisis notifications from Providers** in a BH crisis mailbox to inform our Care Coordination team of Members' involvement in a crisis event. For example, **Aetna provided timely support by outreaching 100% of the 51 Members identified in the BH crisis mailbox in 2022** within the State's 48-hour requirement.

Community Resource Directory: We monitor data from our Community Resource Directory, which has a **dashboard of referrals to BH services and the Family Crisis Response Helpline,** which informs our Care Coordination team for Member outreach and services.

How We Use Data to Drive Improvement

Aetna's BH supports director takes the lead on analyzing internal and external data related to BH crisis services. The BH supports director monitors data for developing trends and identifying gaps of service and opportunities for improvement. This BH and crisis subject matter expert works closely with our BH medical officer, care coordination managers, recovery and resiliency expert, and other Aetna leaders to discuss Member issues and trends in complex case rounds as part of our solution development process. We anticipate our **dedicated, Kansas-based crisis system specialist** will take a lead role in BH crisis services data analysis and program development when we implement the position in 2025. The crisis system specialist will gather and conceptualize data and report to the QM/UM Committee.

Learning from Innovative Programs in Other States

In Kansas, we are learning from the experience and expertise of Aetna Medicaid-affiliated or -administered health plans with similar arrangements with state crisis line and 988 vendors. For example, in Arizona, Aetna Medicaid's administered health plan, Mercy Care, has a **structured data-sharing agreement with Solari, the State's crisis phone line vendor**, that **results in improved coordination and process improvements.** In addition, Aetna's affiliated Kentucky plan is developing a strategy, using 911 and 988 data, to provide a heightened, more comprehensive overview of crisis calls and management. We will expand these resources into Kansas upon further development.

c. Plan for Evaluating and Meeting Network Adequacy with Crisis Services

Aetna's plan for evaluating and meeting network adequacy with BH crisis services includes using **quarterly data analysis** of services available in our network and reviewing Member and Provider appeals and grievances data, as well as Member and Provider feedback, to make sure Members have access to BH, psychiatric, or other community services through referrals to our Provider partnerships. We use data analysis to identify opportunities for service or network improvements for Member crisis prevention and stabilization services. We use data-driven strategies to assess for adequacy, opportunities for network development and to manage and monitor the network. Our network adequacy approach centers on access to high-quality care and

Providers who reflect the diversity of our membership. We contract with any willing Provider, including CCBHCs/CMHCs, FQHCs, and RHCs.

We have developed a **comprehensive BH crisis response network in Kansas since 2019** that aligns with the Healthy Kansans 2030 priority of improving access to care by developing seamless collaborative systems that remove barriers to access and support. As the state of Kansas' crisis network evolves and confirms there is a safety net to serve all children and adults in crisis regardless of health care coverage, we will continue to expand our partnerships with local crisis resources, crisis helplines, mobile crisis teams, psychiatric hospitals, community-based crisis centers, and CITs. Aetna currently has communication, coordination and data-sharing protocols among these entities, guaranteeing timely access to care. Our approach allows us to build upon existing strengths and further evolve a comprehensive, community-based crisis continuum. We will continue our work with stakeholders to refine primary objectives, actionable steps, and timelines to address crisis system needs for each community in Kansas. We currently **contract with all 26 CMHCs,** 20 of which are designated CCBHCs with the remaining scheduled to be certified by July 2024, including mobile crisis services. In addition, we coordinate through a business associate agreement with the Family Crisis Response Helpline for BH crisis services, including mobile response and stabilization services. We contract with **20 mobile crisis response teams,** including **8 that co-respond with law enforcement teams.**

Aetna contracts with 100% of the Providers of crisis stabilization services, including: Central Kansas Mental Health Center, COMCARE, Family Service and Guidance Center, Guiding Lights Crisis Stabilization Center, Marillac Campus, Pawnee Mental Health Center, Rainbow Services, Research Psychiatric Center, Treatment Recovery Center and Valeo Behavioral Health Care. We further expand access to care by implementing **telehealth solutions** that provide immediate access to BH professionals. Through telehealth services we work with Members to make sure they are seeing Providers before they progress to a higher level of need. This includes telehealth services from CMHCs, CCBHCs and private mental health practices; CKF Addiction Treatment for adolescent and adult SUD treatment; Flourish Health for telepsychiatry and therapy for ages 13-26; OneTelemed telepsychiatry for ages five and older; and MDLIVE supporting mild to moderate conditions for ages 10 and older.

We are proud to be part of the crisis stabilization services' growth in Kansas. KanCare Members have greatly benefited from an increase of 3 Providers in 2017 (COMCARE, Rainbow, and Valeo) to 10 today.

166c.KS23

d. Plan for Promoting Awareness of 988 and Access to Local Crisis Services

Our comprehensive plan for promoting awareness of 988 and how to access local crisis services focuses on using multiple communication mediums as well as direct, personalized communications with Members and Providers. Our approach aligns with the Healthy Kansans 2030 priority of improving health literacy.

Member Promotion and Education: We promote 988 awareness electronically through detailed crisis services pages on the Aetna Better Health of Kansas website and the member portal, as well as on-hold messaging with the Member services line. We also include related information in the member handbook, member newsletters, and other member materials. Our care coordinators inform Members of these BH services during their 1:1 meetings. We work with high-risk Members in care coordination to develop comprehensive crisis safety plans that include local,

regional, and state resources such as 988 services. In addition, OneCare Kansas Providers educate Members about 988 and BH crisis services.

Provider and Community-Based Organization Promotion and Education: We promote 988 awareness with Providers through 1:1 meetings with our provider relations representatives and provider bulletins. Our provider relations representatives meet in person with all Providers in our network. Aetna's Collaboration and Real Engagement Solutions (CARES) team, which focuses on developing community partnerships, also has 988 information cards, magnets, stickers, and posters we share with community Providers. In addition, we support and promote 988 services by featuring it in our **electronic community newsletter that we share with over 1,500 individuals with community-based organizations and Provider offices** around the State.

Aetna is committed to participating in community stakeholder meetings, collaboratives, and discussions focused on promoting awareness of the Kansas crisis delivery system while supporting efforts to better meet the needs of all KanCare Members at risk for BH crises.

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Topic Area 4: Utilization Management and Services

17. Describe the bidder's approach to increasing the provision of screening and tobacco cessation services to KanCare Members disproportionately affected by smoking and tobacco use. Include an example of a similar approach the bidder has taken with similar populations that was successful, the measurable impact achieved, and why the bidder anticipates the approach will result in improvements in KanCare.

We know tobacco use is a critical health issue, posing a disproportionate threat to the well-being of KanCare Members. **We currently serve over 140,000 Members in Kansas and have been refining and tailoring our Kansas-specific clinical program to Members' needs since 2019.** In Kansas, 16% of adults aged 18 and above engage in commercial tobacco products, encompassing traditional cigarettes, vaping, or smokeless tobacco.

As a company deeply committed to advancing tobacco cessation efforts, it is noteworthy to highlight our dedication and proactive initiatives thus far. **In 2014, CVS Health took a significant stride by committing to the removal of tobacco products from its stores.** Subsequently in 2016, CVS Health launched the Be The First youth tobacco prevention campaign, a five-year, $50 million undertaking. This comprehensive endeavor designed to help create the first tobacco-free generation has far exceeded its initial target by successfully engaging 15 million youth through education, awareness, advocacy, and healthy behavior programming. This achievement surpasses CVS Health's initial goal of reaching 8 million youth, underscoring its unwavering commitment to effecting positive change in the landscape of tobacco use. 044a.KS23

According to our data, tobacco use impacts Members in several significant ways. Smoking rates compared to the general population are higher due to higher stress levels, mental health issues, and higher level of financial instability. Higher prevalence of smoking contributes to greater health disparities. Members are more likely to suffer from smoking-related illnesses, such as lung cancer, heart disease and chronic obstructive pulmonary disease. Tobacco use is often higher among people with mental health conditions, a group overrepresented in the population. Pregnant women who smoke can have adverse outcomes like low birth weight and preterm birth, impacting not only the health of the mother but the long-term health of the child.

Because we understand these trends and the larger impacts of tobacco use, **our Member Engagement strategy incorporates tobacco use screening. When a qualifying Member (e.g., pregnant Members or Members with chronic conditions) screens positive for tobacco use, our clinical team works directly with the Member** to address the tobacco use, its downstream consequences, and the underlying drivers triggering its use.

For Members that are not identified for care management, we deploy specific population-wide education strategies to create awareness of the dangers of tobacco use and build awareness on treatment options. **Our approach promotes clear access to cessation programs to which Members may not have had awareness, had limited resources to pursue, or experienced other barriers preventing them from a tobacco-free life.** We empower Members with accessible information about tobacco cessation programs leveraging proven communications channels such as a Member Handbook, Member Website, Member Welcome Packet, newsletters on chronic disease management, numerous targeted educational mailings, and outbound

telephone campaigns. As a result of our strategy, **Aetna's survey results for advising Members about tobacco cessation outperform the other MCOs in Kansas by 5%, based on the most recent External Quality Review Audit from 2022-2023.**

Our Approach to Tobacco Cessation: Screening and Intervention

To support Members who use tobacco, our comprehensive strategy begins with screening, and combines care coordination, tobacco-cessation best practice programs such as Nicotine Replacement Therapy (NRT), traditional care management, and targeted education aimed at both Members and Providers.

Screening Members for tobacco use is the starting point to our intervention strategy. We complete screenings through key channels, including health risk assessments (HRAs), predictive analytics that include tobacco use disorder ICD-10 claims inpatient and outpatient utilization; pharmacy data, therapeutic, professional, and ancillary services. We also utilize Member self-reporting through our member services line or nursing hotlines, referrals from internal care coordination team, and referrals through external Providers/practitioners, health and wellness coaches, dentists, and external case managers.

As an example, HRAs helped identify and educate KanCare Members in the following ways:

- **January 2022 to October 2023, Aetna has seen a 21.2% increase in Members identified** with tobacco use disorder receiving any form of treatment (physician consultation, pharmacy, and/or care management intervention). 16.3% in January 2022 receiving support up to 19.8% as of October 2023.
- **January 2022 to October 2023, Aetna has had a 13.6% increase in Members receiving smoking cessation education,** 3.7% in January 2022 and up to 4.2% as of October 2023.

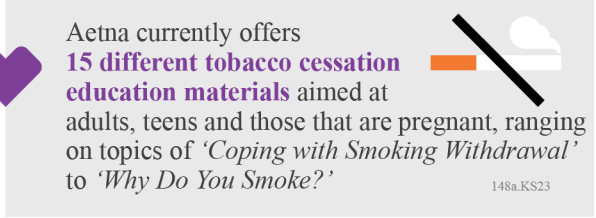
These screening processes require a nuanced understanding of health equity and the cultural context surrounding tobacco use, particularly as seen within American Indian/Alaska Native communities. Our screening tools take this into account by:

1. Developing questions that are person-centered and framed in a way that does not assign blame or guilt.
2. Developing educational content that is culturally aware.
3. Ensuring our data analytics remove unintended biases.

We are also mindful of Members at risk for SDOH-related needs, ensuring we have a comprehensive and culturally sensitive approach to screening questions within our SDOH-related activities.

Within the Kansas D-SNP population every Member receives outreach to complete a Health Risk Assessment (HRA) which includes a question on how many times in the past 12 months the member has used a variety of tobacco products. The Member's Care Manager reviews the HRA responses, in addition to other information, and works with the Member to develop an individualized care plan. If the Member is interested in quitting smoking, the CM will help the member access the D-SNP smoking cessation benefit. **Year to date through August 2023 there have been 499 smoking cessation counseling session claims paid for 308 unique Members.** 044b.KS23

Upon identification of a Member that screens for tobacco use, we deploy the following intervention strategies, with some having been in place since our entry to Kansas in 2019, while other strategies are continued to be enhanced to expand our ability to promote meaningful change in alignment with Healthy Kansans 2030 Vision:



1. Care Coordination: Care coordinators are in a unique position to support cessation activities through individualized outreach, screening assessments, use of motivational interviewing techniques, person-centered service planning, knowledge of relevant Providers, and coordination of care over time, including regular follow ups. **Care coordinators are trained to recognize tobacco use as a barrier to overall health.** When Members are engaged in care coordination activities, our care coordinators ensure that the person-centered care plan addresses tobacco cessation by assessing the Member's understanding and willingness to make tobacco cessation a priority goal.

Once a Member is committed to their customized approach, our care coordinator adds this to the Member's care plan, offers supporting educational material based on the Member's preferences, and encourages Members who smoke to participate in KanQuit. Our care coordinators are licensed clinicians who also educate the Member on the dangers associated with tobacco use citing Kansas data and provide techniques that are evidence-based to support becoming tobacco free. Each touch point with the care coordinator and Member will revisit this topic for additional reinforcement and progress toward quitting. The care coordinator will encourage the Member to review the materials provided and ask follow-up questions of their provider for medicinal support, if appropriate. The care coordinator will share the care plan with the provider for transparency and support of the plan to quit. **Since 2019, Aetna mailed over 900 educational materials, with express Member interest to review them.**

Members with chronic medical conditions identified as tobacco users that require wound care are a specific target for our care coordinators because our data shows that tobacco cessation as part of wound care management is an evidence-based practice. Our chief medical officer worked with KDHE to help establish a new prior authorization protocol that would require documentation of smoking cessation and treatment prior to authorization for products using skin substitutes in ongoing wound care treatment plans. **Because of this new requirement, we will extend our tobacco cessation programming in 2024 by creating an expanded referral process to care coordinators for individuals with long-term wound care needs.**

2. Community Health Worker (CHW)/Community Health Representative (CHR) Based Interventions: By providing culturally appropriate information tailored to all literacy levels, the care coordinator and CHW/CHR teams work together to create an action plan consisting of multiple methods of support for Members wishing to stop using tobacco. Supporting Members where they are, CHW/CHR involvement in care of underserved populations links Members with health care services and supports treatment plans outside of the health care setting. This includes Native American populations, with CHW/CHR resources that are trained in tobacco cessation. The CHW/CHR:

- Visits the Member in their home to identify and address SDOH issues and, if tobacco use is identified either through observation or through self-disclosure by the Member, provides education and resources aimed at promoting cessation.
- Hosts group sessions at convenient locations to facilitate ease in accessing care.
- Proactively contacts with Members to track progress on mutually set goals.

3. Member Real Engagement and Community Help (REACH) Teams: Our Member REACH Team, an SDOH call center, uses social risk analytics, claims data as well as data received from various health information exchanges (HIE) to proactively identify and contact Members at risk for SDOH needs. For Members not identified for care coordinator engagement or who opt-out of care coordination, our Member REACH team also leverages the same screening mechanisms to reach out to Members who use tobacco They help identify resources, assess their readiness to quit, and refer Members to the existing statewide KanQuit program. The REACH team also uses their proprietary community resource directory to support any other Member needs that are identified through the outreach. They provide Members the same educational materials that are available to our Care Coordinators as described above. By mid-2024, the REACH team will also be deploying targeted outreach call campaigns for Members with the tobacco use Z Codes to provide resources, education, and referrals based on the Member's goals.

4. Medication Treatments: We support Provider education through the Statewide KanQuit program, which offers free education materials on tobacco cessation and medication-based treatment options for use in Provider offices. We support medication treatment accessibility by educating Members and Providers on covered benefits, and process of accessing medications. In fact, none of these medications listed below for treatment of tobacco cessation require a prior authorization. **Paid claims for all tobacco cessation products (including OTCs) from 2019 to December 1, 2023,** is $2.1 million dollars**.**

- By prescription, FDA approved nicotine replacement therapy (NRT) replaces the nicotine from tobacco use to help avoid tobacco use disorder withdrawal symptoms and cravings.
- By prescription, over the counter (OTC) such as Nicorette™ patch, gum, and lozenges and work in the same way as prescribed NRT. **Since January 2023, Aetna has mailed over 60 nicotine replacement products directly to members' homes making it easier to get access to these treatments without having to even to go the doctor for the prescription.**
- By prescription, non-NRT medications such as varenicline (Chantix) that is classified as a tobacco cessation aid and blocks the pleasant effect of nicotine on the brain. **Since 2019, we have had an over 26% increase in filled prescriptions for Chantix and Zyban.**
- By prescription, non-NRT medications such as bupropion SR (Zyban), classified as an antidepressant known to support tobacco cessation by improving mood regulation and curbing nicotine cravings.

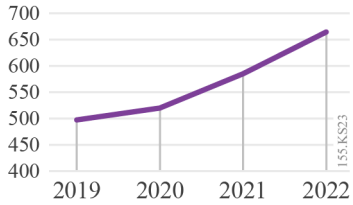


Figure 17-1: Medication Treatment. *Utilization of non-NRT medications 2019-2022.*

5. Provider Education - 5A (Ask, Advise, Assess, Assist, Arrange) model interventions: We educate Providers on implementing **5A model** interventions and inform them that tobacco cessation therapies are in the Members benefit structure and are reimbursable. This model encapsulates the necessary action steps for Providers to optimize their interactions with tobacco-using patients.

Healthcare Providers, including Primary Care Providers, OBGYNs, behavioral health Providers, and dentists, have a unique opportunity in their regular care provision to identify KanCare Members for referral to tobacco cessation within the framework of the 5As model. This approach helps identify KanCare Members who either smoke or encounter secondhand smoke during pregnancy. This model directs Providers in guiding Members through tobacco intervention steps to facilitate quitting.

6. Pivot Breathe as a Value-Added Benefit: Starting in 2025, **Aetna will provide Members with access to our Pivot Breathe program to maximize their chances of success and augment a plan-wide tobacco cessation strategy.** This tobacco cessation program is designed to engage Members early in their quit journey, even if they are not yet ready to quit. In collaboration with Pivot, we will offer **one-on-one support from a certified tobacco cessation coach** and **an FDA-cleared Pivot Breathe Sensor,** a lightweight, pocket-sized device that measures carbon monoxide in exhaled breath and integrates with the mobile app for real-time feedback in support of behavioral change. The mobile app includes in-app activities, on demand access to a certified tobacco cessation coach, and a robust online support community with fellow Pivot participants. Information about Pivot will be included on Aetna's website, mobile app, and Member and Provider handbooks, as well as through care coordination teams and Member services.

Success in a Similar Population

Our affiliated Louisiana plan is partnering with their State program to reduce tobacco use and offers Pivot to Members who need additional support. The program is available to a broad array of Members, offering a breath sensor device, peer contact, and other supports that go beyond telephonic coaching. Aetna Better Health of Louisiana introduced Pivot to Members in **January 2023,** and **participants are displaying increased motivation to quit, favorable quit attempt rates, decreased daily cigarette consumption, and 50% of participants established a quit date.**

Measurable Impacts from Jan. 2023 through Oct. 2023 include:

- 62.5% have reduced their tobacco use
- 12% of Members have completely quit
- 20% who downloaded the app self-reported that they quit smoking (30 days since last use)
- 49% engaged with coaching
- 48% completed lessons in the app
- 84% are active in the app community support feature

Drawing on our experience and understanding of Kansans who use tobacco, our approach leverages the strength of our integrated care model, where Members work with our care coordinators and CHW representatives to initiate positive behavioral changes among Members, fostering improvements in both current and future health and wellness outcomes.

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Topic Area 4: Utilization Management and Services

18. Describe in detail the proposed value-added benefits the bidder intends to offer KanCare Members, including the scope of each benefit (including any limitations), the target population, and the anticipated benefit to KanCare Members. Include the bidder's approach to assessing the impact and value of the value-added benefits to Members.

As a current KanCare MCO, Aetna Better Health of Kansas Inc. (Aetna) knows it takes more than investment to improve the health, wellness and independence of Kansans—it also takes outreach, education and a deep understanding of Kansas. In alignment with KanCare goals and the new contract requirements, below we describe how we are already creating a healthier Kansas, our value-added benefit approach, the value-added benefits we offer today, the value-added benefits we will offer under the new contract and targeted populations, and how we assess value-added benefits for impact and value.

Aetna has spent **more than $15 million on value-added benefits** from the start of our KanCare contract through October 2023.
083.KS23

We are proud to partner with KanCare to create a healthier Kansas. We do this by offering value-added benefits to support Members on their health, wellness, and independence journey. We know the challenges and needs of Kansans, which is why, according to the 2022 KanCare Annual Report, **we spend more on value-added benefits than all other KanCare MCOs combined.** Since Jan. 1, 2020, we have invested more than $15 million in value-added benefits.

Creating a Healthier Kansas

Our value-added benefits programs for Kansas tie directly to the State's vision of KanCare and Healthy Kansas 2030 initiatives to prepare a future-ready Kansas through educational and workforce training supports, improving health literacy, and better health outcomes. Our current value-added benefit offerings will remain in place throughout the new contract. We have also proposed additional value-added benefits to address critical needs such as access to healthy food, support for foster youth, and expanded transportation. The value-added benefit offerings focus on priorities identified in Kansas, including improved prenatal care and birth outcomes, improved access to mental/behavioral health care, and decreasing the percentage of Kansans who are obese/overweight. We continue to draw on our experience to provide strategic, innovative value-added benefits that align with successful outcomes. For example, the following value-added benefits have shown increases in utilization and improved outcomes to date:

- **Healthy Rewards Incentive program** improves access to care by allowing Members to purchase needed items, such as healthy food, over-the-counter medications and supplies, clothing, and household goods from a broad range of stores, including Walmart and CVS.

Healthy Rewards is one of our most popular value-added benefits. **Since adding this program for KanCare Members, Aetna Member utilization has increased by 535%, with an increase in total spend of 2,190%.**
017.KS23

- **Weight Management program,** in collaboration with the University of Kansas, we offer a 12-week class led by a registered dietician with experience in rural areas and food deserts, covering topics on healthy eating, exercise, and behavior change. The program also has an app to track progress and provide support. Member satisfaction with the program has been positive and some **Members want to take the class more than once** due to their successful

results, the group support offered, and the knowledge and support of the health educator to decrease obesity throughout Kansas. From fiscal year 2020 through Oct. 31, 2023, we supported 225 unique Members (229 Members completed classes, 19 Members currently enrolled in the program, and 17 Members pending program start) **with a total spend of over $33,250.**

- **No Place Like Home program (NPLH).** Through this grant program we collaborate with Community-Based Organizations (CBOs) and Providers to help Members establish or maintain a home in the community. The program focuses on Members who are homeless or at risk of becoming homeless, including Members exiting nursing facilities or state institutions. This one-time emergency assistance program **provides up to $5,000** to help pay for housing costs such as initial rent assistance, items to purchase for the new home, and other needs for Members such as: housing application fees, deposits, first month's rent, past due utilities, furnishings, and housewares. Members are referred to NPLH by Aetna colleagues, CBOs, or Providers, and the supporting CBOs make purchases on behalf of the Member. Members must be receiving services from a CBO to address any challenges that may have contributed to their housing instability. As of Oct. 31, 2023, **we supported 36 unique Member households with a total spend of over $81,800.**

Member Story
The Melnyk's*

No Place Like Home

The Melnyk's are refugees from Ukraine. The household includes a mother and her two children, while the father is away fighting in Ukraine. Mrs. Melnyk holds a bachelor's degree and is employed; however, her required English classes are interfering with her ability to work enough hours to pay for rent. The family's local sponsor approached Aetna to inquire about our No Place Like Home value-added benefit. Aetna's housing support administrator referred the family to an Aetna care coordinator who conducted an in-home assessment with assistance from Aetna translation services. With this information, Aetna's housing support administrator was able to provide funds to secure short-term rental assistance and work with the family's local sponsor to help Mrs. Melnyk have the time needed to improve her English skills and solidify the family's income.

**Name changed to protect Member privacy*

054d.KS23

- **Working with families,** like the one described in the Melnyk's story, allows Aetna to form deep connections with community organizations like the one sponsoring this refugee family. Many Member households experience similar barriers to income and housing. Through the NPLH program, combined with our collaborative community relationships, we have helped 13 similar refugee households composed of over 20 Members with short-term rental supports.
- **Pyx Health. In 2022,** we began offering the Loneliness Help value-added benefit from Pyx Health where Members download an application that helps them fight loneliness and social isolation. By screening for anxiety and depression, and by engaging with Members and providing support, the app helps prevent potential continued exacerbation of anxiety and depression symptoms. The medication adherence assessment helps improve adherence to prevent further exacerbation of anxiety and depression. Members connect with compassionate humans for a friendly chat or help with resources. Members get the program information through care management or member services. They provide information on how the Member can access the Pyx Health application. **Since the Jan. 1, 2022, inception of the Pyx Health program in Kansas, 42% of Aetna Members showed improvement in UCLA-3 Loneliness screening from initial screening to the most recent screening score, and**

Emergency Department utilization went down by 9.1% from the rolling 12-month period before Pyx utilization started to the six months after beginning using the Pyx Health program.

  - The Pyx Health app is also used to identify SDOH needs and connect individuals with resources. The Pyx Compassionate Call Center can call and onboard Members over the phone. They engage Members by making outbound companionship calls when Members have been identified as being lonely and reach out within one business day.

- **The Over-The-Counter (OTC)** value-added benefit provides a monthly allowance for Members to purchase items they might not otherwise be able to afford. By covering everyday health products, we are investing in preventive care, helping Members stay healthy, and reducing the risk of more significant health issues. Each household can order, by phone or online, up to $25 per month of certain OTC drugs and supplies from a CVS Health catalog. Supplies are mailed directly to the Member's home for easy access. Our OTC program utilization has **increased by 30% since implementing this value-added benefit.**

Since the implementation of our Adult Dental value-added benefit, we have spent **over $3 million and seen an increase in utilization of 205%.**

004b.KS23

Member Success Story

Elizabeth*

Before I learned about the OTC benefit from my insurance plan, I was often faced with the challenging decision of purchasing essential health products or saving that money for other needs. But once I enrolled in the plan that included an OTC benefit it helped me save for other needs. Each month, I'm provided with an allowance to spend on a wide range of over-the-counter products. From vitamins and first aid items to pain relievers and digestive health aids, I've been able to stock my medicine cabinet without feeling the financial pinch. This not only gives me peace of mind but also ensures that I am proactive about my health and my children's health, having all necessary supplies on hand when needed. Additionally, the process is seamless. And the best part? These aren't just generic items – they include trusted brand names that I've known and used for years.

I wholeheartedly recommend anyone eligible for this benefit to take full advantage of it. It's transformed the way I approach my health and wellness, and I'm grateful for the support it offers.

Thanks, Elizabeth

**Member name changed to protect identity*

015.KS23

- **Adult Dental Benefit. In 2020 we were the first MCO in Kansas to offer a denture benefit.** Our comprehensive dentures value-added benefit provides Frail Elderly (FE) waiver, Physically Disabled (PD) waiver, and IDD waiver Members with $2,500 every five years for a complete set of dentures. While the dentures benefit ends Dec. 31, 2023, we are extremely excited that Kansas is now covering dentures and we are spending value-added dollars on additional dental benefits that provide needed oral health services to Members. **Our combined dental value-added benefits spend exceeds $3,622,097 from Jan. 1, 2020, through Oct. 31, 2023, with spending of $3,120,441 for the Adult Dental value-added benefit alone.** We continue to collaborate with our dental subcontractor incorporating their experience to strategically drive enhancements to our value-added benefits for Members.

Member Success Story

Daniel*

Daniel, a KanCare Member on the Frail and Elderly Waiver list, was in critical need of dentures. His care coordinator educated him about the value-added benefits available to him for oral health and dentures. Together, they developed a person-centered plan to address his needs, and his care coordinator assisted Daniel in a call with member services to identify a dental Provider in-network.

Daniel was able to obtain the upper dentures that he needed. This has improved his daily life and confidence. Daniel expressed his appreciation for the help, advocacy, and support provided by his care coordinator.

**Member name changed to protect identity*

013.KS23

Our Value-added Benefit Approach

Our approach to assessing the impact and value of our value-added benefits combines our national and local expertise to determine the best offerings for KanCare Members. Our experience in Kansas drives the design of our value-added benefit offerings, which are available across all regions.

For the past five years, our culturally competent, diverse and experienced team of internal staff has delivered comprehensive value-added benefit offerings to Members throughout Kansas. Our national Value-Added Benefit team meets quarterly and yearly with our Kansas dedicated Value-Added Benefit team to identify best practices from other markets to apply to Kansas. Our Kansas team meets monthly to review utilization, discuss Member feedback, and determine that the value-added benefits offered are appropriate, **resulting in our value-added benefits having the highest Member usage of all MCOs offered in Kansas.**

Since 2019 through October of 2023, we have held more than **2,454 meetings and 88 community events with attendance of over 143,000 individuals.**

004d.KS23

Our deep Member focus helps promote better Member engagement and increased value-added benefits utilization. We achieve this through our extensive outreach, including face-to-face meetings and communications to Members, CBOs, and Providers. These meetings help us obtain feedback to inform the design of our value-added benefits. Our Member newsletter, website, and community events, combined with identification by the care manager are some ways we reach Members to make them aware of our value-added benefits. Ways we educate our Providers about our value-added benefits include the value-added benefits brochures, Provider newsletters, and quarterly trainings on value-added benefits during Provider town hall sessions. Our community development coordinators and Community Collaboration and Real Engagement Solutions (CARES) team listen to Provider feedback to determine possible value-added benefits for Members. In addition to our community eNewsletter, our community development coordinators meet with and educate CBOs on the benefits available to Members.

When combined with our dedicated SDOH program, Better Together: Social Impact Solutions, our value-added benefits help support better health outcomes. The Better Together SDOH team collaborates with the community to implement and support programs in the areas that serve Member needs. These efforts, combined with our value-added benefits, support Members holistically, as individuals and the communities they live in. Because of our trusted relationships with CBOs, we identify what Members need, allowing us to be more targeted with our approaches to see that they are effective. This team works with our national and

local Kansas Value-Added Benefits teams to identify and develop new programs and use strategic investments, as well as integrate our suite of products to meet the greatest needs.

Our SDOH team helps promote our value-added benefits by identifying Members' needs through the Health Risk Assessment (HRA) and Health Care Equity documents reflected in each individual Member's care plan. This includes helping Members in rural areas use telehealth in community resource centers. For example, Aetna is working to create more options to access care [redacted] We identify opportunities to alleviate SDOH barriers Members face to connect them with resources and health care services, as well as opportunities during each Member visit, and customize care plans to incorporate specific action steps.

Our CARES team also collaborates with community-based social service organizations that serve Members' needs to build capacity, deepen knowledge of social resources in the community, and understand Member's social needs. Through this work, we build relationships with Community-Based Organizations (CBOs). We educate CBOs on Aetna's value-added benefits by sharing our knowledge with them and bringing brochures to meetings with them to share with those they serve. Recent examples include:

- **United Way of Reno County:** We met with a representative of United Way of Reno County to walk through the value-added benefits that we provide. They were able to identify which ones applied to the people they served and were given handouts for them to distribute.
- **The Treehouse in Wichita:** When we met with this CBO, we learned that they served mothers and babies, so we focused on providing educational information for value-added benefits such as incentive cards and the Promise Pregnancy benefit because this would be most relevant to their Members.

Our CARES team also collaborates with our Value-Added Benefits team and with people, organizations, and systems across the State. We work with state and local leaders, CBOs, Providers and health care systems, school systems, and other groups serving the community. Our CARES and Community Development teams are integrated in the communities to best understand the needs of Members. We use our conversations with local CBOs as well as data from the Health Equity Community Resource Directory and Z Codes dashboards to evaluate trends in communities to influence our offerings. One example is the need for access to healthy and affordable food. Because of this knowledge, our teams advocate for benefits to give Members not only access to healthy food incentive cards, but access to healthy food cooking classes through Aetna and K-State Research and Extension, offered in-person as well as virtually.

Local Focus and Presence

Our Chief Medical Officer, Dr. Muna Enshiwat and our Director of Community Development, Chris Beurman, are dedicated to bringing meaningful value-added benefits to Members. As a life-long Kansan, Mr. Beurman is personally committed to the health and well-being of Kansans. Chris' ability to engage Members and see that their specific needs are met comes from his deep understanding of and personal connection to, the individual needs of Kansans. Strengthening connections between Members and community health resources is inherent in all the Community

Development team's activities. Member focus, including outreach and education, are a high priority and include participation at community events, and ongoing education of CBOs to see that they know and understand our value-added benefits. This includes working with local organizations supporting critical needs such as housing insecurity, maternal health, behavioral health, food insecurity, senior health, foster youth, and dental services.

Mr. Beurman's team, based in Overland Park, but located throughout the State, meets regularly with internal teams to avoid duplication of efforts and uses these resources to maximize our presence in the community. We consistently receive positive feedback from community organizations about our physical presence around the State, so we know his team approach has been successful. **Since 2019, we have held more than 2,454 meetings and 88 community events with attendance of over 143,000 individuals.** Our Community Development team includes two regional community development coordinators, including a team member who is bilingual in English and Spanish, and a third to be added in 2024. They collaborate with staff from our Care Advocacy Team (CAT), CARES, and D-SNP teams, to maximize our reach across the State.

National Advantage

Dedicated to understanding the needs of all Members, Aetna Medicaid's national Value-Added Benefits team works closely with our Value-Added Benefits team to see that the programs we offer are targeted specifically to the needs of Kansans. The national team uses its 37 years of Medicaid experience across 15 markets working with vulnerable populations, coupled with direct feedback from Members and Providers to create value-added benefit offerings that address the diverse geographic and socioeconomic needs of the communities served. This allows for a full offering of value-added benefits for the Kansas market, in addition to the offerings developed by our Kansas team.

Innovative Technology Drives Value-added Benefits Quality and Member Engagement

Driving Member satisfaction and improving the Member experience through innovative engagement are key components of our Value-Added Benefits program. Our approach to Member engagement makes sure all value-added benefits available to Members are easy to find, understand, access, appropriate for their needs, and delivered in a timely way.

Aetna continually improves on the use of technology. For example, we use our proprietary Health Innovation Platform™ to centralize, monitor, and evaluate a comprehensive array of value-added benefits metrics such as engagement, effectiveness, utilization, clinical outcomes, and spend. Data in the platform is integrated with the Member portal and app. This helps Members understand what value-added benefits they are eligible for, the details of each value-added benefit, and suggestions and notifications for additional value-added benefits that may meet their needs. Members can also view their available balances and request additional information from the Member app and web portal. Additionally, the platform also drives data for

member services representatives and care coordination managers who use it to proactively identify and suggest value-added benefits that are appropriate to a Member's needs and relevant to their individual priorities. For example, member services representatives and care coordinators can see if Members with a diabetes diagnosis have accessed value-added benefits that support diabetes and provide them with information on the value-added benefits they have not yet used.

The Health Innovation Platform's value-added benefits insights are built on our commitment to continuous quality improvement, underpin our rigorous oversight strategy, and streamline those functions to help us monitor utilization trends—critical components of our efforts to address health disparities in key at-risk populations; measure impact through Member satisfaction and health outcomes; and prevent fraud, waste, and abuse through benefit design management.

Aetna Medicaid uses a variety of data including population health metrics, HEDIS scores, Provider encounters, claims, and Member engagement with member services and care coordination management staff to inform our value-added benefits strategy and ongoing development of new value-added benefits.

Our value-added benefits in affiliated plans around the country have increased Members engagement in their health care and contributed to improved health management behaviors and outcomes. We have seen increases in primary care and perinatal care visits, HbA1c testing, and reduced Emergency Department utilization to address behavioral health concerns.

In all our interactions with Members, Aetna Medicaid staff think about what a Member may need, what they are eligible for, and how to work with the Member to identify what value-added benefits may help them most, from the Member's perspective. We also integrate disparate system data to help identify eligibility conditions among Members to engage them and provide information on value-added benefits.

Vendor Selection

Aetna may employ third-party entities (vendors) to provide services on our behalf to provide a comprehensive offering of value-added benefits. The requirements under these contracts are delegated to a Subcontractor. Aetna maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with KDHE-DHC. We routinely conduct plan-do-study-act cycles as part of our oversight plan for each value-added benefit and subcontractor and track performance on value-added benefits Key Performance Indicator dashboards at daily, weekly, and monthly intervals. This process helps us monitor outcomes and identify lessons learned and opportunities for improvement and helps the Value-Added Benefits team support the Vendor Oversight Committee, which includes subject matter experts, health plan leaders and vendor representatives.

The Vendor Oversight Committee conducts quarterly reviews of value-added benefits and promptly addresses opportunities for improvement. The Vendor Oversight Committee makes decisions on any modifications to value-added benefits under review based on the provided insights. We submit any additions, deletions, or modifications to the State for approval at least 90 days in advance of the effective date.

Value-added Benefits Promotion, Education, and Training

Notifying Providers, Beneficiaries, and Members about Value-added Benefits

We have multiple ways to inform Members of the value-added benefits and extra benefits available to them, as well as community events in which they may participate. Aetna employees are trained and encouraged to provide this information to Members at every opportunity. Furthermore, care coordination managers also routinely review encounter data and identify those Members whose utilization may suggest that outreach and education on a particular value-added benefit is appropriate.

Value-added benefits information is included in new Member welcome packets, newsletters, the member portal, our mobile app and on our website. Our value-added benefits brochure promotes programs available to Members through our outreach activities and Member mailings. Our marketing materials and Member handbook describe limitations or conditions specific to each value-added benefit as well as how Members may access the benefits. We have a continuous review process of value-added benefits. If we find that a value-added benefit is not being used, or we identify a need for a new value-added benefit based on Member needs, we add or remove the benefit after receiving approval from the Kansas Department of Health and Environment (KDHE).

Our SDOH Member Real Engagement and Community Help (REACH) team works with Members to identify their SDOH needs and works with the Value-Added Benefit team to determine available resources and programs to be sure those needs are met. The Community Resource Directory is our proprietary social service referral platform that connects, tracks, and evaluates Member referrals to local CBOs to address social care needs. This nationwide directory of CBOs and agencies provides services that help address the social care needs for our Members. Member materials include information on how to contact the Reach team. As of Nov. 1,2023, our Community Resource Directory contained over 15,000 resources in Kansas.

Members may also use our mobile application and web portal to see a dynamic list of value-added benefits they are eligible for, request to receive the benefits, view their current use of those benefits, get more information, and provide feedback through simple one-click interactions. Our member services and care management staff actively promote Member education and use with each Member interaction.

Methods of Promoting and Providing Continuing Education and Awareness of Value-added Benefits

Value-added benefit education is one of our continued top priorities as a health plan. We look for ways to educate all individuals who have a personal stake in either being a Member or by serving our KanCare Members.

For Members:

- Attendance at community health events is targeted at membership throughout the State. While in attendance, we offer materials providing more information about the value-added benefits we provide to Members and answer direct questions from our Members about these benefits.

- We produce a Member newsletter three times per year that is sent to all Member households containing more information about our value-added benefits.
- Value-added benefits are featured prominently on our website with more information on how Members access the benefits.
- Our care managers work directly with certain Members and are trained and well-versed on all the value-added benefits we have to offer and are communicating the benefits to the Members they serve. We also provide value-added desktop aids on each value-added benefit that are accessed by care managers whenever they need more information on Member value-added benefit access.
- Our member services staff have access to a Health Innovation Platform. The platform allows each representative access to the value-added benefits available to Members who call into the health plan. While the Member is on the phone, the representative educates the Member on the value-added benefits they are eligible to receive.
- Our Quality team sends text messages and interactive voice messages to Members who elect to receive text messaging educating them on their direct medical needs and reference value-added benefits whenever appropriate within those messages. Our Quality team also houses our Member advocates who work to go deeper with Members to solve issues regarding their benefits. While the Member advocate is working with them, they educate those Members on the value-added benefits they are eligible to receive. Our Medical Management team has oversight for all care management activities.

For Community-Based Organizations (CBOs)/Stakeholder Education:

- Our community development coordinators located throughout the State are constantly working to meet with and educate CBOs on the benefits available to Members. We find that Members trust working with these CBOs and stakeholders. By providing education, they in turn educate Members directly by providing them with our brochures or direct education on the value-added benefits they can receive.
- The CARES team coordinates with our community development coordinators. Their approach supports our local teams who are consistently in the community investing their time to build strong relationships with people, organizations, and systems that impact health. Teams seek to collaboratively identify innovative ways to support the social safety net through strategic outcomes-based investment. We start by proactively identifying community strengths and needs through social risk analytics, community needs assessments, and social referral data through our platform. We embed ourselves in the community, serving on boards of nonprofit agencies, volunteering at CBOs, and attending coalition meetings. As of June 29, 2023, **the Community CARES team has completed more than 1,500 community activities across eight markets with local staff, and over 500 community activities in Kansas.**
- We provide a monthly community eNewsletter to over 1,500 CBOs and stakeholders throughout the State. Within this publication, we regularly highlight value-added benefits, so they understand the benefits we have available to KanCare Members.

- We also refer CBOs and stakeholders to the other locations mentioned so they can receive more information.

Furthermore, we conduct outreach calls and mailings to address gaps, improve HEDIS rates, and inform community stakeholders about our programs. Outreach calls have been especially helpful in reminding Members of value-added benefits and linking Members quickly to these services by simply referring to the welcome packet and directing Members to the website for further details.

For Providers:

- Provider relations representatives share value-added benefits brochures with Providers during offices visits.
- Our community development coordinators help community health clinics such as county health departments, FQHCs, and RHCs get access to our materials to educate Members who visit their clinics.
- The value-added benefits are featured prominently on our Provider website.
- We add our value-added benefits to our Provider publications, found on the Provider landing page of our website. We also send these bulletins electronically to Providers who elect to receive emails.
- We also feature the value-added benefits at Provider town hall meetings and training sessions targeted at our Provider community.

Aetna Medicaid provides a complete description of our value-added benefits program in its Policy and Procedure Manual, including information on all individual value-added benefits and any limitations, restrictions, or conditions specific to the services. The Policy and Procedure Manual includes the names of Providers responsible for services, processes for documenting value-added services encounters, and how and when Aetna Medicaid communicates with Providers and Members about value-added services eligibility while still meeting the federal marketing requirements. We document in the Policy and Procedure Manual how a Member may obtain value-added benefits. The Policy and Procedure Manual is made available to the State for approval.

Training Staff on Value-added Benefits

Member focus is ingrained in our culture and begins with training on value-added benefits. Our training confirms that all programs are understood and integrated throughout our Member interactions. This includes:

- New employee orientation.
- Ad hoc trainings on value-added benefits so all areas understand and integrate value-added benefits throughout our Member interactions. Staff are educated on where to access value-added benefits desk top aids, which reminds them of the process for accessing value-added benefits.

Most of our value-added benefits do not require prior authorization so Members may quickly access these services. Our case managers are trained in the Health Innovation Platform and help Members access and navigate the information they need.

Proposed Value-added Benefit Offerings

As part of our continued commitment to drive positive health outcomes for Kansans, Aetna will implement three new value-added benefits **in 2024 with a focus on Foster Care children and Members with diabetes and congestive heart failure.** These new strategic offerings include:

[redacted]

iFoster:
Combined Outcomes in Kentucky and West Virginia

100% Member improvement in digital access and literacy

66% reported that they used it for school

88% Annual uptake among target membership

63% use their device to improve communication with friends, family, or their support network

90% reported that the device had been useful to them

80% (YOY) Improved resource portal access

67% (YOY) Annual growth in member VAB utilization

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[redacted]

[redacted]

[redacted]

Driving Innovation and Addressing Disparities for 2025

In addition to our 2024 offerings, in 2025, we will also offer value-added benefits to help address the State's concerns regarding:

- Tobacco use
- Services for pregnant and postpartum Members
- Preventive behavioral health services for families with infants or toddlers at risk for behavioral health conditions
- Services to promote independence and address changing health care needs related to maintaining choices of housing and activities of daily living
- Services that support a bridge to independence and private health coverage
- Expanded transportation benefits.

Some examples of our new 2025 benefits are highlighted below.

[redacted]

[redacted]

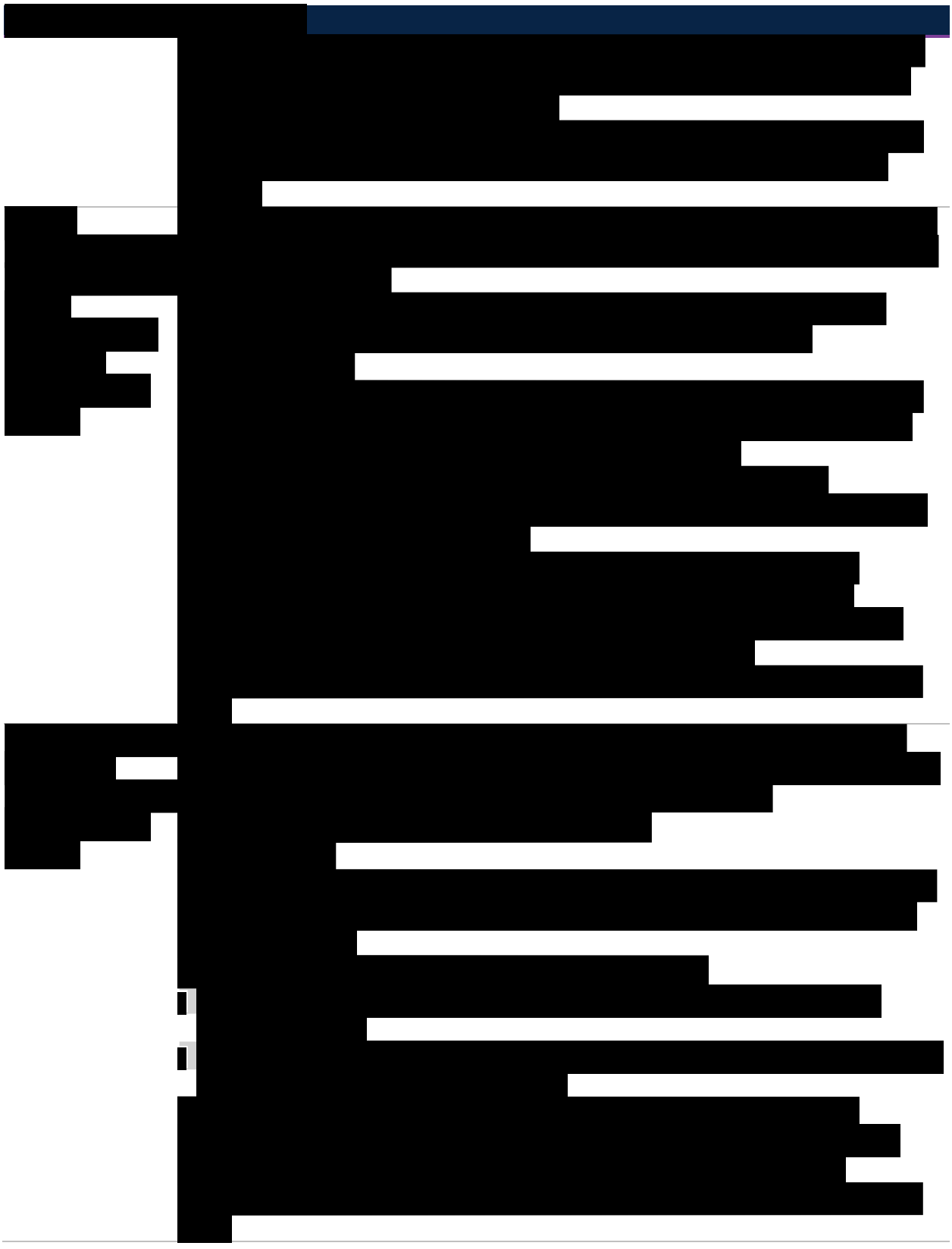
[redacted]

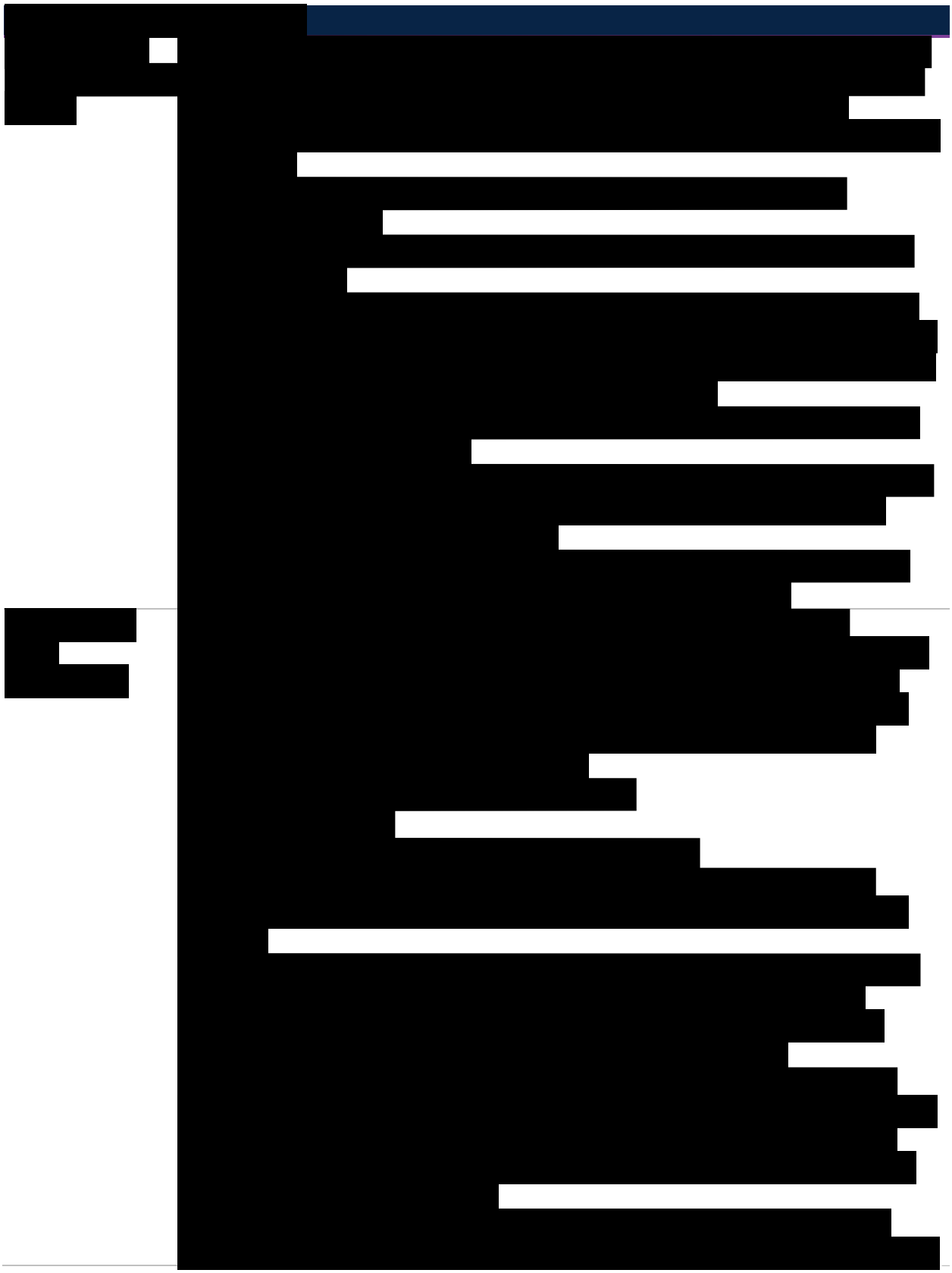
[redacted]

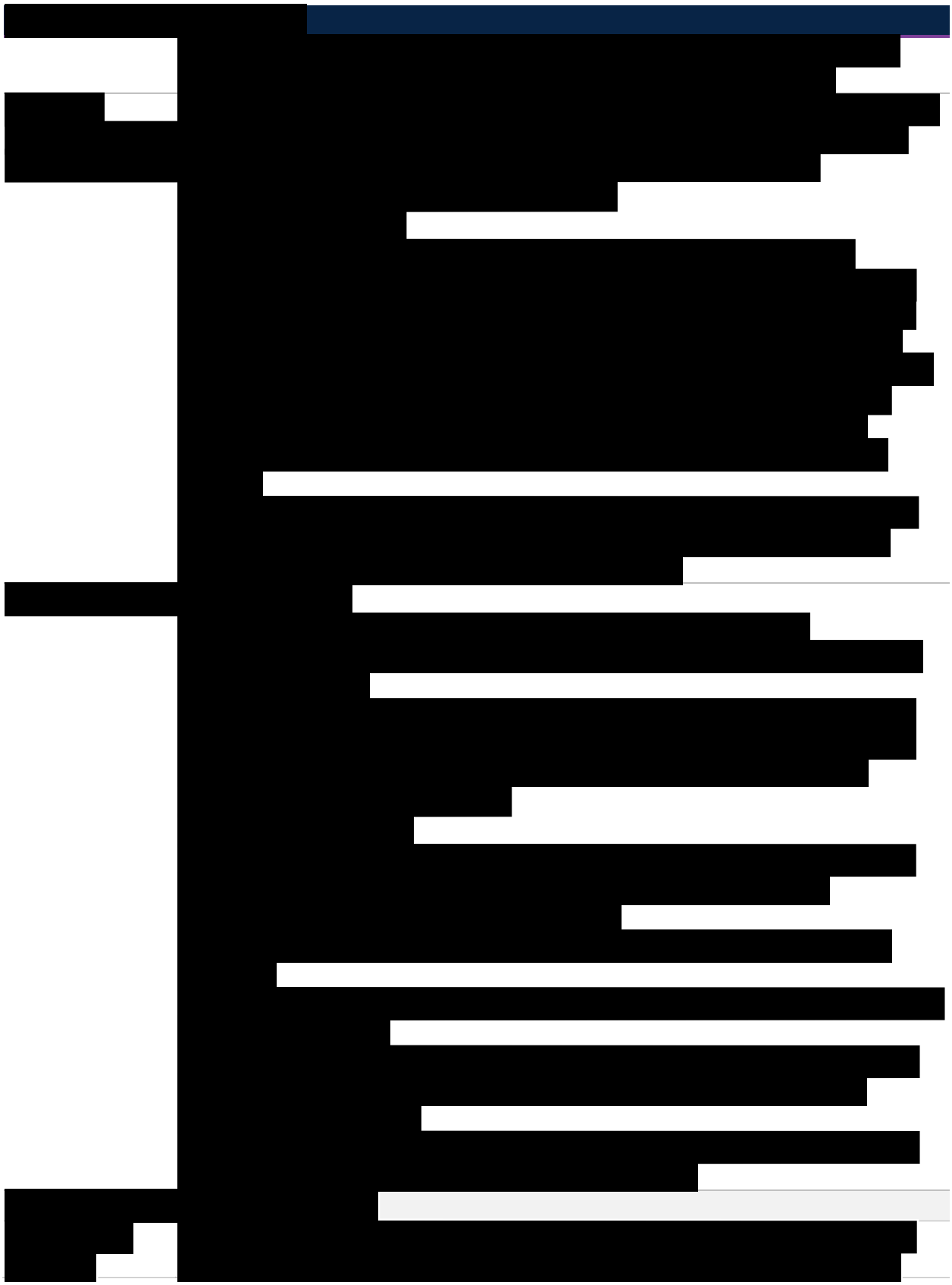
Proposed Value-Added Benefits for 2024 and 2025

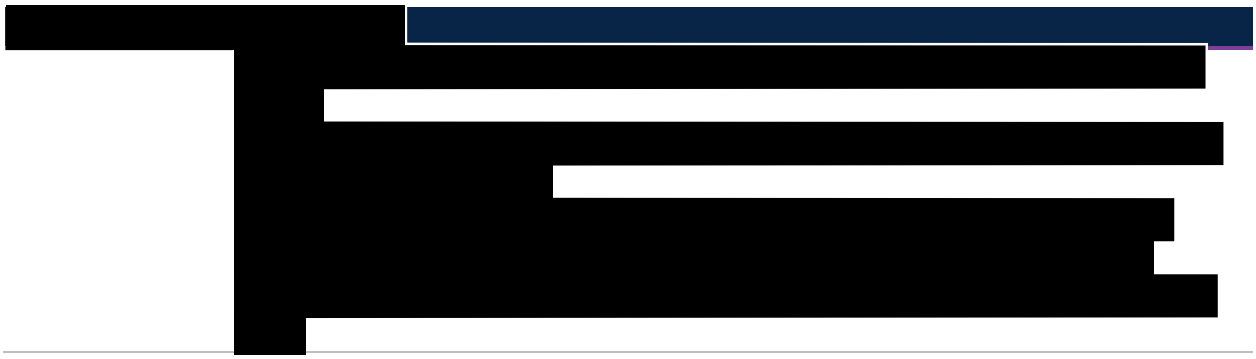
We design our value-added benefits with the State's goals in mind. The table below reflects a complete list of our value-added benefits offerings in Kansas already approved by the State for 2024. It also identifies the category of Members eligible to receive the value-added benefits and any limits and/or restrictions, including Prior Authorization (PA) requirements. We have supplied examples of outcome data from the use of these benefits in Kansas and our affiliate health plans. In addition to our 2024 offerings, we have included proposed value-added benefits to be added in 2025. All our value-added benefit offerings are available statewide to all KanCare Members.

[redacted]





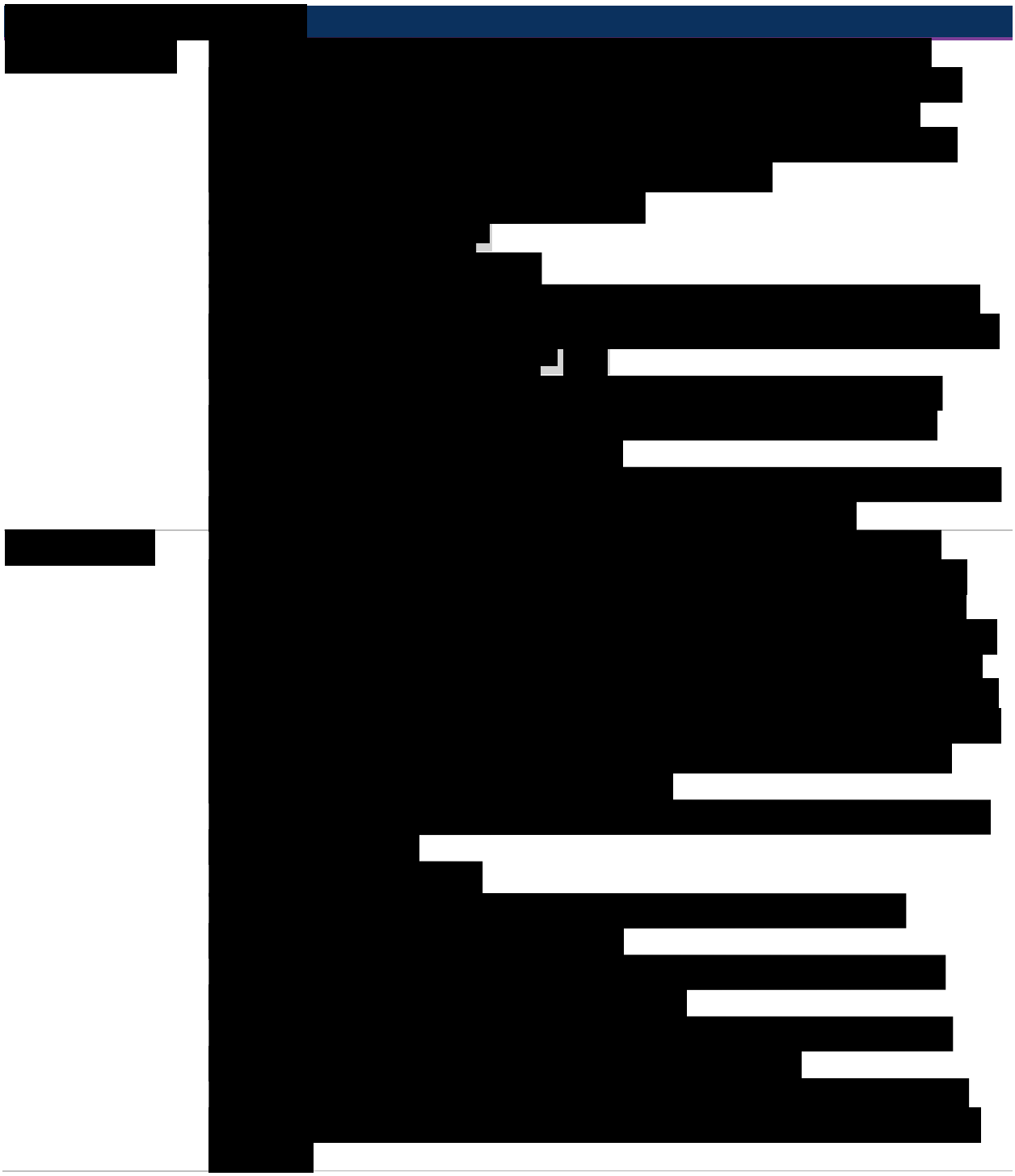




The 2024 value-added benefit offerings depicted in the table above have been approved by the State. We will submit for approval all future value-added benefit offerings for 2025 by June 2024.

Addressing the D-SNP Population

We recognize that the D-SNP population is particularly vulnerable in terms of their medical and SDOH needs. We offer value-added benefits, referred to as supplemental benefits in the Medicare space. These benefits are important to the health and quality of life of our D-SNP Members. Our supplemental benefits include items not covered by Original Medicare that add value to our Members' lives and complement our Medicaid value-added benefits. We assess the types of benefits that our Members value most using consumer research, broker feedback, Member HRA responses, and benefit utilization data. Our supplemental benefits are available to each of our D-SNP Members, regardless of the absence or presence of chronic conditions. We want each Member to take advantage of these Aetna funded benefits. The following table describes our 2024 D-SNP value-added benefits.



Assessing Impact and Value

Aetna Leadership convenes a committee to review the KDHE State value-added benefits usage report, in conjunction with the criteria for each value-added benefit, to determine if Members are using the current benefit and is meeting the established qualifiers. Before we consider renewing or retiring a value-added benefit, we ask ourselves the following:

- Are we fully promoting the value-added benefit to Members, so they understand the value-added benefit and its purpose to help them be healthy?
- Is the current structure of the value-added benefit conclusive to Members understanding of the benefit?
- Is the benefit able to prevent future health complications?
- Is there a new benefit that could replace the current benefit to improve utilization by Members?
- In looking at SDOH information, can we assist with these needs by offering a value-added benefit?

This committee reviews the current value-added benefits and makes recommendations for new value-added benefits that meet the qualifiers as described. When looking at new value-added benefits to offer Members, we look at the following information:

- Quality measures established by KDHE and/or KDADS for the Pay for Performance or Performance Improvement Project considerations.
- Medical advances, clinical guidelines, and insights from our chief medical officer, and the Medical Staff of our team in Kansas.
- Interpretation of pharmacy usage.
- Interpretation of claims data.
- Key drivers of SDOH within our Membership and how a value-added benefit could be used to assist with addressing these needs. We also reference statewide reports such as the Kansas State Health Assessment Survey to determine other health issues we can address.
- Evaluation of how we can eliminate barriers to care when considering SDOH needs of our Members.

These value-added benefits, coupled with covered services, aim to improve quality of life and health outcomes for Members. Annual and ongoing monitoring of value-added benefits sees that the intent is achieved. Additional activities include:

- Routine monitoring of utilization reports by directors of community development and quality management. Increases or decreases in utilization that appear as outliers are investigated and addressed.
- Various measures are monitored to show effectiveness in outcomes such as HEDIS measures, childhood immunization status, breast cancer screening and cervical cancer screening, and outcome measures developed by Aetna (diabetes related value-added benefits /prevention of amputation/ED utilization, prenatal visit compliance/NICU utilization, adult wellness value-added benefits /ED utilization).
- We review reports showing the geographical utilization of value-added benefits and compare them to areas with gaps being filled, like the GED compared to areas with decreased graduation rate.

- Information is reviewed from Aetna's Membership grievance reporting, member advocate inquiries and Member Advisory Committee (MAC) discussions.

Our cross-departmental workgroup meets annually to review reporting and evaluate current benefits, along with recommendations to retire or add new benefits before plan approval and submission to KDHE for State approval.

Access to necessary resources and benefits positively affects Members' lives and outlook, enabling them to focus on making the best choices for their well-being and independence. The unique regional needs of Kansans are a key consideration in determining the curated suite of value-added benefits that bring the most value to Members and to Kansas. **Our local Value-Added Benefit Team in Kansas** is dedicated to the specific needs of Kansans. The committee lead and director of community development drives the committee's evaluation of current value-added benefits use, promotion of the benefit to Members and determining whether value-added benefits need changing or updating.

An example of improvements we have made through our ongoing review and analysis of value-added benefits is our improved Healthy Rewards Incentive card programs. Members use their incentive cards from a list of retailers, such as Walmart, Family Dollar, Target, and others. To be sure we meet Kansas quality metrics and that our incentive card offerings are as comprehensive as possible, we gathered feedback from our MAC to see that we design programs that meet the needs of our Members. Recent feedback to the committee requested a faster way to deliver incentive cards. As a result of this feedback, our Quality department investigated ways to improve the delivery of incentive cards and we are working with inComm in 2024 to provide more flexibility and efficiency to our card program to improve the Member experience. This enables us to enhance usability, allowing for wider use at a broader range of retailers. MAC Members collaborated with us, and we listened. Our quick response to their concerns helps Members eligible for their incentive cards get them timely. It was not only the feedback from these Members that brought the issue to our attention, but also their willingness to engage with us to solve the problems and develop a better work plan so Members are getting the benefits they deserve.

Identifying Value-added Benefits in Encounter Data

In addition to using applicable Healthcare Common Procedure Coding System (HCPCS) codes, applicable Current Procedural Terminology (CPT)/HCPC codes, and information reported to the State through financial reports, care coordination managers routinely review encounter data and identify those Members whose utilization may suggest that outreach and education on a particular value-added benefit is appropriate. For example, when a Member has exhausted their carved-out dental or vision benefit and is offered information about the Extra Incentives Card, or rapid engagement in behavioral health follow-up, leveraging a Healthy Incentive program benefit. In all our interactions with Members, we work to identify and engage Members on what may help them most.

Acknowledgements and Confirmations

Aetna Medicaid offers these value-added benefits at no additional cost to KanCare Members. Aetna Medicaid understands and agrees that the costs of value-added benefits are not reportable as allowable medical or administrative expenses and are not factored into the rate setting process.

Aetna Medicaid provides these value-added benefits as an augmentation of Member benefits and will not pass on the cost to Providers. Our Member communications, portal, mobile app, and other engagement tools have information about value-added benefits, including the conditions and parameters regarding the delivery of the value-added benefit. In addition, some value-added benefits are included in Member outreach from Aetna Medicaid care coordination managers as deemed appropriate for the Member's needs.

Aetna offers the value-added benefits described throughout the contract term and we understand all value-added services require approval by the State. Further, we provide all value-added benefits statewide, and these benefits are of no cost to the Member, Provider, or State.

We continue to submit a value-added benefits report to KDHE monthly in the format and frequency determined by the State.

Our Ongoing Commitment to Kansas

As a proud KanCare partner, we remain committed to creating a healthier Kansas, supporting Members with value-added benefits that encourage health, wellness, and independence. In addition to our value-added benefit offerings, we continue to demonstrate our commitment to helping Kansans remain healthy through our nearly $1 million in community investments over and above our value-added benefits investments. This includes food pantry support, housing security funds, general health and vaccine clinics, maternity programs support, mental health resources events, and other community investments focused on the critical needs of Kansans. We look forward to continuing our support of the State's vision of KanCare and Healthy Kansas 2030 initiatives to prepare a future-ready Kansas.

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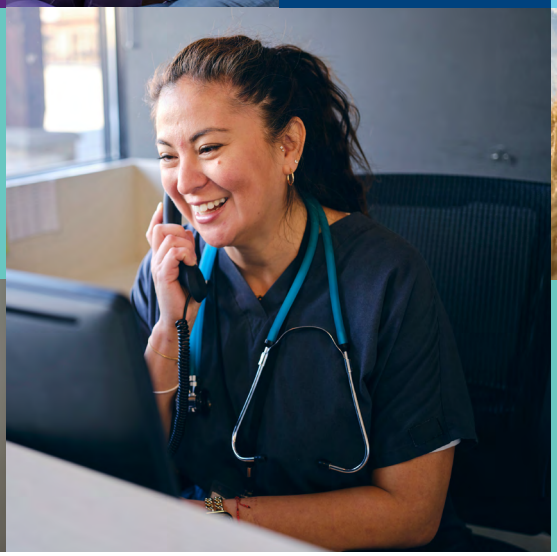
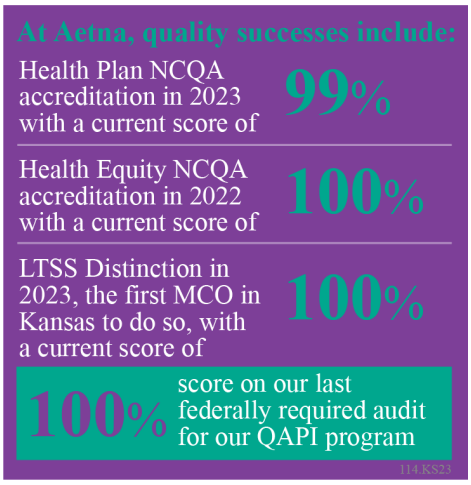


Topic Area 5: Quality Assurance

Tab 7e

Topic Area 5: Quality Assurance

19. Describe the bidder's quality program and the bidder's approach to implementing a quality program for KanCare that drives a program-wide culture of continuous quality improvement. Include the following in the bidder's response:
    a. The structure, composition, and responsibilities of the bidder's quality-focused committees and how the bidder will use its quality structures to promote changes in plan and Provider practices and operations.
    b. The bidder's capabilities to collect and examine quantitative and qualitative data and information to evaluate clinical and LTSS quality, including health outcomes and Member experience, and effective health care operations. Include the bidder's approach to utilizing data, information, and analytics to drive continuous performance improvement.
    c. The bidder's approach to regularly providing information available to the public about the bidder's program performance in KanCare, including the information the bidder proposes to publicly share and how the information will be shared.



To continually improve Member health outcomes and well-being, Aetna Better Health of Kansas Inc.'s (Aetna) quality assurance approach includes continually monitoring our Quality Assessment Performance Improvement (QAPI) program and regularly reviewing and updating the workplan. These processes allow us to oversee Member medical care, behavioral health (BH) services, Member safety, and service delivery. Our ongoing program standards assessment monitors the quality, accessibility, and appropriateness of care, case management, and care coordination. **Our Quality Begins with Me** companywide approach focuses on resolving barriers and improving Member care. **We support Members holistically by eliminating barriers to care, providing quality care, and resolving gaps in care** using a culturally appropriate, integrated, person-centered approach focusing on health equity, SDOH, and Member experience.

Quality Assurance—Our Program and Approach

Our local health plan, Aetna Medicaid, and our parent company, CVS Health, embed continuous Quality Improvement (QI) into everything. We start by integrating our medical and administrative leaders at the health plan and hold them accountable by the respective CVS and Aetna Boards of Directors (BOD). This approach assures that leadership holds the plan accountable to meet or exceed standards and requirements, in addition to regulatory and accrediting agencies, including Kansas Department of Health and Environment (KDHE) and the NCQA. **Aetna confirms that we align with all requirements addressed in Scope of Services (SoS) Section 7.9.3.** Nationally, CVS provides enterprise wide assets, such as investing in infrastructure and proper platform administration, supporting medical and administrative efforts, and providing audit and oversight functions through a national BOD. Together, this leadership brings Kansans the care, technology, talent, and community resources each Member needs to unlock their best health care outcomes.

Healthcare Quality®, celebrated Healthcare Quality Week October 15–21, 2023, to recognize the contributions of health care professionals toward improving the health and well-being of Kansans. Aetna hosted social media events to highlight the achievements of health care organizations and professionals.

Figure 19-1: Health Quality Week. *The governor (center) surrounded by Aetna staff commemorating Healthcare Quality Week.*

Structure, Composition, Responsibilities of Quality-focused Committees

We support our governance structure through committees, subcommittees, and ad hoc work groups accountable to our Quality Management Oversight Committee (QMOC) and our local BOD. A formal quality committee structure allows for QAPI program oversight and for the flow of information to and from the BOD. Committee members integrate plan medical functions, operations departments, network, and Members into the QM program through their participation on one or more committees, overlapping membership and leadership responsibilities, and integrated reporting requirements. The following Quality Governance Organizational chart in **Figure 19-2** shows our quality committees' reporting structure and includes a new LTSS Member Advisory Subcommittee. Focusing on quality and appropriateness of LTSS Member care, this subcommittee seeks to improve LTSS clinical performance measures, cultural competency, Member outreach plans and educational materials (e.g., readability, content), prevention programs, and other initiatives requested by QMOC, and solicits enrolled LTSS Member feedback concerning access and quality of care, services programs, activities, and materials.

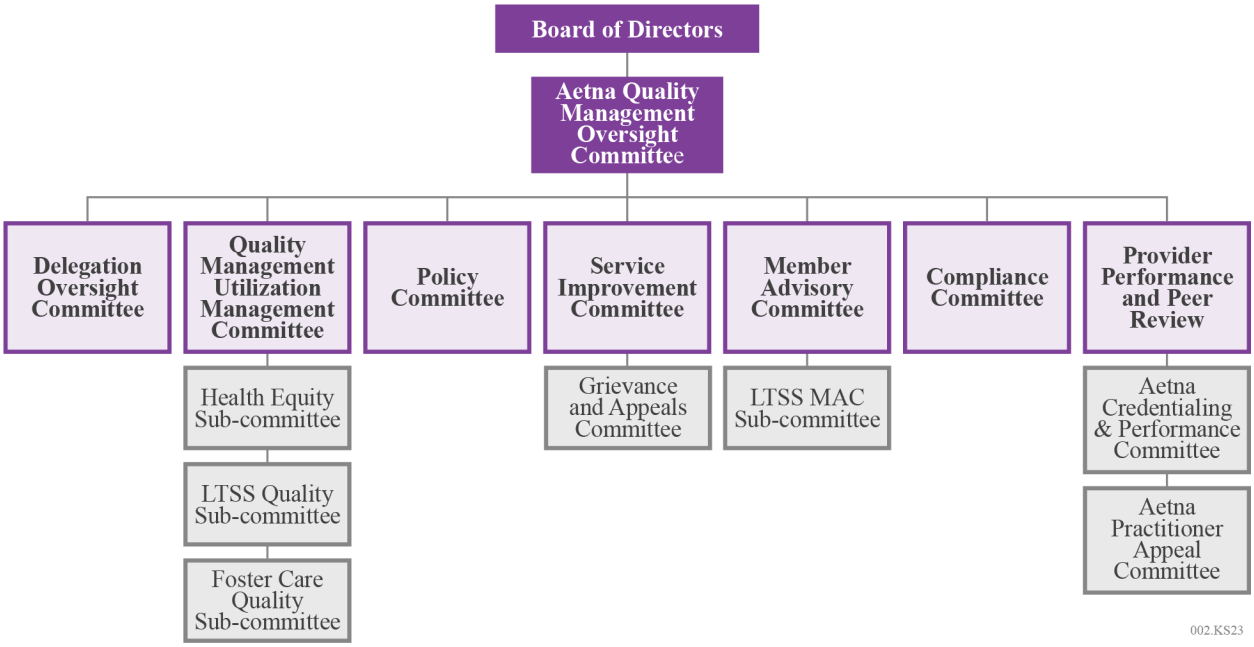


Figure 19-2: Quality Management Oversight Committee. *Aetna's quality governance reporting structure shows how our subcommittees report directly into the QMOC, MAC, or the Provider and Performance Peer Review Committee providing all quality functional areas with access to the QMOC and the BOD.*

Committee Structure

The following table describes the quality committees highlighted in Figure 19-2, along with the responsibilities and members of each committee.

Committee	Responsibilities	Committee Composition
Board of Directors (BOD)	**Accountable for the QAPI** program and related processes, activities, and systems. Implements systems and processes for monitoring and evaluating care and services Members receive. Oversees the QM program and submits an evaluation of the previous year's QAPI.	Chief executive officer, vice president Medicaid division, assistant vice president, vice president clinical health services, senior vice president clinical health services.
Quality Management Oversight Committee (QMOC)	**Confirms that the QAPI integrates Quality Management (QM),** Performance Improvement Plans (PIPs), and network activities. Provides executive oversight and makes recommendations to the local governing body.	CEO (chair); chief operating officer; chief financial officer; chief medical officer; director QM; director medical management; compliance officer; director network contracting; director Provider services; director Member services; directors/managers from other functional areas, Members, and BOD members.
Delegation Oversight Committee	**Advises the QMOC** on monitoring and oversight findings of delegated entities. Evaluates delegates or prospective delegates' quality assurance plan and ongoing reporting, reviews oversight assessments results, recommends delegation status to the QMOC.	CEO (chair), chief medical officer or designee; director medical management; director QM, compliance officer, pharmacy director, and other departments (e.g., Member Services, Provider Experience).
Quality Management/ Utilization Management Committee QM/UM	**Advises the chief medical officer** about quality of care and services to Members, including oversight and maintenance of the QAPI and Utilization Management (UM) program. Uses data to design value adds and gathers UM data and decides how to reduce Provider burden. Focuses include PIPs and pay for performance efforts. Receives summary reports for approval/submits reports to QMOC.	CEO (chair); medical director; BH medical director; BH supports director; and a representation of key stakeholders/network Providers (e.g., PCPs/medical homes, pediatricians, BH Providers) and pharmacy director, lead director case management, lead director LTSS, and support staff.
Health Equity (HE) Committee (QM/UM sub-committee)	**Advises the QM/UM** Committee about equitable and culturally competent Member services, including program oversight. Evaluates data sets and other information (e.g., Member demographics, performance indicator results, and recommended actions) and results of	Lead director QM; systems of care, Member services; UM; CM LTSS; operations, network, BH staff, Member advocates (BH and LTSS), and requested support staff.

Committee	Responsibilities	Committee Composition
	Health Equity (HE) activities (e.g., HEDIS® and satisfaction survey results).	
LTSS Quality (QM/UM sub-committee)	**Reports on performance** data (e.g., quality of life, community integration activities). Oversees quality and appropriateness of Member care (e.g., assessment of care between settings, compares services and supports received with service plan requirements). Monitors Home and Community-Based Services (HCBS) waiver performance.	LTSS director, CMO, health services officer, director of QM, LTSS managers, LTSS supervisors, Provider experience representative, Senior QM analyst, other areas as needed.
Policy Committee (PC)	**Directs development**, implementation, approval, and communication of QI policies. Facilitates development, implementation, approval, and dissemination of policies according to accrediting, regulatory requirements, and annual review.	Compliance officer (chair), manager, Member services, appeals, medical management director, QM director, Provider experience director, finance, and administrative support.
Aetna Service Improvement Committee (SIC)	**Guides the QMOC** and management about Member and Provider issues. Reviews and evaluates data, surveys, and trends in Member and Provider complaints, grievances and appeals for improvement in satisfaction. Formulates recommendations for continuous improvement and evaluates operational measures. Will align with SoS section 7.9.	Director of operations (chair), chief medical officer or designated medical director; representatives from Member services, Provider experience, medical management, QM, compliance and grievance, and appeals, and others as required.
Grievance and Appeals Committee (SIC sub-committee)	**Reviews appeal trends** and may render decisions on appeals filed by Members or Providers. Reviews trends, resolves issues, and renders decisions about grievances/complaints/appeals filed by Members or Providers. Decisions do not require a vote therefore none of the members are voting members.	Grievance and appeals manager (chair), chief medical officer/medical director, compliance officer, grievance and appeals analyst, Member services, QM/UM, medical management, and Provider experience (clinical decisions include Provider/RN of the same or similar specialty), Member advocate(s).
Member Advisory Committee (MAC)	**Recommends strategies** to improve clinical performance measures, cultural competency, Member outreach plans, educational materials (e.g., readability, content), prevention programs, and other QMOC requests. Solicits Member feedback for issues with access and quality of care, programs, activities, and materials.	Director community development (chair), QM, Member representatives (up to 15), and ad hoc members (e.g., KDHE and KDADS).

Committee	Responsibilities	Committee Composition
Provider Advisory Committee (PAC)	**Fosters partnerships** between Aetna and the local health care community that provide Member care. Supports communication and provides feedback on training topics and education materials. Provider feedback is based on Provider type: HCBS, BH and Physical Health (PH), and ancillary.	Director Provider experience (chair), Provider relations manager, Provider experience representatives, CMO, quality practice liaisons, LTSS director, UM director, compliance director, program integrity director, medical directors, external Providers.
Compliance Committee (CC)	**Reviews, monitors, and assesses** compliance plan effectiveness. Approves annual work plan (e.g., areas identified by the Office of Inspector General/Medicaid Program Integrity to confirm compliance/State agency updates). Reviews External Quality Review activities, and all auditing/monitoring.	Compliance officer (chair), CEO, chief operating officer, chief medical officer, medical management director, quality management director, manager operations, manager complaints and grievances, government liaison, QM consultant(s), Provider relations manager, BH coordinator.
Provider Performance and Peer Review Committee (PPPRC)	**Reviews Provider practice** methods and patterns (e.g., quality outcomes, prescribing patterns, morbidity/mortality rates, and grievances). Evaluates appropriateness of care/services and develops policy recommendations.	CMO (chair), Provider experience director, QM director, operations director, LTSS director, UM director, compliance director, program integrity director, medical directors, other areas as needed.
Credentialing and Performance Committee (CPC)	**Oversees credentialing** and recredentialing individual Providers who deliver Member services. Facilitated by an Aetna medical director. Reports to our QMOC.	Includes four regional or national Providers appointed by the Aetna CPC: three participating practitioners; a medical director facilitator, with at least one-fourth of the members from the participating network with at least one licensed in the same state as each practitioner reviewed; at least one member who practices in a similar specialty to the practitioner if specialty knowledge is required.
Practitioner Appeals Committee (PrAC) sub-committee to CPC	**Conducts review hearings** of Providers who appeal decisions made by the Credentialing and Performance Committee involving professional competence or Provider conduct. Facilitated by a medical director. The committee reports through CPC and to our QMOC.	Includes four regional or national Providers appointed by the Aetna CPC: three participating practitioners; a medical director facilitator, with at least one-fourth of members from the participating network, and at least one licensed in the same state as each practitioner reviewed; at least one member who practices in a similar specialty to the practitioner if specialty knowledge is required.

Our Quality Structures Drive Change

The following narrative describes how we use our committee structure and tools (e.g., data hub, Member surveys) to promote change in our health plan, Provider practices, or operations. Each description states the department's function, committee, and tool, plus an example of an activity that triggered an action or change, and the result of that action or change.

QM Department

Function: Provides administrative support for health plan committees and serves as our hub for receiving and responding to potential quality and/or risk management and compliance issues while coordinating QM/QI activities. This role links the entities involved (Members, their representatives/families and caregivers, practitioners and Providers, applicable state and regulatory agencies, and other Aetna teams and staff) and keeps information about requirements and activities current.

Example: Understanding the numerous variables that create barriers to care and wellness for Members, and that the PCP is a conduit of information related to these determinants, our local Kansas QM team proposed an incentive program for Provider locations to report Z Codes and SDOH information to Aetna for program development, analysis of disparities, and direct support to Members.

Member Advisory Committee

Function: Recommends strategies to improve clinical performance measures, cultural competency, Member outreach and educational materials as requested by QMOC. It also solicits enrolled Member feedback regarding their issues with access and the quality of care and services.

Example: In a recent Member Materials review, Members suggested more pictures or illustrations to explain difficult processes (i.e., grievance and appeals). Members stated that the slide deck used during the same MAC meeting to explain appeals and grievances was exactly the type of illustration needed for complex processes.

Result: This positive feedback led us to add the grievance and appeals process illustrations to our Member Handbook to aid Members in understanding and navigating this complex process.

Service Improvement Committee

Function: To annually assess Provider satisfaction with services that are important to network Providers and overall satisfaction with Aetna. Survey results allow us to measure how well the health plan is meeting Providers' expectations and needs and how to create a better Provider, and in turn, Member experience. Administered annually, this survey uses a sampling of PCPs and specialists to measure satisfaction with our UM procedures (prior authorization, concurrent review) claims processing, and our response to inquiries. Results are presented to the SIC Committee for review. The committee then provides recommendations for improvement and monitors improvements.

Example: Comparison and analysis of Kansas results to prior results and national benchmarks provide information to identify areas that changed or require additional improvement. We report the analysis of results and applicable follow-up actions developed to address unfavorable results to the SIC Committee. Actions to address results included:

- Expanding Availity to assist with Provider communication
- Expanding Value Based programs
- Using KART ticketing process to manage Provider concerns
- Executing a PAC

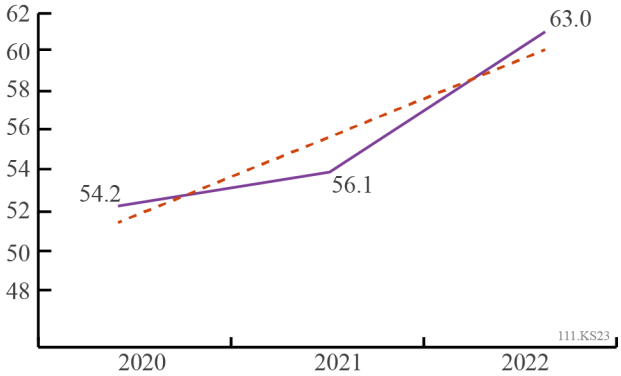


Figure 19-4: Provider Overall Satisfaction. *Increase of Provider satisfaction from 2020–2022.*

Result: Overall Kansas Provider satisfaction showed a 15% increase from 2020 to 2022. The net Provider satisfaction score improved from 34.8% to 45.5%, a 27% increase over the 2-year measurement period. As shown in **Figure 19-4**, the related net loyalty score also increased by 23%, (39.3 in 2020 to 49.6 in 2022) showing gains with the Provider network in satisfaction and loyalty with Aetna. In addition, we have seen improvements in our other markets. We have seen overall satisfaction improve for the following affiliated Aetna health plans: Kentucky by 1.7%, Louisiana by 3.9%, Michigan by 5.1%, West Virginia by 4.9%, and Illinois by 4.2%. Improvement was a result of authorization

process improvement, increasing the number of in-network BH Providers, helpfulness of call center staff, and improvement of the Provider orientation process and relationships with Provider relations representatives.

Performance Improvement Projects

Function: To create projects that improve performance in the quality or appropriateness of service provision and new or revised programs, each performance improvement project (PIP) selected must achieve and sustain demonstrable improvement over time and include objective, measurable, and outcome-oriented performance objectives.

PIP topics are identified from areas of importance or weakness as indicated by regulators or by the health plan and are based on examination of relevant clinical, survey, financial, demographic, encounter data, membership, Providers, or the larger community. When not specified by a regulator, PIP design can include a specific condition or conditions among Members, the need for specific services, identified barriers to service, demographic characteristics, identified racial disparities, and Member or community health risks. The chief medical officer, QM/UM Committee, and QMOC review and approve PIP proposals.

Example: Figure 19-5 is a comparison of recent PIPs, including State-required EPSDT measurement, a federal program of benefits for Medicaid children. Kansas follows the Bright Futures Pediatric Periodicity table, and Aetna is the highest scoring of the current MCOs.

Result: Aetna scored higher on this PIP (and overall) than all other MCOs in Kansas in the High Confidence to Confidence range. The overall validity and reliability of the PIP is based on whether the MCO adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis, assessed for statistical significance of any differences, and provided an interpretation of the PIP results.

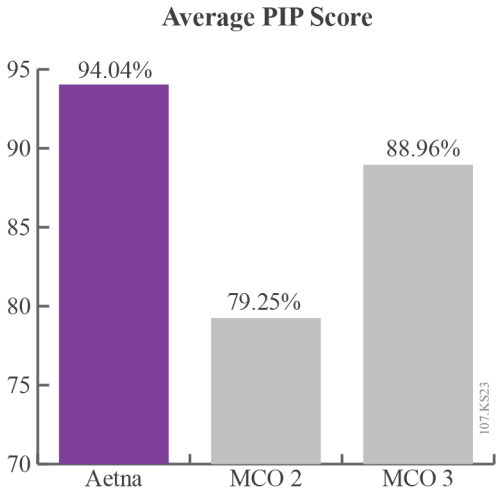


Figure 19-5: Average PIP Score. *This graph shows Aetna's PIPs success.*

Pay for Performance Measures

Function: KDHE defines a set of HEDIS and non-HEDIS measures and withholds additional funding that each health plan can receive if specific performance goals are met for the designated measures. All measures must meet the Quality Compass 50th percentile goal or increase performance rate from the previous year.

Example: Figure 19-6 illustrates improvement in the pay for performance postpartum care (PPC) HEDIS measure over the past 4 years with 2023 projected rate following evaluation of all programs, initiatives, and interventions related to maternal health and wellness.

Result: Aetna improved the reported HEDIS PPC rate by 6.57 percentage points from 2019 (67.64%) to 2022 (74.21%). The 2023 projected rate of 81.90% will result in a 14.26 percentage point improvement from 2019. These improvements are a result of multiple updated and new interventions. This includes updated Maternal Health Care Management Program, multimodal (IVR, SMS, Live call) Member outreach for reminders, encouragement, and education, live call outreach to Members by Pyx Health to assess for loneliness, SDOH issues, assistance with coordination of Provider visits, and expansion of Baby Talk program statewide in Kansas with education on Aetna specific value-added benefits, among other efforts.

Performance Measures

Function: Aetna's performance is measured based on HEDIS and other performance indicators mandated by KanCare, NCQA, or specified in contract agreements and in alignment with KanCare's QMS. Through these measures, we are focused on improving Members' experience, and attention to care access, prevention/wellness activities, and management of chronic conditions.

[redacted]

This year we have implemented the QPL program, Pyx Health targeted outreach, the Careforth Caregiver Coaching program, the Stellar VBS program, the CVS Retail/Quality Optimizer program, and the Farmbox incentive program. We also executed four quarters of Member communications, the healthier outcomes 2023 program, our incentive program, and year-round Medical Record review; and completed targeted community events, clinic/gap day events; and began a Cares/Cares+VBS program.

[redacted]

Result: As demonstrated in **Figure 19-7,** the reported change was the group receiving the specially designed campaign outperformed the group who did not receive the campaign in both prenatal (+1.3 percentage points) and postpartum care (+4.0 percentage points). These results demonstrate the effectiveness of outreach materials, messaging, and live calls to change Member behavior in completing postpartum care appointments. This campaign and others executed, plus robust analysis, provide proven methods for Member engagement in future prevention and wellness campaigns.

Member Satisfaction Surveys

Function: Member Satisfaction surveys improve and measure Member experience help us better understand the populations we serve through surveys. Various surveys we use throughout the year include the CAHPS Survey, BH Member Satisfaction Survey, LTSS Experience Survey, Integrated Care Management Satisfaction Survey, HCBS Satisfaction Survey, among others. **Figure 19-8** depicts the first three months' worth of these surveys that offer Members multiple opportunities to provide their opinions and express their

satisfaction with our plan (all surveys are either sent to the entire population or a statistically significant random sample).

January	February	March
Care Management Survey	CAHPS - Adult and Child	CAHPS - Adult and Child
National Core Indicators - Aging/Disabled	Care Management Survey	HCBS Experience
Condition Mgmt. Survey - Diabetes	National Core Indicators Aging/Disabled	Care Management Survey
Call Center	Condition Mgmt. Survey Diabetes	National Core Indicators - Aging/Disabled
	Call Center	Condition Mgmt. Survey - Diabetes
		Call Center

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Figure 19-8: Member Survey Example. *This sampling of our Member Survey Experience Timeline highlights the numerous Member contacts we initiate throughout the year to gather information on the CAHPS, LTSS, and HCBS Member experience.*

Example: The CAHPS surveys (adult and child) are used to collect information about consumer-reported experiences with health care. The surveys measure how well the health plan is meeting Members' expectations, which we use to identify areas of opportunity for improvement to improve the quality of care and service provided to Members. As children younger than age 21 make up most of our health plan population (nearly 75%), this is a key performance indicator for Member experience. In 2022, initiatives were executed to educate Members/caregivers on accessing the right care at the right time. Various modes of communication were used to educate Members on when and how to access the Nurse Advice Line, urgent care services, primary care services, and emergency services. This allows for greater access to care in every situation, both urgent and non-urgent. Results are shown in **Figure 19-9.**

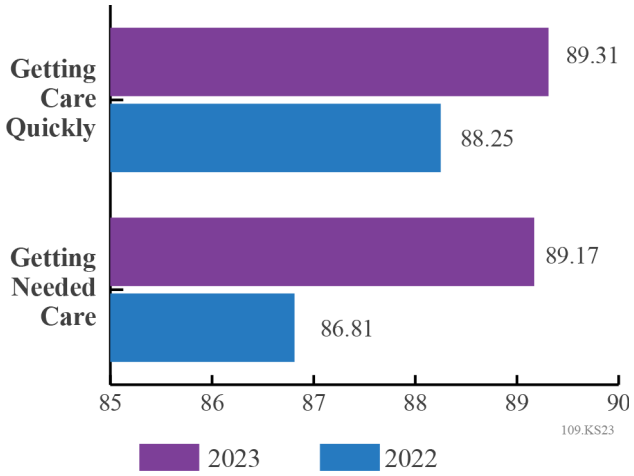


Figure 19-9: Medicaid Child CAHPS. *Comparison of CAHPS survey results from 2022 to 2023.*

In 2022, Members receiving D-SNP services through Aetna's Medicare plan expressed satisfaction about their services and benefits resulting in remarkable improvement in our Member Experience CAHPS survey. **Members positively rated level of assistance from care coordinators at 97.8% (0.3% increase from 2021) and supporting Members with things that were important at 95.2% (1.6% increase from 2021).** Service Providers were reported to be respectful at 93.3% and available to assist our Members in a quality manner at 96%. Together, Aetna's Kansas Medicaid and Medicare plans are providing services for which Members are satisfied, feel supported, respected, and cared for appropriately.

Value-based Payment Strategies

[redacted]

b. Our Capabilities to Collect and Examine Quantitative and Qualitative Data and Information to Evaluate Clinical and LTSS Quality

Outlining the technology and data-sharing platforms we use to analyze health care outcomes, Member experiences, and how well our health plan functions operationally is crucial for positive outcomes. Managed by our Informatics team, data allows us to analyze health care outcomes, Member experiences, and how well our health plan functions operationally.

Collecting/Examining Data and Information to Evaluate Clinical and LTSS Quality

Aetnalytics Hub provides an analysis of clinical, operational, and supplemental data and is used to prepare data for Quality and HEDIS reporting. We are committed continual investment in innovative reporting and data analytics technology. This commitment led to the creation of our internal, proprietary Aetnalytics Hub. The Aetnalytics Hub web landing page provides a comprehensive, centralized library of various Kansas dashboards and reports, tailored to state requirements, to drive effective program administration through reporting and insights. This innovative platform is the cornerstone of our support for seamless program administration, reinforcing population health initiatives, and elevating the standards of quality management.

The reports and dashboards we use fall into three main platform categories:

- **Quality, Member outreach, and medical management analytics dashboards** include gaps in care, outcomes, trending data, aged, blind, or disabled data, UM, case management, operations, pharmacy, Availity (a tool that allows for familiarity and a single user-ID and password for all Aetna reports), and value-based purchasing. These dashboards include gaps in care, outreach attempts to close gaps and success, among other types. Used by all functional areas of our health plan, these dashboards include:
  - **Trend/UM dashboard** summarizes plan level UM trends, such as readmissions, Emergency Department (ED) admissions, service authorization, and claims.
  - **Care Management dashboards** include key indicators and trends for the ICM and LTSS programs, including assessment completion and results, HEDIS results for Members within care management, caseloads, outreach, and risk stratification.
  - **Operations dashboard** includes UM, claims [redacted] key indicators, care management, HEDIS trends in case management, and call tracking.
  - **Pharmacy dashboard** summarizes prescription claims, pharmacy summary, weekly prescription lite, pharmacy high-utilizer, and pharmacy market share.
- **Population Health Analytics, Outcome Evaluation, and Health Equity dashboards** provide an analysis of clinical, operational, and supplemental data, including health outcomes and Member experience and are used to prepare data for our Quality and HEDIS reporting. **Used by all our teams that work with Members, Providers, and community-based organizations, these dashboards support population health activities, such as:**
  - Sharing integrated electronic health records, health information exchanges, SDOH, and claim-related data.
  - Delineating targeted case management roles and responsibilities with KDHE.
  - Capturing information in one place to create a centralized Member data view for Providers

at the point of care and to enable our Member-centered care team to manage care in real time regardless of care setting.
  - Providing Member-level, practice-specific, and population health segment wide analysis to support technical assistance, education and training, and reporting activities.
  - Facilitating community-based collaboration among traditional and nontraditional Providers.
  - Using SDOH and other assessment tools to support closed-loop data capture and confirm assessment completion status (e.g., housing status and food insecurity).
- **HEDIS Engine** allows us to collate data that informs how we intervene in Member care for the best quality outcomes. We share this system with Providers and internal staff, including care management and Member services, so there is a coordinated effort to close gaps and improve quality. Our dedicated, locally based quality team accesses advanced analytics and outcomes through our comprehensive Quality Performance Management System (QPMS). The QPMS incorporates clinical and administrative data including medical records, CAHPS, claims, appeals, grievances, encounters, authorizations, quality of care incidents, pharmacy data, and SDOH from administrative and supplemental resources.

Our quality team uses the HEDIS Engine to quickly assess the quality and appropriateness of care that supports our community, Providers, and Members. It allows the team to perform disparity reporting and analyze HEDIS measures by geography, race, ethnicity, and gender to target efforts and resources where they are most needed. This approach allows us to make available a suite of reports to Providers, Members, and staff, including ED utilization, ED high utilizers, pharmacy high utilizers, physician profiling, authorization weekly trend review, among other reports. Data gathered from these tools is analyzed to gain insights that support business decision-making about health care costs and trends, quality, and outcomes. Our functional teams then use the results to drive continuous improvement by addressing business questions regarding population health management, tracking health and economic outcomes, measuring the quality of the benefits and services we provide, and our overall health care program and product design.

Data, Information, and Analytics to Drive Continuous Performance Improvement

The information we glean from our data platforms and dashboards informs our QAPI and annual workplan and helps drive continuous improvement by constructing sound PIPs, revising quality goals, updating programs, and creating improvement activities or corrective action plans.

Annual QAPI Evaluation. QM department staff conduct an annual evaluation of the QAPI program to assess the overall effectiveness of our quality management program, including the quality and safety of clinical care, quality of service, and safety of clinical practices. The annual program evaluation assesses completed and ongoing activities as outlined in the QAPI work plan and QAPI program description. It also identifies and evaluates barriers encountered during the calendar year and in previous years. Performance monitoring and assessment of activities are evaluated using data trends and against established goals and benchmarks.

This process provides Aetna with the opportunity to improve the quality management program for the upcoming year. We review the annual evaluation and use the findings to establish quality management and performance improvement goals for the upcoming year. Opportunities for improvement identified in the evaluation or articulated by state regulators and other key stakeholders drive development of the goals and objectives. The information collected by all the

dashboards listed inform our evaluations and include continuity and coordination of medical care, continuity, and coordination of care between medical and BH care, assessment of availability of practitioners, Member, cultural and linguistic needs and preferences, and utilization management evaluation. **QAPI 2022 Program Evaluation Summary showed:**

- Aetna continued to improve processes to manage and report data related to outcomes. HEDIS rates showed improvement over 2021 in approximately 80% of the hybrid measures.
- The UM team continued to meet/exceed goals related to turn around times for prior and concurrent authorizations. Understanding that authorizations are a concern for Providers, this is successful news.
- Aetna scored 100% in the Health Equity Accreditation survey, proving that the infrastructure is present to support a robust Health Equity program.
- Partnerships with new and innovative vendors is expected to improve health outcomes for our Members. These include Pyx Health, Augeo, SeniorLink, Signify, among others.

QAPI Work Plan. The QAPI work plan is an activity-tracking tool used to facilitate achievement of quality management goals for the year. In response to the findings in the annual evaluation, activities are documented in the work plan. This plan outlines a timeline and description of deliverables, and includes quality management and performance improvement activities, resources, designated staff and department responsibilities, follow-up of previously identified issues, and progress toward completion.

QM department staff use the tool as an action plan to document the status and changes in activities throughout the year. Structured using the last three years' HEDIS measure data, PIP results and other quality assurance efforts such as CAHPS scores and initiative success will be included as we develop our annual QAPI work plan. Completed within the first quarter of each year, this plan will outline requirements and timelines we will use to complete all QAPI activities and shape our QAPI program. Results of the annual QAPI workplan will be reported in our annual evaluation and includes an assessment of how well we met our goals and objectives and recommendations for continuous quality and service improvement.

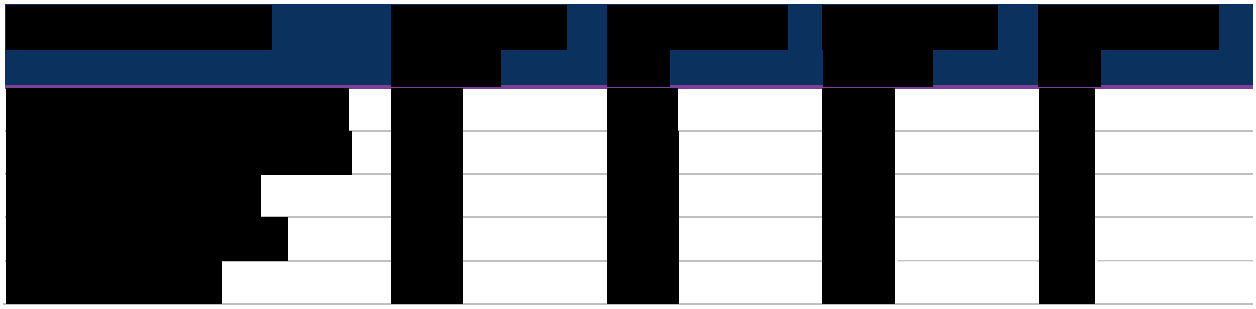
PIPs. Aetna conducts PIPs in accordance with state requirements and designs projects to improve performance in the quality or appropriateness of service provision and new/revised programs. A PIP annual report is submitted to the External Quality Review Organization (EQRO) that analyzes all the data collected through our dashboards within each measurement period to determine intervention and PIP effectiveness. For interventions that do not show improvements, we execute a new intervention and for those that do show improvement, we update the main goal and continue the PDSA continuous improvement cycle.

PIP topics are identified from areas of importance or opportunity for improvement as identified by KDHE, KDADS, or the health plan. The selection of PIP activities considers the prevalence of conditions among Members, the need for specific services, identified barriers to service, demographic characteristics, identified racial disparities, and health risks among Members/communities served by Aetna. The chief medical officer, QM/UM Committee, and QMOC review and approve PIP proposals. These committees receive ongoing reports of performance, barriers identified, and recommended interventions. Current PIPs include increasing influenza vaccinations, improving EPSDT anticipation, improving prenatal visit rates, reducing ED visits in LTSS, and reducing food insecurity. We use the EQRO to review and

approve the technical specifications of the outcomes measures and data collection for each of the six state required projects. Data and successes are illustrated by proof points listed below. Data is collected at least monthly and submitted to EQRO for review and monitoring by the State and Aetna. **The 2022 EQRO review of all KanCare MCO PIPs, noted that Aetna outscored the other Kansas MCOs. Average PIP Scores from high to low were Aetna at 97, MCO #2 at 80, and MCO #3 at 89**.

Population Health Management (PHM) Evaluation. Aetna performs an annual population assessment to evaluate membership characteristics such as age, gender, race/ethnicity, chronic conditions, and eligibility categories and monitor population changes such as geographic distribution, language preferences, cultural diversity trends, and changes in age distribution within the health plan's membership. This data is used to inform program changes and confirm Member needs such as Provider access and availability, interpretation services, provision of complex health care services, and continuity and coordination of care meet the highest standard. The evaluation helps identify sub-populations of Members that would benefit from health plan intervention and implement programs and services to improve or maintain Member health. Aetna defines the measurements and goals used to evaluate the performance of programs and services. **Current Population Health programs include influenza vaccination, promise pregnancy, living with diabetes, ED utilization management, complex case management, and Member restriction/lock-in.**

Goals are developed using our population Health Analytics, Outcome Evaluation, and Health Equity dashboards to analyze past performance, available industry benchmarks, program resources, and desired results. Annual results are assessed against goals to determine which goals were met. Goals that were met continue program interventions into the following year, while goals not met represent opportunities to improve. Goals not met undergo barrier analysis to determine root causes that inhibited performance. Subsequently, interventions are developed to break down barriers and improve performance. Current population health programs include influenza vaccination, maternity matters, diabetes, ED utilization, complex case management, and lock-in program.



LTSS Program Evaluation. Aetna annually reviews LTSS components of the Integrated Care Management program. LTSS program components provide support and coordination to Members enrolled in an LTSS program, regardless of their residential setting. Using our Quality, Member Outreach, and Medical Management; Population Health and Health Equity; and HEDIS Engine dashboards, we appraise our overall program effectiveness by setting relevant measures and analyzing annual results against annual goals. Goals not met are further analyzed to determine the barriers that inhibited performance. Interventions are developed to break down barriers and

improve performance. Key Indicators measured include LTSS program participation rate, Members residing in community setting, Members transitioning from custodial to community setting, Members remaining in the community 30-days post readmission, ED visits/1,000, unplanned inpatient admissions/1,000 Members, and Member experience. For example, LTSS reporting noted that the key performance indicator, Members transitioning from custodial to community setting, was not met. Barriers, opportunities, and interventions were developed including a biweekly transition case round platform implementation to support care coordinators with transition process and implementing the Careforth Caregiver Coaching program to better support caregivers. As a result, improvement has been noted in the first half of 2023.This result, along with the final rate, will be addressed in the 2023 LTSS annual evaluation.

Utilization Management Program Evaluation. The UM program evaluation is a comprehensive annual evaluation of completed and ongoing UM activities performed under the scope of the UM program description and UM work plan. Through the UM program evaluation, Aetna identifies program strengths and improvement opportunities using the Trend and Utilization Management dashboard among others and identifies existing program modifications and development of new interventions on this data. The UM program is integrated with quality management, Provider services, and Member services with the common goal of coordinating high quality, cost effective, and outcomes-oriented health care. It is designed to coordinate delivery of care aligned with evidence-based standards, assess satisfaction with processes, evaluate outcomes data, and evaluate utilization reports including under or overutilization. Through robust reporting, monitoring, and analysis, the UM program maintains optimal

2020-2022 Timeliness of UM Decision Making: BH and Non-BH

Measurement	Concurrent (Urgent)		Urgent Preservice		Non-urgent Preservice		Post Service	
	PH	BH	PH	BH	PH	BH	PH	BH
2020 Rate	99.0%	97.0%	99.0%	100%	99.0%	99.0%	90%	100%
2021 Rate	96.4%	89.0%	99.7%	83.0%	99.5%	81.0%	93.0%	95.0%
2022 Rate	97.2%	99%	99.7%	98%	99.7%	99%	98.7%	100%

turnaround times for behavioral and non-behavioral authorizations. Results are reviewed through the Quality Committee structure and annual results. Effectiveness of interventions are reported in the annual evaluations of the UM program and the QAPI.

c. Our Approach to Regularly Providing Information Available to the Public about Our Program Performance in KanCare

Our approach to regularly providing information to the public about our KanCare performance begins with actively seeking input from Kansas Department for Aging and Disability Services (KDADS), KDHE, Providers, subcontractors, key stakeholders such as associations and legislators, and Members to make sure that our public information and reports provide a comprehensive understanding of the program's impact and effectiveness. Our proposed public reports for 2024 include our program overview, Member demographics, quality improvement information such as performance measures and health outcomes, dashboard indicators, utilization of health care services, Member satisfaction, access to care, and Provider engagement. We will continue to work closely with the Kansas to tailor and structure content to align with goals and priorities.

For example, we will use State requirements for health literacy and cultural competency and pictures and graphics to better impart information to Members and their families. To enhance the communication of information available to the public in the future, we will develop **a dashboard to communicate this information to the public via our website.** Examples of our stakeholders and the information they receive are listed below:

- **State agencies** like KDHE and KDADS will continue to receive information via their website/portal such as compliance and auditing reports or other information requested.
- **Community partners** such as Ronald McDonald House, Kansas Food Bank, Baby Talk, and others will receive our monthly Community E-Newsletter, which covers topics like prevention and wellness, value-added benefits, and special events. Partners can participate in our Community Health Councils to share information. **In the future, partners will also be able to use the performance reporting in the proposed dashboard on our website, which will include search tabs for enrollment, quality of care, Provider network analysis, coordination and continuity of care, clinical outcomes, and operations and will list specific data such as number of Members, populations, and age gender, ethnicity, race, and region.**
- **Members** and their families can stay informed through MAC meetings, newsletters, and our website. As with Community Partners, **Members will also have access to the proposed Performance Reporting dashboard.** Also, we will begin a campaign to encourage Members to use the website's online Member portal or phone app, creating another mode of communication with our Members.
- Practitioners and Providers (individuals and Provider groups) currently receive information via Availity (e.g., Member, claims), the Provider Advisory Committee, quarterly Provider newsletter, weekly provider bulletins (email), and through contact with Provider relations representatives and quality practice liaisons. Aetna also engages and presents in multiple Provider-led organizations. Providers will also be able to access the proposed dashboard and its data related to Member and Aetna performance.

Topic Area 5: Quality Assurance

20. Describe the bidder's experience and approach to improving performance for the following two (2) Healthcare Effectiveness Data and Information Set (HEDIS®) measures in programs similar to KanCare. Include the actions the bidder will take to improve performance on these measures in KanCare and the anticipated improvement for KanCare.
    a. Timeliness of postpartum care
    b. Lead screening

Aetna's approach to creating a holistic care model, **Figure 20.1** and improving performance, includes tracking, monitoring, and closing care gaps through consistent person-centered care. This established approach embeds a culture focused on continuous quality improvement, innovation, and service excellence at all levels of quality program design and implementation. Organizationally, we offer a transparent, collaborative environment for Members, Providers, and stakeholders such as KanCare and the Kansas Department for Aging and Disability Services (KDADS) to promote best in class health care service delivery and improve access to care, quality of care, and Member outcomes. **Successes since entering the Kansas market in 2019 include NCQA health plan accreditation, LTSS distinction in 2020, and NCQA health equity in 2022**.

Staff. Our experienced KanCare leaders create change by addressing individual and population needs, including the vast differences between rural and urban areas, state requirements, ongoing training, education, mentorship, and best practices shared by affiliate health plans to integrate their successful lead screening programs. We maintain staff excellence through a rigorous hiring process and relevant ongoing training, education, and mentorship.

Figure 20-1: Care Model. *Our approach wraps the Member in a holistic care model to resolve care gaps.*

Experience. Our Kansas-based leadership includes seasoned Medicaid business professionals (chief executive officer, chief financial officer, chief operating officer, and strategy and actuary leaders) and licensed medical and behavioral leaders with relevant care delivery experience (chief medical officer, director of behavioral health, director of quality, director of pharmacy, and specialty leaders). Together, this team combines their business and clinical acumen to develop strategies to confirm KanCare Members receive high-quality care, benefits, and services in accordance with Kansas priorities.

Data. Our Aetnalytics Hub, which is our data platform, harnesses data from information systems throughout our health plan and engages data analytic approaches to produce actionable information that is consistent, timely, valid, reliable, and supports evidence-based decision making. This approach guides quality efforts such as our HEDIS improvement goals. Our HEDIS Engine platform embedded within our Hub produces complete administrative and hybrid rate reporting services that support the NCQA HEDIS submission process and certifies data accuracy, timeliness, completeness, integrity, and validity. The HEDIS Engine platform identifies Members who have gaps in care through claims along with the HEDIS technical specifications. And, once identified, steps we take to close gaps include live call outreach, text reminders, forward gap in care lists to Providers for outreach/closure, community events/education, participation and sponsorship of clinic/gap days, Provider education via webinars, newsletters, and the Quality Practice Liaison program, among others.

Tracking performance. Our platforms track all activities to improve performance and the results of those activities for all HEDIS measures including timeliness of postpartum care and lead screening using a Rapid Cycle Plan, Do, Study, Act (PDSA) approach, which includes PDSA, FOCUS-PDSA, and Six Sigma. This cycle, and the evaluation process examines intervention success and helps create impactful programs, services, and processes for Members. The result is improved safety, quality of care, access to services, and Member satisfaction and outcomes. The following two HEDIS measures, timeliness of postpartum care and lead screening outcomes, illustrate this process and successful outcomes. **Aetna confirms that we align with all requirements addressed in Scope of Services section 7.9.3. and 7.4.11.**

a. Aetna Measure Number One, Timeliness of Postpartum Care

Focused on the delivery of services to Members, we use rapid cycle Quality Improvement (QI) projects to drive improvement in postpartum care. While improvement is shown year to year in the administrative rate, we are always improving this measure and will continue to target and monitor through 2024, including African American women, as part of our health equity focus.

Postpartum Care-Final Rates			
Year-over-year	**2020**	**2021**	**2022**
Hybrid Rate (reported)	76.64 (Not available)	73.48 302/411	74.21 306/411
Admin Rate	39.23 1116/2845	41.13 1162/2825	51.51 1692/3285
[redacted]	[redacted]	[redacted]	[redacted]

Plan. We understand that women who have recently given birth can be overwhelmed, lonely, and in need of encouragement and help to complete their postpartum care. We provide a full 12 months of postpartum monitoring through Pyx Health. Aetna partnered with Pyx to outreach to Members who recently delivered to help coordinate a postpartum visit, assess for barriers to care, including SDOH, and to invite them to engage in their 24/7 app to provide support and companionship specifically addressing loneliness in this vulnerable population. We anticipated an improvement in care compliance because of this specialized outreach. As we continue monitoring this PIP in 2024, we will align Member contact as stated in the **Scope of Services section 7.4.11 with care coordination.** We will focus on both low- and high-risk maternity care. Low-risk Members will receive a monthly call to confirm their service plan meets appropriate pre- and postnatal care. High-Risk Members, such as those with chronic physical or mental

health conditions that directly impact their health or that of their infant, will receive one year of postpartum follow-up care. Both groups will be monitored.

Do. Beginning in Q1 2023, a monthly list of Members who delivered the previous month, along with Members who were currently pregnant, was sent to Pyx Health for outreach, assistance in scheduling prenatal and postpartum care visits, and to offer Pyx Health services to address loneliness and isolation. Members were outreached by Pyx Health peer support certified staff who have completed cultural competency training. This provides for culturally respectful and sensitive engagement between the Member and outreach staff.

[redacted]

Postpartum Care			
Point in Time Comparison	10/2021	10/2023	Delta
[redacted]	[redacted]	[redacted]	[redacted]

[redacted]

Addition Interventions include:

- **Maternity Matters™.** An Aetna Medicaid Maternal Health program, Maternity Matters provides Integrated Care Coordination (ICC) to all pregnant women during their pregnancy and for a minimum of 12 months postpartum. Maternity Matters™ promotes early prenatal/postpartum care to reduce maternal morbidity and mortality, decreases infant mortality and low birth weight, and enhances healthy birth outcomes. We enroll babies diagnosed with Neonatal Abstinence Syndrome into care management in addition to extending case management for the mother to 18 months postpartum to support abstinence and provide resources and support to assist mom to care for the baby. **Outcomes include 10.4% in NICU admissions per 1000 deliveries between 2022 (248.3) and 2023 (224.9) and a $1.5 million in total savings throughout the life of the program.**
- **Expansion of the Baby Talk Program:** Seeking to eradicate preventable infant deaths and improve maternal health, the Baby Talk program, open to anyone who is pregnant and under 32 weeks of gestation, was developed in Sedgwick County from a partnership with University of Kansas Wichita Pediatrics, the Kansas Department of Health and Environment (KDHE),

and March of Dimes. It is now a statewide program with financial support from Aetna. Women who complete all six classes, plus pre- and post-assessments receive an infant safety item of their choice, such as an infant carrier car seat, portable crib, or breastfeeding kit, at no charge. **Since its launch, Baby Talk has gifted more than 1,500 car seats to Kansas moms.** The program consists of six, two-hour classes with topics such as how to have a healthy pregnancy, infant care, and postpartum changes and concerns. Since the expansion in March 2023, nearly 60 Aetna pregnant Members have participated in the program.

- **Community Development/Baby Showers:** Community baby showers further support maternal and child health education efforts. We sponsor or attend baby showers in communities in concert with trusted Providers and health departments. These baby showers provide expectant mothers with games and giveaways of new baby equipment while learning about healthy behaviors. Since 2019, Aetna has attended or sponsored 56 baby shower events attracting over 3,900 individuals to these events.

> **We found a program in Wichita that we know will work for all Kansas families... ...Participants in the BabyTalk program are more likely than the county average to reach full-term pregnancy, and more likely to initiate breastfeeding.**
> *– **Jane Brown,** Chief Executive Officer, Aetna Better Health of Kansas*
> 004c.KS23

- **Targeted Outreach:** Targeted campaigns designed specifically for Members of child-bearing age and those currently pregnant are executed throughout the year to educate on maternal health, encourage contact with Provider, remind of benefits, and offer further assistance. These campaigns can be digital (SMS/Text), through the Aetna website, mailers, or live calls.
- **Incentives:** Providers receive $25 per visit for each eligible Member who competes a prenatal and a postnatal checkup and a $50 per notice of pregnancy received by Aetna ($100 with a behavioral health diagnosis). Members receive a $75 incentive card for completing first prenatal visit with Provider within the first trimester. Members can receive another $75 for completing further prenatal and postpartum care. Aetna also offers a $10 incentive for completing dental care during pregnancy. **Incentive Card Incentive Rates include** 2,072 women qualified for incentive cards for completing 11 or more visits before delivery and one after; 174 women qualified for incentive cards for completing dental visit; and 1,422 women qualified for incentive cards for initial prenatal visit completion.

Postpartum Care Measures in Aetna Affiliate Programs Similar to KanCare

- [redacted]
- [redacted]
- [redacted]

b. Aetna Measure Number Two, Lead Screening

Aging residential water pipes (especially in homes built prior to 1974) throughout Kansas present a threat to children. To combat this, we are using successful approaches from Aetna affiliate health plans and continuing to focus on using rapid cycle QI projects that drive Member lead screening rates for children. While improvement is shown year to year in the administrative rate, the reported administrative rate has not met the goal of equal to or greater than the Quality

Lead Screening for Children-Final Rates			
Year-over-year	2020	2021	2022
Admin Rate**	48.66 1549/3183	47.08 1957/4157	51.51 1692/3285
African American	45.09 156/346	45.64 225/493	45.97 211/459
Caucasian	44.07 661/1500	44.37 780/1758	45.59 708/1553
Asian	58.46 38/65	38.76 31/80	47.92 46/96
***A hybrid rate is not applicable here*			

Compass National 50th percentile. As part of Aetna's health equity focus, the screening rates of Asian, African American, and Caucasian Members was also monitored.

Plan. We understand Kansas children are still at risk for lead poisoning, and the only way to know if a child has lead poisoning is through venous or capillary screening. We also know that knowledge about lead and its dangers is limited for Members and the community. Education through live call outreach, digital campaigns, and flyers at community events are the most effective ways of providing information and coordinating screenings and care.

Do. From June to July of 2023, a targeted live call outreach campaign was conducted for children soon turning two years old who needed a lead screening. Outreach coordinators provided Members with education regarding lead screening and offered to help coordinate screening, among other support. During this same time, an educational flyer regarding the importance of lead screening was published and distributed at community events attended by Members and the community at large. That flyer is still distributed during events as health literacy regarding the need for screening and the developmental considerations related to lead poisoning is needed throughout Kansas.

Lead Screening for Children			
Point in Time Comparison	10/2021	10/2023	Delta
All Medicaid	46.85	49.07	+2.22

Study: During this targeted campaign, 328 Members were called with 50 Members successfully outreached. Out of 50, five had completed the screening, two had coverage that had ended, four refused the testing, one had an appointment scheduled, and 38 received reminder and education, but declined assistance in making appointment. These results may also show improvement through other interventions, including general EPSDT outreach through test messages, interactive voice response message and a targeted call campaign of African American Members in Sedgwick County. From July through September, 149 community events were attended by Aetna staff with the lead screening educational flyer available for distribution. **Over 3,000 participants attended the various events increasing the literacy and knowledge related to lead screening and safety. A point in time comparison in October of 2021 and October 2023, illustrates a 2.22 percentage point or 5% improvement in compliant screenings.** By evaluating data and the screening practices across the state, discussing with KDHE, and participating in the Public Health workgroup related to lead screening and mitigation, we know several data issues exist, including missing or mismatched ID numbers, limited or no access to data from agencies such as Women, Infants, and Children Program, and leads to an incomplete report of true screening and results for Aetna, the other KanCare MCOs, and the State of Kansas.

Act. Based on the incremental improvement, we will continue live call outreach to help Members understand the need for screening and assistance with accessing their benefits. Because a limited number of accurate Member phone numbers exist, we have expended our efforts to accessing current contact information through other databases. We are currently developing a campaign to gather further accurate information, using the knowledge gained during our redetermination efforts along with simplified options to communicate (e.g., Member portal and phone app). We will continue to partner with the other KanCare MCOs and the public health department to understand barriers related to data and continue to participate in the larger Public Health Lead Workgroup quarterly meeting to address screening issues and coordination and care

during episodes of mitigation. [redacted] As part of our process, we perform ongoing Provider check-ins to see how we can help them better identify barriers to properly completing lead screens and assist with mitigation. **We have paid out grants to Provider locations to purchase point-of-care blood lead level analyzer screening equipment for their offices** and provided five locations with grant money, including William Newton Pediatrics in Winfield, Health Partnership Clinic in Olathe, and Swope Health in Kansas City. **In 2024, we anticipate offering grants to at least 10 other Provider locations and will track the number of Members participating in screenings.** [redacted]

Lead Screen for Children Measures in Aetna Affiliate Programs Similar to KanCare

[redacted]

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21. Topic Area 5: Quality Assurance

21. In practice, MCOs have experienced challenges in providing necessary HCBS Waiver services, including those that have been authorized for a Member, creating service gaps. Describe the bidder's approach to identifying and addressing HCBS service gaps to ensure needed services are provided to KanCare Members who are enrolled in an HCBS Waiver and what the bidder will do when Providers/direct care workers are not available to deliver an authorized HCBS Waiver service.

Aetna is privileged to serve 9,870 KanCare waiver Members who receive HCBS services. Through HCBS services, Member can gain independence in the least restrictive setting of their choice. **Our team actively monitors for service gaps to confirm that we deliver high-quality, timely services to meet Member needs.** Despite our efforts, we have experienced workforce related challenges, which impact service availability and waiver Members ability to live independently and safely. Service gaps are a serious quality issue, as a result, we actively work to advance strategies to address gaps and deploy innovative and results-driven solutions that support complete service plan delivery.

Figure 21-1: Road to Independence. *Bridging gaps so Daniel and his daughter can reconnect successfully*

How We Identify and Monitor for HCBS Service Gaps

Our Care Coordination model, which includes quality management and quality improvement strategies, provides HCBS Members robust support. As part of our model, our LTSS Clinical team and care coordinators receive training on the importance of consistently providing waiver Members with all services included in their service plan. **When working with Members like Daniel, Figure 21-1,** we use tools and analytics to monitor for service gaps. In the last 90 days, **Aetna maintains > 90% assessment compliance. Gap of 10% includes member-driven delays and unable to reach members,** newly enrolled Members, Members in process of setting up their service plan, Members exploring service preferences, and Members receiving services pending billing.

LTSS Oversight Dashboard

In 2022, we created a comprehensive **LTSS Oversight dashboard to address workforce challenges.** This dashboard offers a direct view of waiver Member compliance measures, including timeliness with which care coordinators completed initial assessments, outreaches, and service plans. Additionally, the dashboard:

- Tracks contractual obligations
- Organizes caseloads
- Facilitates/informs management of in-person visits and telephonic outreaches
- Identifies unused service authorization based on custom pre-populated thresholds that tie back to each Member's service plan
- Summarizes data from Aetna's Clinical Documentation System,

- Serves as tracking and accountability tools to inform our Quality Assessment and Performance Improvement (QAPI) program.

In part, due to the LTSS Oversight dashboard, in 2023, we improved and maintained an interRAI assessment compliance rate of close to 100%.

The dashboard also includes key information regarding service plan adherence, which in turn allows us to identify unmet needs and service gaps. **As of Dec. 15, 2023, Aetna is compliant with timely service plan letter completion.** The dashboard is designed to identify unused service authorization based on custom pre-populated thresholds that tie back to each Member's service plan. The dashboard is updated with daily file feeds from multiple sources, including our enrollment files, service plans, claims data, and authorization data. In 2024, we are adding electronic visit verification data feeds to our dashboard so we can have more details regarding personal care services delivery. Today, our entire LTSS Clinical team uses the dashboard to monitor for service gaps.

Member Interaction

Care coordinators meet with Members in-person and telephonically to review service plans and available Providers. This interaction affords care coordinators an opportunity to identify and address service gaps. Whenever a service gap is identified, care coordinators work with the Member to find a timely solution. Care coordinator solutioning efforts may include reaching out to area Providers, making referrals, providing alternative options, and coordinating with the Network partners to negotiate single-case agreements or enhanced rates.

Network Analysis

We identify HCBS service gaps by conducting monthly network service inventories and reviewing network adequacy and capacity standards. Kansas' size and geography, the current service mix, a Members location, provider feedback, and performance quality of existing HCBS Providers all factor into our decision-making process. Members' needs are also compared to the existing service inventory to pinpoint specific service gaps. **Taking this holistic inventory approach helps us shape programs and solutions that consistently and timely address any service gaps.** For example, we identified that staffing personal care attendant hours can be difficult, especially for our most complex Members. and especially in rural parts of the State. To help mitigate this gap, we increased reimbursement and value-based purchasing options (which are described in detail below). Our most recent inventory assessment shows that there are some gaps relative to personal care and home-delivered meals.

LTSS Member Survey

We deploy an annual LTSS Member Survey to solicit feedback from Members receiving HCBS waiver services. Survey responses are used to assess service gaps in the program. Surveys are mailed to Members in all residential settings. Our 2022 LTSS Member survey results show our NCQA LTSS distinction yielded positive results, including:

- **97.8% of Members positively rating Care Coordinator Level of Assistance**
- **95.2% of Members positively rating Care Coordinator Supporting Members**
- **Members' satisfaction with care management increasing 2.5%** from 2021 for both home-based and facility-based Members

- **93% of Members rating service Providers as respectful**
- **96% of Members were satisfied with their service Providers' ability to assist them in a quality manner.**

How We Address HCBS Service Gaps

Aetna uses a variety of tools and programs to address HCBS service gaps, recognizing that each situation may have a different solution and outcome. Our toolbox includes our Community Resource Directory, self-directed services, workforce expansion, education, and partnerships. The table below details the tools and programs we use to address and close service gaps.

Tools and Programs for Addressing and Closing Service Gaps

Tools/Programs	Description
Community Resource Directory	Our proprietary, closed-loop Community Resource Directory, a nationwide repository and directory of Community-Based Organizations (CBOs) and agencies, is a reference guide used to address the spectrum of SDOH needs. We train staff, CBOs, Providers, and others on how to pull data for an area or intervention. This platform connects, tracks, and evaluates Member referrals and can be adapted to be used with other platforms. All connections are noted in the Member's care plan. **The directory contains more than 15,000 Kansas resources, with over 720 Kansas Members successfully closing gaps.**
Self-Directed Services	Self-direction promotes personal choice and control over the delivery of services, including who provides the services and how the services are provided. Members use self-directed services when it is the best fit for their needs providing flexibility and control over their own care and independence. Members can opt to self-direct care if an agency worker is not available to meet specific needs of a Member, or if there is already a caregiver involved in caring for the Member among other reasons. Support includes: • Locating Providers and community/natural supports • Contingency/backup plans for effectiveness • Discussions about using others, such as friends and family and other organizations they belong to such as faith-based communities, as well as researching additional waiver benefits, in lieu of services, or other HCBS benefits that may help the Member (e.g., PERS versus enhanced care support, Telehealth) **We have 3,834 Members receiving LTSS waiver services who choose to self-direct their care, which is 34.7% of the population we serve.**
Single Case Agreements	Aetna executes single case agreements with enhanced payments for network Providers and single case agreements for non-participating Providers to support timely service delivery. We understand that every Member's case is unique and continuity in care between Providers and Members is vital. **We have executed a total of 556 single case agreements for HCBS services since 2019.**
Utilization Management (UM)	Our UM team proposes alternative solutions and short-term ideas for time sensitive situations where urgent service gaps are identified without

Tools and Programs for Addressing and Closing Service Gaps	
	sufficient Provider capacity to address the Member's needs. For example, when Member needs are not met, they are referred to case rounds which are staffed by our entire interdisciplinary team; medical, behavioral, pharmacy, and subject matter experts on housing, employment and even foster care placement. **In 2023, over 200 Members were referred to rounds and their needs met in novel ways.**
Telehealth Options	Telehealth improves access to care and, in some instances, provides a viable alternative to in-person services. In 2024, we are expanding our services and launching a new telehealth solution, Vheda Health, for remote patient monitoring and active Provider outreach in the event of an identified need.
Pipeline Initiatives and Workforce Expansion	We host job fairs, like the Caring Hearts Career Expo to match employers with potential caregiver staff. **Aetna invested $25,000 to market the event through radio, social media, and billboard advertising, bringing awareness to the need for caregivers and the opportunities available to a broad audience**. We sponsor research to help determine the needs of direct care workers. **In Q2 2024, we are launching a partnership with Kansas school districts enhancing workforce expansion efforts related to HCBS services aimed at IDD Members to reduce service gaps for this population.** We developed a pipeline program by collaborating with Kansas school districts to deliver information targeted at eighth grade through high school students with the goal to introduce students to health care employment opportunities early as part of their journey to a fulfilling career.
Certified Worker Workforce Expansion	Aetna is one of two MCOs participating on a Behavioral Health Technician (BHT) Certification Workgroup hosted by the Wichita State University Community Engagement Institute and the Kansas Department for Aging and Disability Services (KDADS) Behavioral Health Commission. The goal of the workgroup is to make recommendations to the State on the criteria and pathway to a BHT Certification. BHTs, who work in inpatient settings, are one of the most needed and least available of the BH workforce. This effort is grant funded to date and Aetna has offered to fill in any future funding gaps as needed, including budgeting at least $50,000 in 2024.
Dental Provider Education	**In 2023, we provided $30,000 to Oral Health Kansas to help educate dental Providers** on the importance of accepting IDD Members, recognizing that some waiver Members struggle with oral health access and services. Oral Health Kansas works with partners to create a culture that values oral health as a part of overall health for Kansans. The University of Kansas Medical Center Project Extension for Community Healthcare Outcomes (ECHO) will partner with Oral Health Kansas on the Pathways program to provide training for dentists, hygienists, case managers, and other health care professionals on the unique oral health needs of IDD Members. The goal of the Project ECHO training is to

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	increase participants' ability to treat and manage complex health care challenges in their own communities.
Hospital Companion Program	Members on the Frail Elderly (FE), Physically Disabled (PD), Brain Injury (BI), and IDD waivers can receive up to **16 hours** of hospital companionship a year provided by their personal care service worker while the Member is in the hospital. Services are authorized by their care manager. This helps with service gap closure because it **keeps the personal care service worker engaged in the Member's care** despite hospital admission and supports continuity at discharge.
Respite Care (Aetna Differentiator)	Members on a waiver or those on a waiting list for HCBS services can receive up to **120 hours annually** with approval by the Member's care coordinator. Since 2020, we have supported 111 unique Members with a total spend of over $34,000. This helps with service gap closure because it prevents caregiver burn out.
No Place Like Home	Our grant program provides one-time emergency housing assistance to help keep Members in their home or to establish a new home in the community. **Year-to-date in 2023, we supported 36 unique Member households with a total spend of over $81,882. Based on this success, we dedicated a budget of $200k for 2024.**
EPSDT	For waiver Members eligible to receive services under EPSDT, we review for alternative service options that may not otherwise be offered to identify opportunities to close service gaps in situations where there are workforce challenges.
Careforth	We partnered with Careforth in 2023 to render coaching and support the Member's care team. Careforth's model provides each participating Member's caregiver with a team of trained care managers, nurses, and social workers to advise and close gaps on a range of topics such as condition-specific care, caregiver self-care, and access to services. Careforth will support the Member's caregiver to: • Gain the skills and confidence to provide care, manage behaviors, identify changes in condition, and mitigate risks in the home and how to prevent burnout • Share Member insights with care coordination and medical professionals • Better understand advanced care planning, comprehensive back up support plans, medication management, and care transitions • **Support caregivers to prevent their burn out, and keep them engaged in providing care, creating for a larger pool of natural supports that lessen the burden on the service delivery model, which at times is strained for lack of staff.**
CareBridge	Promotes timely and culturally appropriate care through a virtual, value-based innovative model to support Members receiving HCBS in their home by addressing medical, behavioral, social, and functional needs. Care Bridge supports caregivers/direct care workers with: • 24/7 Clinical team to confirm the care being provided is competent and appropriate care.

Tools and Programs for Addressing and Closing Service Gaps

- A cell-enabled tablet that is used for virtual visits with the Care Bridge clinical team. The tablet includes a red button that can be pushed 24/7 by the Member, family member, or direct care worker so the Member can reach a clinician.
- A Clinical team includes physicians, nurse practitioners, pharmacists, BH specialists, therapists, and other disciplines.
  - Care examples include support during an acute episode so more intensive services can be delivered through telehealth or other means and providing wound care and caregiver coaching for wound care to avoid further placement in an institution, thus mitigating barriers to care in even the most remote rural settings.

Value-Based Purchasing Agreements and Increased Shared Accountability with HCBS Providers

The tools and programs leveraged to close HCBS service gaps are enhanced through the development of a targeted Value-Based Purchasing (VBP) program, consistent with Alternative Payment Model (APM) methodology. With current Provider workforce shortages, we use VBP arrangements to build shared accountabilities with HCBS Providers by providing them needed investments and holding them accountable for closing gaps in the current care delivery structure. Our APM payments are tied to three key mandatory outcomes: meeting defined quality targets, achieving sufficient staffing levels, and emergency room diversion.

In addition, we have successfully **executed three VBP arrangements with Agency Providers who commit to passing on enhanced rates directly to their workers and are expanding this to others in 2024.** We believe doing so will further increase workforce capacity and reward the direct care individuals delivering services in the home. These models enable us to identify high quality Providers across all seven waivers, while creating clear incentives for Providers to operate with sufficient staffing levels. Furthermore, by meeting HCBS Providers where they are, and using the metrics relevant to them, we are creating a pipeline of Providers who we can bring further down the path of shared savings with focus on quality outcomes.

Aetna monitors each VBP program for effectiveness and shares information with Providers as part of a dynamic monitoring process so both parties can track progress toward payment goals. For example, our Pay for Quality Performance monthly report produces provider performance profiling at the organizational, group and individual Provider level and includes Member level gaps in care for quality measures.

Direct Care Workers Unavailable to Deliver Authorized HCBS Waiver Service

To assist Members in need of immediate assistance, Aetna developed an escalation protocol. If we discover that a Member's direct care worker is not available to deliver an authorized HCBS waiver service, for any reason, we immediately reach out to the Member, activate their contingency/backup plan, and work swiftly to locate an alternative Provider. Additionally, we engage the Member in discussing others who might be able to provide immediate assistance, such as friends and family, and evaluate alternative options for them.

Care coordinators determine how quickly unscheduled gaps in services will be filled based on Member preferences. Depending on the situation, we may contact the agency or facilitate a conference call between the agency and the Member. The goal is to confirm that the agency is aware of the non-provision of service and that it can provide coverage for the Member within the appropriate timeframe. We will coordinate care between the Member and the agency if the agency has a backup care worker available so the Member knows when someone will be able to visit them. If the agency does not have a backup caregiver, Members and their care coordinator discuss alternatives.

In the absence of friends or family members, all other agencies are contacted, and incentives are used to provide appropriate care when necessary. Upon identifying a Provider, we follow up with the Member the day substitute services are rendered to confirm the caregiver arrived according to the backup plan, document the situation and actions taken by all parties in our case management activity tracking event, and complete and submit a Potential Quality of Care report if a caregiver was unavailable and backup was unavailable from the source agency.

The contingency/backup plan is reviewed after the urgent need has been addressed and any necessary revisions are made. In addition, we track agencies that have consistent or repeated gaps and correct them as needed, including terminating their networks if necessary.

The road of independence is emphasized by Aetna's approach to develop and implement programs and solutions that address and close gaps consistently and in a timely manner. Through oversight reporting, strong partnerships, and innovative solutions, we have proven effectiveness in our care coordination model and feedback strategies to supporting Member and Provider satisfaction, outcomes, and performance.

Aetna has established and implemented a written Quality Assurance and Performance Improvement (QAPI) program for KanCare to provide the structure and processes necessary to identify and improve clinical quality, maximize safe clinical practices, and promote health equity and cultural competency across the various settings of care within the care delivery system. Our surveys, for instance, are part of our QAPI workplan, allowing us to monitor performance and Member satisfaction that align with their goals and promote independent, safe living.

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Topic Area 6: Provider Network

Tab 7f

Topic Area 6: Provider Network

22. Describe the bidder's approach (including methodology, data used to assess network adequacy, timeline, and use of selective contracting) to developing, managing, and monitoring an adequate, qualified Provider network for the KanCare program. Describe anticipated challenges, network gaps, and how the bidder will address those challenges, including the use of telehealth and other technologies.

Aetna Better Health of Kansas Inc. (Aetna) has the expertise, experience, innovative strategies, and capabilities needed to advance the KanCare vision and goals. We contract with any willing Provider to promote network expansion, adequacy, and diversity. Our approach is to use data driven strategies to assess for adequacy, opportunities for network development, and to manage and monitor the network. Starting in 2019, when our full commercial network became KanCare Providers, we have had a robust Kansas-wide network dedicated to all lines of business, thereby preserving continuity of care throughout a Member's life and their varying circumstances. Currently, our KanCare Network is larger than our commercial network, with more LTSS and Skilled Nursing Facilities (SNFs). We have a state border strategy in which we will contract with any willing Provider licensed in the state of Kansas to preserve cross-state-border patterns of care as part of our Member-centered approach.

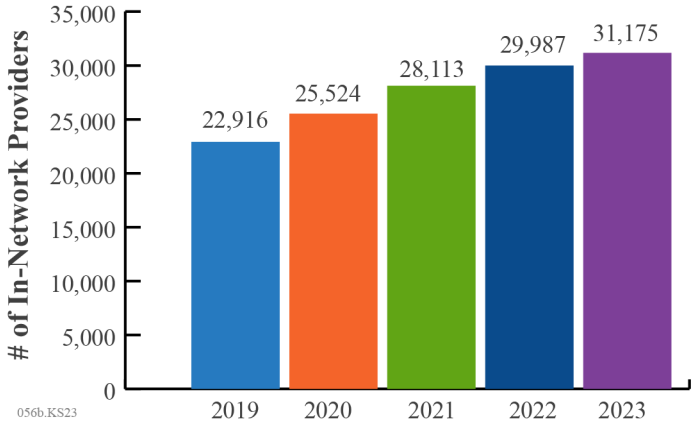


Figure 22-1: Provider Network Growth. *36% growth since 2019*

We are proud of our network growth. **Our network has grown 26% since 2019, with an average of 7% year-over-year growth**, **Figure 22-1**. **Additionally, over the same period, we have retained 98.4% of the network.**

Our network management and contracting director, who has over 30 years' experience, is responsible for developing and implementing the Provider Network Development and Management plan, while overseeing the Network Development team. They are also responsible for assessing network adequacy and availability, including expanding the use of telemedicine and implementing innovative strategies to improve network access and availability. Aetna delegates dental, vision, NEMT, and pharmacy network development and management to KDHE approved subcontractors. Aetna provides oversight and monitors network adequacy to confirm compliance with all contract requirements.

Current Network Adequacy Performance

Our approach to maintaining a comprehensive Provider network for KanCare Members is guided by **Aetna Medicaid's experience building Medicaid networks from the ground up in 15 states across 31 different programs, including the past five years working with KanCare.** Our network adequacy approach centers on access to high quality care and Providers who reflect the diversity of our membership. At Aetna, we develop this approach with Kansans in mind.

Our Network Adequacy reports demonstrate the comprehensiveness and breadth of our network. The table below highlights a sample of Kansas Members' urban, rural, and frontier access to our Kansas network's most critical Providers.

Kansas Members' Access to Critical Providers, Q3 2023

Provider Type	Proportion of Members in Urban and Suburban Areas with Access to Provider Type	Proportion of Members in Rural and Frontier Areas with Access to Provider Type
PCPs	100%	100%
OB/GYN	100%	100%
Pediatricians	100%	100%
Adult Behavioral Health	100%	100%
Pediatric Behavioral Health	100%	100%
Regional Alcohol and Drug Assessment Center (RADAC)	Contracted: 1; locations across the state: 13	
Hospitals	100%	100%
Pharmacy	99.9%*	100%
Dental, Adult	100%	98.1%*
Dental, Pediatric	100%	97.9%*
HCBS Waiver Providers—Adult Day Care**	100%	100%
Providers for IDD**	100%	100%
SNFs, total number across Kansas	Contracted: 193, Required: All licensed/certified SNFs; requirement met	
NEMT % Trips which met all applicable standards	99.8%	99.9%
DME/Medical Supply Dealer	Contracted: 184 suppliers; with delivery of mail order supplies to all 105 Kansas counties	

** Provider type scarce in rural/frontier areas. Aetna has an approved network exception in place today. **We contract with 153 adult day center Providers with 170 locations throughout Kansas, and with 133 Providers of care for Members with IDD, representing 172 locations statewide*

We meet or exceed nearly all adequacy standards for all Provider types throughout Kansas; however, we know areas where confirmed shortages exist. For example, there is a small number of available pediatric neonatologists in rural and frontier areas of the State. **To address this shortage, we are building a telehealth partnership with Ouma, a telehealth provider for high-risk pregnancies**. Ouma provides access to maternal fetal medicine physicians, obstetricians, and certified nurse midwives, and they partner with current RHCs in Kansas to confirm Members receive ongoing care during their complex pregnancies. Additionally, we contract with Kansas-licensed Providers in bordering states, and we work with Members to solve issues related to access to care. This includes supporting additional NEMT rides as part of our value-added benefits and supporting continuity of care for new Members beyond the typical 60-day limit.

Similarly, we monitor our dental network monthly. Based on Medicaid requirements, **100% of urban and suburban Members, including children, have access to oral health care within geographic time and distance parameters to a general dentist. For rural and frontier Members, 98% of them, including children, have access to a general dentist, within geographic time and distance parameters.** Nevertheless, we will continue working to optimize access to preventive and restorative oral health care, including sedation dentistry with network expansion, Teledentistry options for pre- and post-procedure consultation, and Value-Based Purchasing (VBP) models to encourage Provider participation. We use monthly Quest Analytics mapping to identify geographical dental network gaps and we monitor the accessibility of appointments using Provider surveys and secret shopper calls.

Developing an Adequate Network

Aetna Inc. has Provider networks in all **50 states that serve over 23 million lives,** and has more than **300,000 Providers** credentialed and enrolled as Medicaid Providers. 059c.KS23

Network adequacy starts with network development, and our network meets or exceeds KanCare network access requirements in urban, suburban, rural, and frontier parts of the state, and is sufficient in size, scope, and Provider types to deliver all medically necessary covered services and satisfy all service delivery requirements in the Scope of Services. In addition to Quest Analytics reporting, we use input from stakeholder groups including Members, PCPs, and safety-net Providers, and we monitor Member appeals and grievances to understand and act upon gaps in the network. **We deliver a clear, consistent message: if the Provider network does not meet every Members' unique supportive and medical needs, the network is not adequate.** We do not limit ourselves to meeting the required standards; instead, we develop our network to meet our Members' needs and we offer Members a choice of Providers to the extent possible and appropriate. Today, we align with all requirements in the network development portion of the Scope of Services, and we do not use selective contracting in our provider contracting strategy. We do not discriminate against any Provider or group of Providers serving high-risk populations or specializing in tertiary care. We contract with any willing Provider and all essential community Providers. Aetna will not employ or contract with Providers excluded from participating in the federal health care program. We monitor and identify Providers who become excluded from participating in our network, and we notify KDHE in writing.

Our KanCare network is more robust than the Aetna Inc. commercial network with more rural and safety-net Providers. 167.KS23

All Aetna Inc. Kansas commercial Providers also participate in our KanCare network. This means the same covered services are accessible to KanCare Members in terms of timeliness, amount, duration, and scope as those services available to non-KanCare Members in Aetna Inc. commercial plans within the same service area. We compare our KanCare and Aetna Inc. commercial networks quarterly and look for opportunities to bring in additional Providers to our KanCare network that are newly contracted with our commercial networks.

Our Provider Relations team meets with Providers to assess for access to care concerns and conducts a monthly sampling audit of the information in the Provider directory to confirm it is up-to-date in terms of location and hours of operation. We assign Provider Relations Representatives (PRRs) regions throughout Kansas and PRRs spend most of their time in the field engaging with Providers and addressing their concerns. They continuously gather and validate data, including confirming practice locations, hours of operations and timeliness of

appointments at office visits, teleconference/online calls, and phone calls. They note updates in cultural competency, change in hours of operation, and information about open and closed panels of PCPs. Annually we conduct a formal Access and Appointment Availability and After-Hours survey to confirm that practices have an open panel and can schedule all types of appointments within contractual standards. Providers notify the State of any changes, and the State adds the information to the Provider Network File. As we receive changes from the State, we update our Provider directory in real time to confirm it is up-to-date.

Network Diversity Promotes Access to Holistic Care. Aetna strives to build a diverse Provider network to serve our diverse membership, inclusive of Providers of color, non-native English-speaking Providers, Providers specializing in serving LBGTQ Members, and other Providers of diverse backgrounds, including home- and community-based Providers for culturally diverse populations. For example, based on Member feedback, we learned that Members want to know which Provider practices specialize in LGBTQ issues. We will initially identify LGBTQ-fluent Providers by reaching out to our connections in the LGBTQ community across Kansas to confirm their practice status. We deliver culturally and linguistically appropriate services as described in the Scope of Services. We contract with Providers based on the overall needs of KanCare Members while giving particular focus to subpopulations. This includes racial and ethnic minority populations, which need culturally sensitive Providers trained in recognizing implicit racial or ethnic bias, as well as expanded accessibility to non-English speakers and non-discriminatory language assistance. Our directory identifies the languages spoken by Providers and interpretation capability, as well as whether Providers have completed our health equity and cultural competency training.

At Aetna, culturally and linguistically responsive care (**Scope of Services section 7.5.4.**) is at the core of our service delivery, including our Provider network. We continually foster and enhance Providers' understanding and application of techniques to identify and address health disparities and to identify and adapt to Members' cultural preferences and health literacy needs as an integrated component of service delivery. **Providers receive cultural competency training, which includes American Indian and Alaskan Native competency and health equity, at new provider orientation and on an ongoing basis as needs are identified.** We are NCQA Health Equity-accredited as part of our commitment to health equity, cultural competency, and health literacy in delivering covered services. As part of our NCQA Health Equity recognition, we report on both Provider network and Member diversity, allowing us to connect the two and, as needed, recruit Providers that reflect the diversity of the membership.

We recruit and subcontract with vendors as needed to provide high quality services to the Member. We work with the following subcontracted Vendors: NEMT, Access2Care; PBM, Caremark; and vision and dental Provider network vendor, SKYGEN. **We integrate subcontractor oversight into our network organizational structure, with clear lines of responsibility and oversight** for a streamlined experience for Members, Providers, and the Kansas Department of Health and Environment (KDHE) and Kansas Department for Aging and Disability Services (KDADS). We perform monitoring and evaluation of service-level agreements between our organization and subcontractors on a monthly and/or quarterly basis, in compliance with performance monitoring standards in **Scope of Services section 7.5.14.** Aetna's **Delegation Oversight Committee** reviews reporting to identify areas that are substandard.

Routine monitoring affords collaboration between our organization and subcontractors to address deficiencies and to implement corrective action.

We recruit high quality Providers. We track quality and cost effectiveness metrics across all lines of business, providing the ability to recruit the highest quality Providers to our Aetna Kansas network. Aetna maintains commercial and Medicare networks in Kansas—as Aetna Inc. contracts with high-performing Providers in our other lines of business, we encourage them to join our KanCare network.

Our VBP programs with Quality Practice Liaison (QPL) support allow Providers to optimize their VBP earnings while delivering high-quality care. QPLs deliver data and review gaps in care reports for preventive care or chronic disease management services. Other QPL duties include tracking Provider performance for HEDIS compliance, providing NCQA and HEDIS technical specification updates, and developing and delivering current scorecards and measure-focused improvement action plans. These individuals focus on HEDIS outcomes and interventions related to VBP arrangements to support Providers to maximize their VBP earnings.

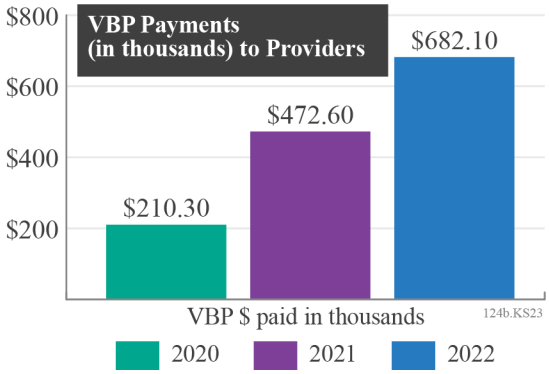


Figure 22-2: *Our value-based payments to Providers increased by 69% since 2020.*

Aetna executed a capitated risk agreement with Children's Mercy Integrated Care Solutions (Pediatric Care Network or PCN). Within this Agreement, some services are delegated to PCN, including medical management, utilization review, concurrent review, and discharge planning. Aetna is responsible for the adjudication of claims submitted by Providers providing care to PCN Members. PCN Members are 21 years old or younger and resides in the counties of Johnson, Wyandotte, Leavenworth, Miami, Douglas, and Franklin. The agreement does not include children using HCBS waiver services. This is an HCP-LAN category 4B model.

Our flagship VBP program is Healthier Outcomes. All PCPs and local public health departments are eligible for the pay for quality component and those that are ready may move to more lucrative arrangements under the Healthier Outcomes program, including shared savings and even assuming downside risk. We assess PCP readiness and have increased Provider participation by over 400% since 2021 moving us toward more sophisticated versions of Healthier Outcomes program. These programs help attract and retain Providers. **Figure 22-2 shows that since 2020 value-based payments to Providers have increased by 69%.**

Encouraging our Existing Providers to Move Through the VBP Continuum. We use mechanisms like VBP arrangements to help existing Providers expand their capacity. For example, we have a new VBP arrangement with Minds Matter, an agency that supports Members living with traumatic brain injury. **The arrangement specifically states that Minds Matter must use the funds to hire and retain direct care worker staff to provide more services to its clients.**

We have another VBP arrangement with CKF Addiction Services. We had a gap in the network for adolescent SUD treatment. The VBP arrangement supports moving Members from referral to active treatment status using telehealth technology to expand access for Members in rural and frontier communities. **As a result of the volume of referrals for adolescents, CKF began extending services to adolescents, a new population for them to serve.**

Finally, we worked with our dental subcontractor and First Avenue Dental to open a satellite clinic in Liberal, Kansas. We paid an increased reimbursement rate for services rendered at the satellite clinic. **The clinic has had a measurable impact in providing care to an underserved region of Kansas**. Since opening the First Dental clinic in Liberal in 2019, 2,150 Members, including 2,095 children and 55 adults, received general dentistry and oral health care at First Dental in Liberal. Overall, the satellite clinic serves a 50-mile geographic region, including Hugoton, Montezuma, and Sublette, which did not have access to dentistry until Aetna, our dental subcontractor, and First Dental collaborated on this solution.

Managing an Adequate KanCare Network

Providers want simplicity when working with health plans and our Provider Engagement Model (PEM) makes certain Providers of all sizes and types can obtain the information they need to care for our KanCare Members. Reducing administrative burden is the bottom line, allowing Providers to focus on delivering high-quality care.

Our priority is to pay claims timely, and **we meet or beat timely claims payment standards, paying clean claims within 30 days 100% of the time.** We understand the frustration Providers have with delayed or inaccurate reimbursement, and we know that some Provider types cannot afford to experience delays in payment. We are currently addressing this in several ways, including:

Provider Relations Team: Our director of provider relations will oversee the team of PRRs, with dedicated PRRs to address claims issues and other needs specific to HCBS, Behavioral health (BH), Skilled Nursing Facilities (SNFs), and medical and ancillary Providers. Providers can reach out to their PRR who will lead the path to resolving claims issues; this person becomes a dedicated point of contact to triage issues and achieve quick resolution.

Our PRRs, in collaboration with our internal teams, continually monitor to identify patterns and trends in Provider claim submissions, over and underutilization, claim denial trends, and utilization reports to identify common issues. We then deploy tips and tricks via regular provider communications to address and resolve common claims submission errors. **Easing provider**

burden is key to network development and retention, and we work to support Providers in many ways, including:

- Our dedicated Kansas-based PRRs track incoming calls from Providers, health systems, and hospitals for claims, contract, education needs, policy, and compliance issues. We have a customer relationship management tool to track date, progress, outcome, and close date to manage and confirm resolution of all issues. We currently align with KanCare's preferred credentialing process to support a smooth transition to centralized credentialing
- **We reduced Prior Authorization (PA) burden by removing several ancillary services and medical equipment from the list of items and services where PA is required**.
  - [redacted]
  - Additionally, Providers may complete the PA process on the provider portal and receive an authorization within prescribed timeframes—in some cases receiving an immediate authorization
- Our comprehensive provider portal helps verify eligibility, track claims and payment, enter and track prior authorization requests, and provides status on quality measures as well as gaps in care lists to confirm needed preventive and chronic care is addressed while the Member is in the office.
- We provide care management to optimize PCPs' and specialists' ability to care for complex Members.
- We have a dedicated provider services line, with first-call resolution over 90% of the time in 2022 and 2023.

Monitoring an Adequate KanCare Network

We continually monitor and build upon our comprehensive statewide Kansas network to meet or exceed contract requirements for time/distance and appointment availability standards using quantitative and qualitative data. The Network team is responsible for establishing and managing a compliant Provider network, which includes provider development; contract negotiations; maintaining network adequacy for each county throughout the statewide Aetna service area; monitoring gaps in network adequacy; providing Member accessibility to required health care services; anticipating network disruptions; and making sure that, in the event a network issue arises, the issue neither disrupts the network of Providers nor adversely affects Member access to covered services. Our strategies for monitoring the network include:

We contract with any willing Provider and all essential community Providers, including FQHCs, RHCs, Certified Community Behavioral Health Clinics (CCBHCs)/Community Medical Health Centers (CMHCs), health departments, RADACs, and other essential Providers. We encourage contracted Providers to participate in all available network contracts, including KanCare, to promote continuity when Members move from KanCare to employer group coverage or vice versa. We also contract with Kansas-licensed Providers in states that border Kansas to confirm access and preserve patterns of care. In many cases, we can leverage current

networks in bordering states to contract in Kansas as Aetna Medicaid Providers and increase access to PCPs and specialists. Kansas borders are rural and frontier; contracting with Providers across state lines increases access in these sparse geographic areas.

We use Quest Analytics data to measure time and distance standards within geographic areas of the state for all Provider types including PCPs, OB/GYNS, BH, LTSS, HCBS, adult and pediatric specialists, and dental; we use PCP-to-Member ratios by ZIP code to determine access needs; and we monitor current and anticipated enrollment monthly to confirm we have an appropriate number of Providers to accommodate Members. We use an annual survey to assess appointment and after-hours access, and to help confirm Providers maintain scheduled office hours and that panels are open to new Members. Finally, we complete quarterly secret shopper calls to confirm Providers are accepting new patients, scheduling appointments appropriately, and aligned with access to care requirements.

Qualitatively, our care coordinators collaborate with Providers and listen to their comments about Member volume and other access-related issues. Additionally, we review grievances and feedback from our internal operations departments regarding access, including care management, utilization management, and the member services and provider services lines. If a non-participating Provider requests prior authorization, we will invite them to join the network after processing their request. We receive input from Provider Advisory Committee findings and Provider and Member Experience survey results. We conduct network panel studies using the open/closed panel reports. Other qualitative monitoring includes monitoring quality of care and Member outcomes, SDOH heat mapping to identify opportunities to fill in with Community-Based Organizations (CBOs), or other resources to address SDOH.

If we hear of access to care issues from a Member, we first connect the Member to the care they need as quickly as possible. In the process we investigate the concern and proactively reach out to Providers to address access issues, including inviting them to enroll in the network.

If we find gaps in our KanCare network through monitoring, we confirm that participating Providers in the Aetna Inc. commercial or Medicare networks are also participating as KanCare Providers in that region and, if the Provider is enrolled in Kansas Medical Assistance Program, we will deem them as part of our KanCare network or offer them a direct contract. If a Provider type is not available within the distance standard, we will offer transportation, meals, and lodging if appropriate. Aetna will also offer telehealth options where Provider types are not available. We reach out to any non-participating Providers in the region to invite them to the network, prioritizing those who have delivered services to Members.

Tools and Technology

[redacted]

We implemented Availity as our payer-agnostic provider portal. This is a one-stop shop for Providers to access interactive claims status information, Member panel reports, and quality reports, including practice profiles. **Payers often have separate applications for these functions; having them in one place reduces the time Providers spend to get their questions answered**. On Availity, Providers can access the claim dispute resolution function, claims history, and look-up function for claims or Member eligibility. The prioritized Member outreach list is based on gaps in preventive and chronic care, key to delivering high-quality care. It is easy for Providers to access the searchable provider manual and dashboards that show a continuum of quality, cost, and utilization performance so Providers can gauge where they are with respect to potential VBP earnings. We continue to maintain the Secure KanCare Medicaid portal to ease the transition to the new portal for KanCare Providers.

Provider support capabilities offered through Availity include the ability for Providers to:

- Review precertification requirements, submit/modify authorizations, and monitor status
- Look up Member eligibility, benefits, and claims
- Access EFT and ERA forms
- View Member risk assessments and care plans, practice guidelines, HEDIS documentation, and quality improvement activities
- Submit specialty pharmacy prior authorizations (with procedure code)
- Submit grievances and appeals

During new provider orientation, we review the provider website and functionality and assist Providers in registering for the portal. Providers may also request ongoing or refresher guidance, as well as assistance with logging into the portal, either by contacting their PRR or the provider service line. Providers can also register for Availity through the provider website.

Anticipated Challenges, Network Gaps, and Solutions

The sizable number of rural and frontier counties in Kansas relates to Provider shortages and access to care challenges. **In Great Bend, Kansas, Aetna is partnering with Kansas Family Healthcare, Inc., an FQHC, to establish a Community Resource Center, opening in 2025**, to expand access to care for Members in an underserved community by offering in-person care in tandem with enabling telehealth. This strategic partnership will provide physical health and BH services. Because reliable broadband access can be challenging in rural areas, the area's **Community Resource Center will offer a private, comfortable space with a dedicated hot spot and computer equipment to help Members easily and privately access telemedicine services and identify available resources**. Community health workers will be available to assist Members on-site. The Center will include a wellness room to support programming that connects Members to local services and provides access to health and wellness classes, condition management programs, and coaching.

The following table reflects the additional strategies we are deploying in Kansas to address anticipated challenges, network gaps, and solutions.

Challenge	Strategy / Solution
Specialty care providers shortages in rural areas	• Bring specialists into FQHCs. • Partner with CCBHCs, CMHCs, and other sites suitable for telehealth visits to provide telehealth access for Members. – Our Community Resource Centers (CRCs) will also have private rooms for holding telehealth visits. • Sponsor Project ECHO sessions through our partnership with the University of Kansas to provide training and increased capabilities for PCPs to deliver specialty care and treat their Members without referral to a specialist. • Partner with RubiconMD, which offers virtual consultative conversations with PCPs for more than 140 subspecialties. • Refer Members to specialty care practices with telehealth options for care.
Dentistry and Sedation Dentistry	• Expand use of current telehealth options. • Work with subcontractor to develop VBP arrangements with dentists in the network to support opening of satellite clinics like the one opened in Liberal, Kansas by First Avenue Dental. • Expand sedation dentistry to certified registered nurse anesthetists willing to travel and support sedation dentistry where needed.
SUD/ Medication Assisted Treatment (MAT) provider shortage	• Contracting with all CMHCs/CCBHCs and RADACs for SUD treatment. • Contracting with all willing MAT Providers. • Providing telehealth SUD treatment through CKF Addiction Treatment.
BH provider shortages	• Continuing our VBP arrangement with CKF Addiction Services to provide telehealth-based addiction treatment for adults and adolescents in rural and frontier areas. • OneTelemed, Flourish Health, and MDLIVE: anticipate onboarding these solutions in 2025. These solutions support BH visits for Members as young as five years old and their families with moderate to severe BH concerns.
OB/GYN and Neonatology access in rural areas	• Recruit new OB/GYNs added to the Aetna Inc. commercial network to serve Medicaid Members offering alternative payment methodologies for reimbursement. – Refer Members to FQHCs with current telehealth capabilities. – Partner with Ouma, a **Telehealth solution, to provide access to high-risk pregnancy Providers**. Includes Maternal Fetal Medicine physicians, OB/ GYNs, and certified midwives. Partnerships with current RHCs in Kansas. • [redacted]

Our goal is to confirm Members have choices and access to a wide range of high-quality Providers across the continuum of services. Currently, we meet Member access standards for 100% of our PCPs, psychologists, psychiatrists, oncologist, and hospitals, and measure above 99% for gynecology, general surgery, cardiology, DME, and home intravenous therapy.

There are 23 OneCare Kansas (OCK) Providers who enhance access to care by providing community-level care coordination across physical and behavioral health systems. OCK Providers work directly with hospitals, clinics, and other departments in their own agencies to identify people who are eligible to participate. State-level data shows favorable trends in both outcomes and cost for Members enrolled in the program. OneCare Kansas is a program of KDHE, managed by all Medicaid MCOs.

Additionally, the Provider Relations team receives a monthly report on out-of-network billing Providers in our service areas to enable new provider recruitment, and we recruit Providers with whom we have single case agreements to join the network. Our presence in Kansas extends to the Aetna Inc. commercial and Medicare lines of business and we consistently outreach to those in-network Providers to recruit them into our KanCare Provider network.

Telehealth Solutions and Other Technologies

Aetna Medicaid is one of only two health plan applicants selected across the nation to help NCQA establish a Virtual Care Accreditation to improve the quality of telehealth encounters and is currently participating in a pilot to develop standards for virtual care for this accreditation to be implemented by NCQA in 2024. NCQA initiated the pilot because it views virtual care as an area for quality improvement. NCQA's pilot is focused on primary and urgent care delivered via virtual modalities.

> **CKF Addiction Treatment supports MCOs that have, like Aetna, furthered the integration of behavioral health and physical health, and worked to develop a continuum of care that addresses the needs of Kansas Medicaid beneficiaries.**
> – ***Shane Hudson,*** *President & CEO*
> *CKF Addiction Treatment* 059d.KS23

Aetna has broad experience in supporting and promoting the use of telehealth and other innovative access-extending technologies. **Through our Network Development strategy, we incorporate a wide array of innovative solutions to provide Members with access to high-quality care regardless of where they live or their ability to travel to appointments**. We prioritize contracting with Providers who offer telehealth capabilities as well as establishing partnerships with key organizations offering virtual solutions and wraparound services. Further, we load telehealth capability information from Providers as we receive it (e.g., via credentialing application or on delegated Provider’s rosters), and review claims for telehealth indicators. Our PRRs and care managers promote the availability of these solutions and can help coordinate use and access for Members. We also provide information on these solutions on the member website.

To monitor telehealth's effectiveness, we track utilization and Member feedback related to these innovative services to determine if our Members are using and benefiting from the solution. For example, since March 1, 2020, more than 167,000 unique Aetna Providers across all Aetna Medicaid plans have billed for telehealth services; in Kansas, since March 2020, 2,233 unique Providers have provided telehealth services to KanCare Members.

Aetna's **Advancing Rural Community** program's purpose is to provide access to care to Members who live in areas with risks of PCP and specialist shortages, lack access to needed services to address SDOH, such as transportation, and to provide these Members with increased access to care, education, and empowerment to manage their health and increase health literacy. Through community health workers, we will assist Members in signing up for Kansas' **Affordable Connectivity Program to lower the cost of home internet services and provide mobile phones with data plans,** thereby making telehealth more feasible in households without internet service, in addition to supporting Members to access employment and education opportunities. We also partner to create telehealth availability via private spaces and technology in our Community Resource Centers and satellites, which are open to any Kansas resident in support of healthier communities. And we coordinate with select schools to provide virtual care services for physical and BH for children K–12 to reduce time away from school for children and time away from work for parents.

To address specific Provider shortages, we consistently search for additional specialized telehealth programs and virtual tools (such as apps) that encourage and support well-being, resilience, and overall physical and mental health, which includes suicide prevention care for adolescents, SUD programs, mental health for children and adults, maternal care, doulas, and birth control prescribing. This may include facilitating partnerships with virtual Providers (including FQHCs, RHCs, CMHCs) to expand Kansas' local Providers' capacity and improve their ability to serve Member needs virtually. **The following table details proposed telehealth and other technology solutions to optimize access to care and empower Members with solutions to self-manage their care.**

Solution Partner	Status	Description/Focus Area	Results
Telehealth Primary Care Visits	Current	Independent and large multispecialty practices providing access to primary care telehealth visits.	4,023 unique PCPs have served 110,358 unique Members since Nov. 1, 2022, and there were 6,962 telehealth visits for a medical diagnosis between July 2022–June 2023
Telehealth Obstetrics and Gynecology (OB/Gyn)	Current	Independent and large multispecialty practices providing access to OB/Gyn telehealth visits.	730 unique OB/GYNs have served 15,343 unique Members since Nov. 1, 2022, for KanCare Members
Telehealth Behavioral Health Visits	Current	Community Mental Health Centers (CMHCs), Certified Community BH Clinics (CCBHCs) and private mental health practices.	60,523 telehealth visits for a BH diagnosis between July 2022–June 2023 for KanCare Members
Progeny/ Baby Trax	Current, Dec. 2023	**App for pregnancy management and supporting parents whose babies are in the NICU.** The app provides reproductive health education and support—from cycle tracking and help	New implementation

Solution Partner	Status	Description/Focus Area	Results
		with conception to pregnancy and parenthood. Baby Trax provides the ability to track baby's development, links to helpful articles and topics, and a digital baby book.	
Pyx	Current	**Social Isolation and SDOH for adults.** Focused on supporting individuals dealing with loneliness through member engagement and social determinants screening tools.	Aetna Medicaid Member data across 13 live markets include: • 55% loneliness reduction • 51% depression reduction • 56% anxiety reduction • 67% of KanCare Members screened indicated at least one social determinant need • 38.7% greater decrease in ED use (Louisiana only) • 52.3% decrease in acute hospitalizations (Louisiana only) In Kansas, 1,962 Members actively use Pyx.
CKF Addiction Treatment	Current	**Telehealth Adolescent and adult SUD treatment**. Intake and ongoing assessment, therapeutic group sessions.	166 KanCare Members received CKF TH services since 2022
SKYGEN Oral Health	Current	**Teledental services** for consultative and follow-up appointments, all ages.	Since 2022: Real time encounters: 597; asynchronous: 13 encounters for KanCare Members
Careforth	Current	**App for family caregivers** to alleviate burnout and support care choices.	54 family caregivers actively use Careforth in Kansas
Project ECHO	Current	**Virtual Provider-to-Provider e-consultation** on complex cases and e-learning for specific populations and chronic conditions.	N/A
Flourish Health	2025	**Telehealth Mental Health ages 13-26 Telepsychiatry and therapy for individual and families**. Supporting SMI, high behavioral health hospital utilization, justice involved and youth in foster care.	With current Aetna Medicaid partnerships achieved 56% reduction in hospitalizations, 71% increase in family preparedness, 77% recovery rate at the 1-year mark.
OneTelemed	2025	**Telehealth Mental Health ages 5+** Telepsychiatry, counseling, family and marriage counselors, addictionologists, and transitional care management post psychiatric discharge. Provides	With current Aetna Medicaid partnership, 98% reduction in hospitalizations.

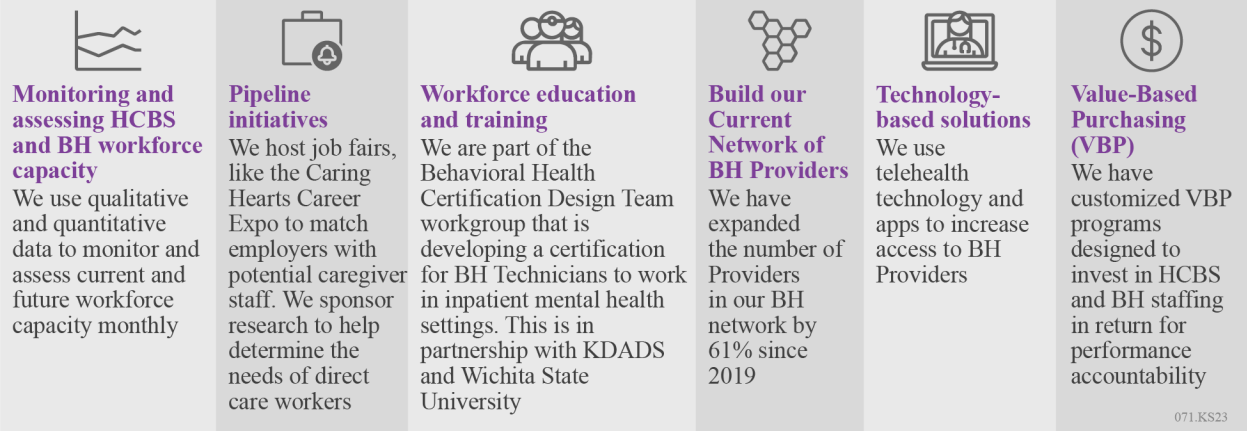
Solution Partner	Status	Description/Focus Area	Results
		integrated care in partnership with PCP.	
MDLIVE	2025	**Telehealth Mental Health ages 10+ supporting mild to moderate conditions**. Psychiatrist for diagnosis and medication management, licensed therapists, and counselors. Solution when in-person visits are not available.	With current Aetna Medicaid partnership overall satisfaction 80%, Net Promoter Score 100, 51% of utilizers have three or more visits. 78% of patients feel better after just three sessions.
Mae Health	2025	In-person and virtual support offering **culturally sensitive maternity support for Black expectant mothers**. In-person doulas and lactation specialists. Address the health inequities in maternity care.	With current Aetna Medicaid partnership, 98% reduction in hospitalizations, 70% reach rate, 90% have engaged meaningfully, 60% enroll within a week with a doula, 31% reductions in C-Section Rate and 58% reduction in pre-term birth rate.
Ouma	2025	**Telemedicine providers for high-risk pregnancies**. Maternal Fetal Medicine physicians, OBs, and certified midwives. Partnerships with current rural health clinics in Kansas.	Ouma reports 92% Patient satisfaction score since inception, 20% lower cesarean section rates, 30% reduction in preterm deliveries and NICU stays, 31% increase in perinatal mental health treatment, 90% postpartum follow-up, 90% postpartum screening.
RubiconMD	2025	Telehealth access for PCP consultation. Access to over 140+ specialists. **Enables PCPs to consult with specialists to optimize treatment decisions**.	With current Aetna Medicaid partnerships <1.5-hour median specialty response time, average provider satisfaction rating 4.94/5.
Care Bridge	2025	**Remote patient monitoring and telehealth for LTSS, frail/elderly and physically disabled Members**. Addresses the medical, behavioral, social, and functional needs of the Member.	Care Bridge reports Inpatient Admissions Per 1,000 Decreased by 12.4%, ED Admissions Per 1,000 Decreased by 18.2%, SNF Admissions Per 1,000 Decreased by 46.6%, Over 90% of Targeted HEDIS Quality Measures Closed Member Net Promoter Score of 84 (World Class level)

We are proud of the comprehensive network we have, and we continually manage and monitor the health of our network using quantitative and qualitative methods. Our outstanding reputation and willingness to work directly with Providers, and our responsiveness to individual and collective Provider concerns, allow us to develop, maintain, and expand trusted relationships with KanCare Providers statewide.

Topic Area 6: Provider Network

23. Increased demand for HCBS and Behavioral Health Services has created challenges in ensuring an adequate workforce to provide HCBS and Behavioral Health Services. Describe the bidder's approach for addressing workforce development challenges for HCBS and Behavioral Health Services.

Aetna is a strong community partner in workforce development, with five years of Kansas-based experience identifying and supporting educational pipelines, vocational organizations that train people in health-related skill sets, and providing support for caregiver burnout. We depict our multipronged strategy for recruiting and retaining the HCBS Direct Care Worker (DCW) and Behavioral Health (BH) workforce in the image below.



We will align with all related provisions in the scope of services. This includes hiring a workforce development manager in 2025 who is qualified by training and experience to be the single point of accountability to coordinate and oversee Aetna's workforce development activities. The manager will work closely with our Health Equity team to help build a workforce prepared to meet the needs of all Members and reduce health disparities.

Monitoring and Assessing Current and Future Workforce Capacity and Capabilities on at Least a Monthly Basis

Today, Aetna has several channels for listening to and understanding current BH and HCBS workforce issues. We sit on state-sponsored committees, including the Psychiatric Residential Treatment Facility (PRTF) Task Force and the Employment First Steering Committee; and we interface daily with various Centers for Independent Living (CILs), Community Development Disability Organizations (CDDOs), Community Mental Health Centers (CMHCs), Members, caregivers, and advocates through our care management programs and community-based advocacy. Through these interactions, we consistently hear about the difficulties in finding DCWs for individuals with IDD or other long-term care needs. We are aware of inpatient BH facilities that have closed beds due to the lack of staff to support intensive inpatient BH care. These formal and anecdotal stories paint a vivid picture of the worker shortage in HCBS and BH environments and the impact on our Members and their families.

We use formal and informal methods for monitoring, assessing, and predicting the impact of future workforce shortages. Internally, we discuss staffing shortages with our BH and LTSS teams, who work side-by-side with our BH and LTSS partners to support Members. We will formally monitor by asking our CMHCs, CILs, CDDOs, and PRTF taskforce for monthly reports on their open positions. This information helps gauge the current workforce shortage. We also use this information to send open position solicitations through our workforce channels to make sure the positions are posted throughout our stakeholder network. Consistent monitoring will also inform us on whether our interventions are having the necessary and desired impact.

We will track and trend the number of Members using BH services and HCBS services using claims and enrollment data. Aetna has a dashboard of BH and HCBS claims and enrollment info that helps us monitor capacity and identify gaps. We will use that to estimate current BH and HCBS workforce needs and calculate the gap between the current workforce and future needs. As we identify shortages and gaps, we will deploy targeted interventions at the service and geographic level.

Current Interventions to Improve Workforce Capacity and Capability to Meet Members' Needs

Pipeline Initiatives

Caring Hearts Career Expo: The shortage of direct support workers in Kansas jeopardizes the ability for individuals living with disabilities to live as independently as possible in community-based settings. Independent community-based living allows Members to maintain close family and social relationships, engage in employment, and participate in social, civic, and recreational activities in the community. Aetna partnered with Starkey, the oldest community-based nonprofit in Sedgwick County serving nearly 500 people with intellectual disabilities to launch the first Caring Hearts Career Exposition (Expo). **The event, held in October 2023, had six employers with four different CDDO agencies and one employment counselor from the Kansas Workforce Center.** Aetna invested $25,000 to market the event through radio, social media, and billboard advertising, bringing awareness to the need for caregivers and the opportunities available to a broad audience. Aetna also attends other job fairs intended to recruit DCW and BH workers. **Our goal is to host four major career expos per year** across Kansas to make certain underserved areas receive this employment opportunity. As part of our commitment, we will help organize, advertise, and bring together key stakeholders (temporary job placement agencies, career services personnel from schools, employers) to these events to help build connections and a pipeline of workers to support our most vulnerable Members. Part of our planning consideration for this and upcoming Expos is to reach out to racially, ethnically, and linguistically diverse populations to provide a workforce that is culturally congruent with the communities in which they work.

Aetna contributed $20,000 in funding for a survey of DCWs and their clients living with disabilities to determine best ways to preserve and grow the current workforce. The study, performed by the Kansas Association of Centers for Independent Living (KACIL), found that DCWs enjoyed their jobs. However, barriers to retaining the current workforce and hiring new workers are due to low wages and lack of benefits.

As part of our VBP efforts, Minds Matter, an organization that provides support for Members with traumatic brain injury (TBI), and Aetna have jointly committed to investing in the caregiving workforce and enhancing the quality and accessibility of care. Together, we launched an innovative value-based partnership in 2023 with the following objectives: 1) Empower and train DCWs; 2) Support career advancement and earning potential for DCWs; 3) Promote care coordination and in-home clinical oversight; 4) Improve access and timeliness of care; and 5) Enhance quality of care and improve patient outcomes.

The VBP model increases HCBS reimbursement rates in exchange for the organization maintaining adequate staffing levels, inclusive of both wage and benefit increase strategies. Aetna's investment to support the HCBS workforce will help agencies pay higher wages to retain current DCWs and potentially attract new DCWs.

Hutchinson Chamber of Commerce Career Quest Mega Tour Day: Aetna is sponsoring this event in February 2024 for sixth grade students to tour Hutchinson and the surrounding areas to explore careers. The workforce program coordinated by Greater Hutch provides career exploration opportunities for Reno County students throughout the school year in the form of on-site business tours for individual schools and mega tour days for multiple schools to explore an industry sector. The event in February is an opportunity for students to learn more about jobs in health care. We plan to host future events to encourage students to pursue careers in physical and various career pathways including HCBS service or behavioral service health care.

Wichita State University Badge Scholarships: Badges are academic short courses of one credit hour or less designed for working professionals. They are online and self-paced, which makes workloads more manageable for someone who is already busy with a full-time job and family. Health Care Badges include everything from Medical Terminology (a required class for many jobs) to population health topics, perfect for people who are working in health care today and need to learn more or for people looking to get into the health care industry. **Aetna has established a $50,000 scholarship endowment, which is expected to grow 4% annually to convey yearly scholarships to pay for Badge classes and other educational opportunities.** We look forward to using this money for other scholarships and certifications such as obtaining a Certified Nurse Assistant (CNA) or medical assistant certification.

Workforce Education, Training, and Job Placement

Behavioral Health Tech Certification: Aetna is participating in a Behavioral Health Technician (BHT) Certification Workgroup hosted by Wichita State University Community Engagement Institute and the KDADS Behavioral Health Commission. The goal of the workgroup is to make recommendations to the State on the criteria and pathway to a BHT Certification. BHTs, who work in inpatient settings, are one of the most needed and least available of the BH workforce. **Aetna's participation in this and the upcoming workgroups to discuss other BH specialty career paths is critical to developing an ongoing strategy to bring more individuals into the BH workforce with well-defined professional pathways.** This effort is grant funded to date and Aetna has offered to fill in any future funding gaps as needed. **Aetna will provide an annual $5,000 scholarship to support students seeking a BHT Certification once we implement the program.**

Rewarding Work: Rewarding Work provides an accessible and easy-to-use online directory and job board **designed to help individuals and families recruit, find, and hire caregivers and for job seekers to match with caregiver jobs.** Aetna supported Rewarding Work with a $17,000 sponsorship investment. During 2023, an average of 54 individuals and families used Rewarding Work each month to find and hire support. Rewarding Work also offers access to free Respite Care Provider Training, a nationally recognized training that provides a certificate upon completion. Approximately 120 individuals in Kansas have registered for the free training. **This education brings more trained individuals into the direct care workforce.**

Technology-based solutions

To address specific Provider shortages, we consistently search for additional specialized telehealth programs. This may include facilitating partnerships with Providers that have virtual services, including FQHCs, RHCs, and CMHCs, to expand Kansas' local Provider capacity and improve their ability to serve Member needs virtually. The following table shows the current and future telehealth solutions that will **directly increase the available BH workforce for Aetna KanCare Members.** Specifically, **three of these solutions will provide greater access to tele-psychiatry.** OneTelemed services children as young as five years old and their families; MDLIVE serves children 10 years of age or older and their families; and Flourish serves adolescents and adults. Care Bridge provides virtual care and support for Members receiving LTSS, including waiver services, which can act as a further extender to the HCBS workforce. We keep in mind that not everyone has access to technology, and we will help Members get a free cellphone with data plan through the Affordable Connectivity program.

Partner	Status	Description/Focus area	Results
CKF Addiction Treatment	Current	**Telehealth for Adolescent and Adult SUD Treatment from a Local Kansas Provider.** Services include intake, ongoing assessment, and therapeutic group sessions.	166 KanCare Members, largely in rural areas, received CKF TH services since 2022.
Flourish Health	2025	**Telehealth Mental Health for ages 13–26 Telepsychiatry and Therapy for Individual and Families.** Supporting SMI, high behavioral health hospital utilization, and justice involved and youth in foster care.	With current national Aetna partnerships, achieved a 56% reduction in hospitalizations, a 71% increase in family preparedness, and a 77% recovery rate at the one year mark.
OneTelemed	2025	**Telehealth Mental Health ages 5+** Telepsychiatry, counseling, family and marriage counselors, addictionologists, and transitional care management post psychiatric discharge. Provides integrated care in partnership with PCP.	With current national Aetna partnership achieved a 98% reduction in hospitalizations.
MDLIVE	2025	**Telehealth Mental Health ages 10+ Supporting Mild to Moderate Conditions.** Psychiatrist for diagnosis and medication management, licensed	With current national Aetna partnership, achieved an overall satisfaction rate of 80%, 51% of users have three or more visits.

Partner	Status	Description/Focus area	Results
		therapists, and counselors. Solution when in-person visits are not available.	78% of patients feel better after just three sessions. 100% would recommend to a friend or family member.
Care Bridge	2025	**Remote Patient Monitoring and Telehealth for LTSS, Frail/Elderly and Physically Disabled Members.** Addresses the medical, behavioral, social, and functional needs of the Member.	Care Bridge reports inpatient admissions Per 1,000 decreased by 12.4%, Emergency Department (ED) Admissions Per 1,000 decreased by 18.2%, skilled nursing facility admissions Per 1,000 decreased by 46.6%, over 90% of targeted HEDIS Quality Measures closed. 84% of Members would recommend to friends or family.

Short-Term and Long-Term Workforce Strategies to Promote Members Receiving Services Included in their Plan of Service

We have immediate (initiatives happening today), short- and long-term plans for increasing the BH and HCBS workforce in partnership with community-based organizations and with the State. We discuss these potential solutions below.

Immediate Solutions

Behavioral Health Workforce Partnership: Aetna has recently joined a BH workforce partnership with the Association of Community Mental Health Centers of Kansas to fund a workforce development consortium in the Wichita area whose sole aim is to build a pipeline of BH workers through training and mentoring programs. This work started in October 2023.

Value-Based Purchasing (VBP) programs: Aetna is aware that in 2020 the median home health and personal care aide hourly wage was $12.98. Fifteen percent of direct care workers have annual earnings below the Federal Poverty Level (FPL), and 44% live in households with incomes under 200% the FPL. [redacted] The first arrangement with Minds Matter will start in 2024.

Short-term Solutions

Background checks: Aetna will support reimbursement of any necessary background checks, drug testing, and TB testing needed for direct delivery staff for them to begin work.

School Based Programs: Aetna will work with Kansas school districts to develop programs targeted toward sixth grade through high school students to introduce them to working in the health care field; host a speaker series from various health care professionals; and sponsor internships, externships, and mentorships. We are starting with school districts in

Wyandotte and Reno counties. Longer term, we hope to obtain letters of agreement with at least 20 high schools around the state with a commitment to provide job placement and workforce support for those interested in entering the HCBS workforce. We will pair this effort with an agreement with a statewide staffing agency like KansasWorks, which will become the main artery for identifying HCBS talent and developing a significant database of talent. The partnership with organizations like KansasWorks would start with the Caring Hearts Job Fairs, scheduled quarterly, to continue to identify individuals interested in working as DCWs or BH Providers.

For individuals with General Education Diplomas: Aetna will offer 15 $1,000 scholarships for students seeking to continue training in the health care field per year upon successful completion of one year of direct care work or BH Tech work. Aetna designates scholarship funds for further training and education, books and supplies, tuition, or other vocational and academic programs. In addition, we will offer $500 tuition reimbursement for Aetna Members who obtain specific certifications to support the HCBS or BH workforce, including CNA, medical assistant, or BHT, through established training resources.

Long-term Solutions

Kansas Behavioral Health Center of Excellence (KBHCE): Aetna donated $75,000 in community funds to help establish the KBHCE. The mission of the KBHCE will be to provide timely access to high-quality treatment and services, exceptional training and education opportunities in behavioral health, and be an incubator for innovation. This intervention serves as a pipeline intervention by training new Members of the BH workforce, as well as generating innovations to improve access to care.

Certified Community Behavioral Health Clinics (CCBHC)/Community Mental Health Centers (CMHC): there is a significant reconfiguration of the workforce required by this new Provider type. Aetna will help solve for this challenge by identifying opportunities to train individuals to support CCBHCs/CHMCs, including crisis services workers, pediatric BH workers, and care coordinators. Aetna can bridge between training resources and CCBHCs/CHMCs and provide training, such as Mental Health First Aid training.

Community Based Organizations: Aetna commits to dedicating at least 1% of its mandatory community reinvestment dollars to community-based organizations that commit to expanding training and education opportunities for the HCBS and BH workforce. This can include education opportunities, employment supports, resume writing supports, and expanded skills training that allows the HCBS workforce the same level of ongoing education opportunities as other supportive therapeutic areas.

Continuing to Grow our KanCare Network of BH Providers: Since 2019, we added 2,789 KanCare BH Providers for a total of 7,395 Providers in our KanCare BH network, representing a 61% increase in all BH Providers in less than five years. The table below shows **BH specialty Provider types in the KanCare network increasing significantly in the past four years.**

BH Provider Specialty	Number of KanCare Providers in 2019	Number of KanCare Providers in 2023	Percent Increase in BH Provider Type
Licensed Master's Level Psychologist	218	273	**25.2%**
Licensed Clinical Psychotherapist	175	191	**9.1%**
Psychologist	324	379	**17%**
Licensed Mental Health Professional (LMHP)	1,302	2,388	**83.4%**
Alcohol and Drug Rehab	83	105	**26.5%**
Intensive Individual Support	476	1,333	**180.0%**
Home Based Family Therapy	295	344	**16.6%**
Licensed Clinical Mental Health Professional	1,429	1,846	**29.2%**
Consultative Clinical and Therapeutic Services	143	341	**138.5%**

Collaborate with the State, other KanCare MCOs, and Providers to Coordinate, Plan, and Implement Workforce Development Initiatives

Aetna will convene and lead a collaborative workgroup with representatives from the State, other KanCare MCOs, behavioral health workforce organizations, academic stakeholders, and HCBS Providers to coordinate, plan, and implement workforce development interventions designed to retain and grow the current BH and HCBS workforce. With Aetna's experience developing pipeline programs and workforce development, we are well-positioned to lead this effort with the other MCOs and the State. **The workgroup would address priority two and priority four of the State Health Improvement Plan to increase access to BH services, and we would include HCBS services as part of this collaborative workgroup.**

Solving for the increased demand for HCBS and BH Services requires a collaborative effort centered on the needs of KanCare Members and their caregivers. **We have a proven record of working across state agencies, community-based organizations, and schools to support collaborative initiatives and we commit to leveraging these relationships to address BH and HCBS workforce challenges.**

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Topic Area 6: Provider Network

24. Describe the bidder's identification of network gaps in dental Providers in KanCare and the bidder's approach to ensuring KanCare Members have timely access to quality dental care in Urban, Rural, and frontier areas. Include example(s) of the bidder's successful use of a comparable approach in program(s) similar to KanCare, the measurable impact achieved, and how the bidder will apply this experience to benefit KanCare

Aetna supports KanCare's vision to improve health outcomes by providing access to holistic care, including oral health care, and developing and maintaining a highly qualified Provider network to improve oral health and health outcomes for all Kansans. We integrate KanCare's goals to improve Member experience and satisfaction, reduce disparities, and grow the dental Provider network. To do this, **we monitor access to oral health care, identify and address gaps, and continually evolve and innovate to expand access to oral health care throughout Kansas.** Our dental network consistently meets or exceeds all KanCare program requirements for the oral health Provider network.

We understand the importance of oral health for overall well-being, as well as for school and employment readiness. Even though Kansas significantly expanded access to dental care for adults, we know that access to dental care for adults is still challenging, as many dental practices are not accepting new KanCare patients and there is a shortage of dental Providers. In 2021, 19% of counties in Kansas had no dentists practicing in the county and 72% of Kansas counties had five or fewer dentists, indicating statewide shortages of oral health care Providers. **Even with these barriers, in 2022, Aetna rated above the national 50th percentile for Annual Dental Visits for all age brackets, 2–18 years old, and rated above the 75th percentile for children aged 7–10 years old.** Additionally, we saw an increase in adults' use of dental services. The **Figure 24-1** illustrates the average number of adult dental services delivered between July 2022 and July 2023. Among our KanCare Members with Autism Spectrum Disorder (ASD), we saw a 14.1% increase from January 2021 to July 2023 in obtaining dental services, representing a 56.7% increase in dental services over Aetna Medicaid's total ASD population nationwide.

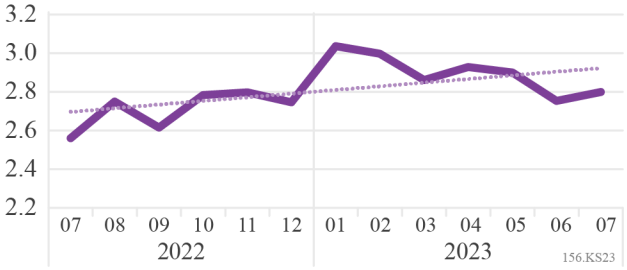

Figure 24-1: Adult Services per Patient.

We use SKYGEN as our dental care subcontractor. We undertake subcontracts only when it adds value for Members, and SKYGEN has 10 years' experience in Kansas with an established network of oral health Providers. Our subcontractor has proven its ability to serve the KanCare population with continued high-performance standards using data analytics to proactively develop its network to maintain adequate service statewide, including to the rural and frontier areas; strong Provider partnerships; and a Kansas-based, experienced, and service-oriented team. We monitor SKYGEN's performance with our delegation oversight processes, a comprehensive reporting structure, and monthly Joint Operating Committee (JOC) meetings.

Aetna Meets Current Access Standards for Timeliness and Distance

Aetna has a robust dental network in Kansas, however, while we meet the access standards of 20 miles or 40 minutes from a Member's home to a dental Provider in Urban areas and 30 miles or 45 minutes for rural and frontier areas, as a current KanCare MCO, we know it is still difficult to get an appointment for adults, and for adults and children with complex needs requiring sedation dentistry or other special care needs. In addition, we see oral health disparities in rural and frontier areas due to the shortage of Providers. Aetna is committed to addressing these concerns by optimizing current access to oral health care and encouraging expanded access to care in rural areas of the State.

Based on KanCare requirements, **100% of our urban and suburban Members and 98% of our rural and frontier Members, including children, have access to a general dentist** within geographical guidelines. 072c.KS23

Since 2021, our dental network retention rate is 84%. Twenty-six new dental practices have signed on to the network, representing 46 new dentists ready to serve KanCare Members.

Identifying Gaps in the Dental Network

We use data driven methods to identify gaps in the dental network. We start with monthly Quest Analytics mapping to identify geographical dental network gaps and we monitor the accessibility of appointments using Provider surveys and secret shopper calls. We use claims data to look for dental Providers underutilizing services and reach out to them to make certain they are accepting KanCare Members and review the dental benefit. Additionally, we look for trends from calls that come through our members services and provider services lines, grievances, and care management. We meet monthly with our dental subcontractor to identify and address gaps, relay trends we see, and work closely with the subcontractor to continually review and resolve dental network concerns. We closely monitor performance on the HEDIS Annual Dental Visit measure to identify gaps in the network as well as other barriers to oral health care.

Recruitment. To identify opportunities to expand the dental network, we monitor the national database to identify new dental graduates and where in the country they start their practice, and we reach out to credential them. SKYGEN's dental advisory group, comprised of dental consultants and dental medical directors, work with us to find solutions to expand the dental network. We conduct quarterly surveys to confirm access to services, including documenting the ages served at the practice and appointment availability. Finally, we talk to dental service organizations to anticipate and encourage coming to practice in Kansas to serve more KanCare Members. We also meet with trade associations and stakeholder associations to obtain feedback on barriers to seeing KanCare Members. We use this information to design processes, technology, and policies that support dentists seeing Members in an efficient manner.

Aetna is continually out in the community, listening to KanCare Members and Providers and acting upon their concerns, including feedback regarding access to oral health services. For example, Aetna and our dental subcontractor both sit on **the Kansas Sedation Dentistry Taskforce, which exists to identify gaps in sedation dentistry care and to improve access to this critical service,** especially for individuals living with IDD. In addition to the Sedation Dentistry Taskforce, we join the Pathway to Oral Health meetings. **We sit on these committees to listen to Member advocates, stakeholders, and Providers to better understand their challenges** when accessing oral health care for Members with complex needs.

We also work closely with safety net clinics offering dental services to better understand the demand for services and their ability to meet demand.

Addressing Gaps in the Dental Network

Aetna is part of the solution to making sure Kansans get the quality oral health care they need.

Leveraging our Current Network: We work with general dentists in rural areas to identify any dental specialty skills they are qualified to perform and credential them appropriately. These specialties are included as part of the listing in the Provider directory, including sedation dentistry, and the information is available from the member service line and the online Provider directory to help Members find the services they need. As needed, we work with non-participating specialty Providers, like anesthetists or dentists external to the network, to arrange services in areas of need. This contact with non-participating Providers leads to discussions regarding becoming a contracted Provider. **This is an urban, rural, and frontier solution.**

Border State Strategy: We recruit all willing dental Providers across all surrounding Kansas state borders who are licensed to practice in Kansas. We offer parity in our reimbursement rates to Providers in bordering states to confirm they are paid at their state's Medicaid reimbursement rate for services. **This is an urban, rural, and frontier solution.**

Teledentistry: Teledentistry is an excellent modality for dental consult visits in advance of an anticipated procedure and for follow-up visits after a procedure is completed. Teledentistry often alleviates transportation concerns and can be less disruptive for individuals with special needs that do not travel easily. We are actively working to partner with Providers in the Southwest Kansas area to add a telehealth location in Seward County. We are targeting January 2025 to open the location. **This is an urban, rural, and frontier solution.**

Aetna Community Resource Centers (CRCs): Our CRCs are situated in Provider shortage areas. To enhance access to dental services, Aetna's CRCs will have the technology resources required to host Teledental appointments. Additionally, we will work to identify and invite dental hygienists with Extended Care Permits (ECPs) to provide services in the CRCs, which can include preventive cleanings, fluoride sealants, decay removal, and temporary fillings. Hygienists with ECPs can serve children, adults, and older adults, making them a valuable partner in areas with dental Provider shortages. In May 2023, Aetna entered into a letter of agreement with the Heart of Kansas Family Health Care, Inc. to build a CRC that will offer telehealth services located in Barton County starting in January 2025. **This is a rural and frontier solution.**

Provider Directory: To confirm our Members have a comprehensive view of our Provider network, the Provider directory shows all oral health Providers in the network as well as Providers that can act as extenders, like hygienists with ECPs, who can practice under the supervision of a dentist, in school-based and other community settings, and anesthetists willing to travel to dental offices which provide sedation dentistry. In-network Providers in border states are also listed. **This is a statewide solution.**

Reducing Provider Burden to Preserve Network Retention: Given the dental Provider shortage throughout Kansas, it is critical that we reduce provider burden to retain Providers in the network. We reduce administrative burden in several ways, including supporting coordination of care, supplying an easy-to-use provider portal, and making certain that Providers have mechanisms to formally and informally give feedback which we then act upon to improve Member and Provider experience. **These are statewide solutions.**

Reducing Provider Burden: Project ECHO® (Extension for Community Healthcare Outcomes) developed at the University of New Mexico, is a lifelong learning and guided practice model that revolutionizes medical education and exponentially increases workforce capacity to provide best-practice specialty care and reduce health disparities. The heart of the ECHO model™ is its hub-and-spoke knowledge-sharing networks, led by expert teams who use multi-point videoconferencing to conduct virtual clinics with community providers. In this way, primary care doctors, nurses, and other clinicians learn to provide excellent specialty care to patients in their own communities. Aetna sponsored the Accessible Oral Health 2023 ECHO: Building Confidence in Serving People with Disabilities series, which aims to increase dental care access for Kansans with disabilities through the education of the dental care workforce and professionals involved in the dental journey of individuals with IDD. The series includes raising awareness of IDD, stigmatization, communication strategies, sensory awareness, the importance of teamwork (both within the dental team, with care coordinators, and with other health care professionals), and introduction to existing tools and resources. All dental teams, including dentists, hygienists, dental assistants, receptionists, and care coordinators, are invited to join. The series kicked off in October 2023 and 80 people, inclusive of dental Providers, hygienists, dental techs, care coordinators, and others attended the five session series. We plan to sponsor additional ECHO series on this topic and will work with Oral Health Kansas on awareness campaigns to address the dental needs of complex populations. **This is a statewide solution.**

Reducing Provider Burden: My Dental Care Passport and Coordination of Care: My Dental Care Passport is a communication tool designed to help people with disabilities provide critical information to the dental team to help them prepare for a successful dental appointment. Sharing how they communicate, what has worked well when visiting the dentist in the past, and what parts of the appointment might be most challenging. My Care Dental Passport allows users and their families/caregivers to voice their individual needs. Opening this communication channel can begin to shift attitudes, improve the dental team-patient relationship, allow the dental team to make changes to the dental office environment before a person even arrives, and improve the chance of a successful visit to the dentist. Based on Member and Provider feedback on increasing the comfort level of children, people with IDD, and their caregivers, **Aetna worked together with the Kansas Oral Health Coalition and other MCOs and stakeholders to develop the My Dental Care Passport program.** To confirm the dental passport was

We socialized My Dental Care Passport through X (Twitter) and Facebook:

Attention, everyone! We have incredible news to share! Introducing My Dental Care Passport, a revolutionary tool designed to assist individuals with disabilities in effectively communicating their needs to dental offices. Best of all, it's absolutely FREE and has been tailored to be user-friendly for people with disabilities and their caregivers. Let's work together to ensure equal access to quality oral healthcare for all! Join us in spreading the word!
#oralhealth #dentalpassport
#oralhealthishealth #disabilityhealth

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available to all Members, including those with limited English proficiency, **Aetna paid for the passport to be translated to Spanish, and other languages upon request, for ALL KanCare Members, not just Aetna Members.** Parents and caregivers fill out the passports with information related to their child's or adult's disability or health condition, share their likes and dislikes, and any preferred special in-office conditions needed to facilitate a smooth dental visit. The dental office reviews the passport before their visit, which helps the Provider to be prepared for the Member's visit and to help make the visit as successful as possible. Oral Health Kansas is initiating a study with University of Missouri–Kansas City to validate and collect evidence of the passport's efficacy in improving the Member's experience during dental visits. **This is a statewide solution.**

Reducing Provider Burden: Dental Provider Portal: We are especially aware of burdens smaller practices with fewer resources face. Our dental subcontractor uses a multifunctional Provider portal that oral health care Providers use to work with all their payer partners. The table below depicts the functionality of the Dental Hub™ Provider portal.

Dental Hub™ Significantly Reduces Administrative Burden for Oral Health Providers
Checks eligibility – Enables the practice to easily determine the Member's eligibility for benefits at the time of the visit.
Claims submission – Enables real-time claims processing with instantaneous claim edits.
Submit prior authorization requests and automatically converts approved authorizations into claims once services are rendered.
Determining co-insurance payments – allows Providers and patients real-time, fully adjudicated treatment plans and Explanation of Benefits (EOBs) statements. Providers do not need to estimate when trying to determine how much they will be paid for their services. They can generate an EOB and share it with the Member while in the office, thus allowing the Provider to answer any questions the patient may have before they leave the office.
Tracking Missed appointments – Providers can note if a Member has missed an appointment. The dental subcontractor will call Members who missed appointments and encourage them to reschedule to get the care they need. The documentation is visible to dental offices and Aetna care coordinators to support care coordination and management. The dental subcontractor collects data from Members as to why they may have missed an appointment (transportation, scheduling conflict, personal issues, etc.) and records in the portal.
Enables Aetna customer service and care coordinators to view records (based on role and other PHI security parameters) to enable continuity of customer service and continuity of care from care coordination.
Gives the ability to **manage multiple practices and locations** using a single login. 072d.KS23

Reducing Provider Burden: Streamlining Processes. We know that Providers can be frustrated with delayed claims payment and other processes that add administrative burden. We are proud to say that our average dental claims processing time is nine days over the past three years, dental providers are credentialed within 18 days of receipt of materials, and prior authorization determinations consistently meet or beat the 14-day turn-around time, thereby leading to less burden and frustration for dental Providers. In 6 of the last 9 quarters of data, greater than 80% of Providers surveyed reported they were satisfied or very satisfied with their experience.

Oral Health Director: To lead efforts to expand access to oral health care, we will have a dedicated, Kansas-based oral health director who is also a dentist licensed in Kansas; this individual will report to the chief medical officer. This position is key personnel required by the KanCare contract and will oversee and be responsible for all oral health activities related to our KanCare Members, including developing and implementing strategies to expand Member access to oral health services and increasing utilization of preventive services, and is the main point of

contact for the State regarding oral health services. Aetna's oral health director will be a vital part of our Member case rounds bringing in the oral health expertise to the Member's holistic care discussions. The oral health director, along with our Kansas-dedicated vendor manager, will actively oversee our dental subcontractor and work to confirm access to oral health services for all KanCare Members.

Our dental subcontractor hosts a quarterly national advisory board, and the executive director of the Kansas Dental Association sits on this Board. Our oral health director will be included in the board to represent Aetna KanCare Members' needs.

Aetna's Innovative Approaches to Making Sure KanCare Members have Timely Access to Quality Dental Care in Urban, Rural, and Frontier Areas

Appointment no-shows. Providers are frustrated when a patient does not present for their appointment since it is disruptive to the schedule and costs time and money to resolve. Using Dental Hub, Providers can note the missed appointment, which alerts the Care team. Aetna will send a follow-up letter discussing the importance of keeping their dental appointments and offering NEMT in case the issue was transportation related. We will also have a text campaign to share the importance of oral health and remind our Members of their oral health benefits for both children and adults. The text will include information on the importance of keeping their appointments and on the NEMT benefit to reassure Members they have transportation available if needed.

Satellite clinics. In 2019, GeoAccess reporting showed gaps in the network in Seward County where many of our Members live. Our dental subcontractor reached out to First Avenue Dental, a Provider partner, to collaborate on a solution. We offered First Avenue Dental an enhanced reimbursement rate for opening a location in Liberal, the largest town in Seward County. We and our subcontractor made this possible by paying an increased reimbursement rate for services rendered at the satellite clinic. We are continuing discussions with First Avenue Dental to further expand their satellite network into other areas needing additional Provider coverage.

The satellite clinic has had a measurable impact in providing care to an underserved region of Kansas. Since opening the First Avenue Dental clinic in Liberal in 2019, 2,163 Members, including children, adults, and Members with IDD, received general dentistry and oral health care at First Dental in Liberal. Overall, the satellite clinic serves a 50-mile geographic region, including Hugoton, Montezuma, and Sublette, which did not have access to dentistry until Aetna, SKYGEN, and First Avenue Dental collaborated on this solution.

Value-Based Payment (VBP): Aetna understands that the Medicaid rate for dental services in Kansas makes it difficult for dentists to have an incentive to see KanCare Members. Therefore, we will propose value-based contracts for dentists that reward them for providing quality care to our KanCare Members. Our dental Providers will receive VBP payments to support them to accept and treat high complexity Members as well as to establish a dental home so Members may receive consistent preventive care. The primary objective of our VBP program is to address oral health disparities and encourage exceptional quality of care while adhering to a VBP model with an emphasis on Member-centered care, timely preventive services, and improved oral health outcomes. A February 2021 Brief from the Center for Health Care Strategies (CHCS) stated that, "VBP may serve as a pathway to advance the field of oral health — through greater integration

with physical health, a renewed focus on prevention rather than restoration, attention to clinical and cost data collection and analysis, and further development and dissemination of robust evidence-based guidelines." VBP models can improve access to care for Members, including adults, children, children in foster care, and individuals living with IDD.

VBP arrangements emphasize preventive oral care, like annual dental visits and fluoride sealants, over preventable care, like filling dental caries. We will add VBP for treating Members with complex needs, providing sedation dentistry, extended practice hours, and expanding into rural areas (as we did with First Avenue Dental). For pay-for-quality arrangements, we will pay Providers based on performance on several standardized HEDIS quality of care measures, including annual dental visit by age group, and future oral health HEDIS measures—Oral Evaluation, Dental Services, and Topical Fluoride for Children. Evaluations of quality of care are based on HEDIS reporting.

For Members with complex conditions, our subcontractor will administer a VBP program for Providers who meet certain training criteria and have the skills for behavior management and desensitization. Patients are identified on claim forms through diagnosis codes specific to IDD-related conditions. The purpose is to create more access to care for this population, and, in the process, lower costs through service provision in outpatient dental practices instead of emergency departments and operating rooms.

Supporting ECP Hygienists: ECP hygienists can practice in settings inclusive of dental offices, homes, schools, assisted livings, CRCs, and other nontraditional sites. They can independently provide preventive treatment, like cleaning and varnishes, as well as more advanced procedures under the supervision of a dentist and based on the level of their permit. Under Kansas regulations, there are three levels of ECP hygienists: ECP 1 and 2 certifications are lower in cost to obtain and require both clinical hours and a supervising dentist to obtain and maintain the certification. ECP level 3 is a more costly permit due to the educational requirements. Aetna will survey select hygienists as a grassroots effort to determine if barriers to earning these certifications exist, identify the barriers, and understand the best way to resolve those barriers. As a pilot, we will use up to $70,000 of our community investment dollars to support hygienists to earn their ECP permits which will improve access to preventive oral health care for vulnerable populations, including people living in rural and frontier areas, older adults, and children, as well as individuals with complex needs. We will advertise the education funding opportunity for ECPs on the Dental Hub platform since the primary users are dental practice staff.

Aetna is very aware and actively creating solutions to dental care access for KanCare Members. From advocacy to action, Aetna is on the ground every day participating in statewide meetings, creating solutions for the most underserved Members, and working toward addressing oral health care shortages in rural and frontier areas of Kansas. Aetna has trusted relationships with leading Kansas dental advocacy groups, including Oral Health Kansas, making us well positioned for success in meeting KDHE goals to improve access to dental care for all KanCare Members.

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Topic Area 6: Provider Network

25. Describe the bidder's strategies and approaches to encouraging Provider network participation and improving the experience of Providers participating in KanCare.

Aetna Better Health of Kansas Inc. (Aetna) values Providers as essential to our success in serving Kansans with the accessible, high quality of care they deserve. **Our goals align with the KanCare RFP goals, specifically to recruit and retain all Provider types statewide to provide access to care throughout Kansas.** We are expanding the capacity and skill sets of our provider relations workforce, creating an outstanding Provider experience, encouraging Provider participation in Medicaid, reducing administrative burden, and proactively soliciting and responding to feedback in a timely manner. **We consistently meet or exceed all provider network contract requirements.** Paula Kies, with nine years' experience in provider relations, and over 17 total years' experience working in the health plan field, will serve as the local, dedicated provider relations director responsible for provider services and provider relations, provider payment issues, provider education, development, and execution of provider training as described in **Scope of Services Section 7.6.** She and her team of Provider Relations Representatives (PRRs) have collectively over 100 years of experience working with Providers in Kansas and elsewhere. As our Provider Relations Director, Ms. Kies will continue to act as the single point of contact to the State for all provider experiences, such as policy and procedure, education, notifications, and escalated issues.

> **As a healthcare professional who has had the privilege of working closely with Aetna Better Health of Kansas, I have witnessed firsthand your unwavering commitment to providing high-quality healthcare services to the residents of Kansas. Aetna Better Health of Kansas has consistently demonstrated your dedication to improving the health and wellbeing of your members. Your comprehensive and person-centered approach to healthcare has set you apart from other insurance providers.**
>
> ***– Janet M Williams,***
> *MSW, PhD CEO Minds Matter, LLC, HCBS provider*
>
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Our vision for Kansas is to deliver an unmatched Provider experience by supporting our Providers in delivering high quality, accessible, and affordable care for our Members. **For our Members, the most important interactions in their care journeys are often with Providers, so making sure Providers have a great experience impacts how Members experience their care.**

Our Approach: The Provider's Journey

At Aetna, we aim to support Providers from recruitment, to orientation, and retention. Throughout the process **we are committed to reducing provider burden, encouraging provider input and transparent communication, leading to provider satisfaction and an outstanding provider experience.** The following image depicts the Aetna Provider journey.

Recruitment and Encouraging Provider Participation
We recruit any willing Provider, including in border states and concentrate on Providers in rural and frontier areas as well as critical Provider types, including FQHCs, RHCs, CMHCs, CCBHCs, HCBS*, Primary care, Dental, Behavioral Health (BH), Pharmacy, and Hospitals

New Provider Orientation and Ongoing Education
Our orientation is comprehensive, convenient, and easily accessible online or in-person

Dedicated Focus on Provider Experience
We reduce administrative burden starting with the credentialing process and then throughout the journey, inclusive of claims payment, prior authorization, and ongoing training and communication to support a best-in-class provider experience

Provider Input and Committees
We have several formal and informal opportunities for Provider feedback and input, and we close the loop on Provider issues using a variety of means, based on the concern

Transparent Communication and Responsiveness
We communicate frequently, via several channels, including emails, newsletters, the provider portal, conferences, town halls, and other methods. We provide information to close the loop on feedback as well as update the Provider regarding changes in processes, new codes for reimbursement and other issues

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Our network has grown 26% since 2019, averaging 7% year-over-year growth. Figure 25-1 illustrates this steady growth from 2019–2023. Across all Aetna Medicaid plans, **we maintain a 98% provider retention rate, with practice closure accounting for most terminations.** In Kansas, our provider retention rate since 2019 is 98.4%.

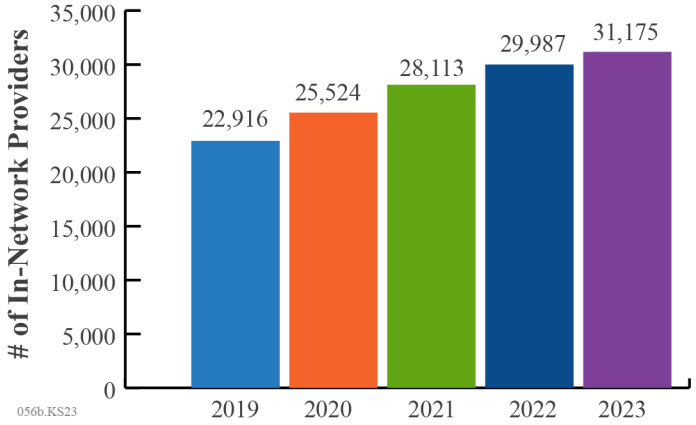

Figure 25-1: Provider Network Growth. 26% growth since 2019.

Strategy for Recruitment—Encouraging Provider Network Participation

We are committed to providing an effective service experience for Providers, built upon sustained partnership, collaboration, and action to address challenges that may exist today. Our innovative strategy for achieving adequacy requirements, recruiting, and retaining Providers includes offering competitive reimbursement rates and our contracts allow for reimbursement growth based on quality performance leading to full value-based payment along a continuum of Alternative Payment Models (APM). Our PRRs offer a comprehensive onboarding process and ongoing training, and we minimize provider burden from the time the Provider expresses interest through the contracting and credentialing process. As part of our credentialing and recredentialing processes, we comply with all provisions of the **Scope of Services** as well as nationally recognized quality standards, including reviewing and approving our participating Providers' credentials every three years, maintaining processes consistent with industry standards and state and federal regulations, and encouraging participation of board-certified PCPs and specialists. Then, **throughout the relationship, we reduce burden with timely claims processing, minimized prior authorization processes, and our Provider Support team of PRRs and Quality Practice Liaisons (QPLs) to support administrative processes and Providers achieving quality goals to optimize value-based payment.**

We share the Kansas Department of Health and Environment's (KDHE's) goal to expand the Behavioral Health (BH) network by enhancing BH specialty Provider types and the overall number of Providers. **Since 2019, we have added 2,789 BH Providers for a total of 7,395 Providers in our BH network, representing a 61% increase in BH Providers in less than five years.**

We recruit and subcontract with vendors as needed to provide high quality services to the Member. We work with the following subcontracted Providers: NEMT, Access2Care; PBM, Caremark; and vision and dental provider network vendor, SKYGEN. **We integrate subcontractor oversight into our network organizational structure, with clear lines of responsibility** for a streamlined experience for Members, Providers, KDHE and the Kansas Department for Aging and Disability Services (KDADS). Our Provider Relations team, as part of Aetna's **Delegation Oversight Committee** reviews subcontractor reporting to identify areas that are substandard. Aetna and its subcontractors conduct monthly Joint Oversight Committee (JOC) meetings. Aetna is represented by a cross-functional group including clinical, operations, provider, and grievance and appeal representatives. The JOC covers a variety of key topics including access to services; operational questions or concerns, new processes or initiatives; and performance concerns. If we identify deficiencies or areas for improvement, we take corrective action.

New Provider Orientation and Ongoing Education

All Provider types, including HCBS Providers, receive an orientation to Aetna and information relevant to the services they provide to Members. We tailor new Provider orientations to the Provider's preferences and needs. **To alleviate provider burden and support provider preference, we offer all trainings online and in person.** Orientation consists of information on providing accountable, quality care, as well as the unique safety and wellness issues associated with HCBS Waiver services. It also includes an overview of the State's goals for care delivery transformation shared in the RFP.

Our standard onboarding process is comprehensive and streamlined, with Providers reporting **98% satisfaction** with our process in our most recent survey. 060e.KS23

The training topics include:

- Medicaid and Availity provider portals
- Interpretation Services—How to Access
- D-SNP Model of Care for Medicare Providers
- Person-Centered Care
- Additional training: As guided by Provider feedback and Member outcomes, we continuously develop programs, education, trainings, and resources, including Continuing Medical Education (CME) credit for some trainings, to assist Providers in developing their skills, education, and ability to better serve our Members
  - **For example, The Behavioral Health Association of Kansas (BHAK) asked us to develop and deliver a training on the new CCBHC model for their Members. This initiative arose from our Chief Executive Officer, Jane Brown's, Listening Tour across the State in 2023.**

We offer provider training using several methods customized to provider preferences: face-to-face training with Provider teams and our PRRs, self-paced website trainings, town halls, virtual trainings, and other modalities; with availability at various times of day and a variety of

locations. From January 2021 through Q3 2023, we provided 171 total training encounters, inclusive of all-MCO trainings, cultural competency trainings, town halls, billing, EPSDT, website trainings, and presentations at provider association conferences. In addition, we aim for a more individualized touch with our quarterly **Tips and Tricks emails to offer current updates and tips, outside of the more formal bulletins and newsletters.**

Strategy for Improving the Provider Experience and Reducing Administrative Burden

Aetna's approach to improving the Provider experience is to **engage, enable, and empower Providers to practice at the highest level with minimal interference.** We **empower** Providers with timely claims payment and Value-Based purchasing (VBP) arrangements, and the supportive people and technology needed to achieve full APM payment. We **enable** Providers with **people, process, and technology** support to address and minimize administrative burden.

Approach to Empowering Providers: VBP Arrangements and Timely Claims Payment

VBP Arrangements

Our VBP program conveys pay for performance and shared savings arrangements to PCPs, BH Providers, and LTSS Provider types and prioritizes all Members receiving services from those Provider types, inclusive of children, Members receiving LTSS services, individuals in Foster Care, and those receiving BH services. We link priority populations to targeted outcomes using standardized quality measure sets and nationally accepted strategies for measuring changes in utilization and overall cost of care. **Our VBP measures align with KDHE priorities** and were approved by KDHE for inclusion in the program. **Our growing VBP program payments to Providers increased by 69% since 2020, with $210,300 paid to Providers in 2020 and $682,100 paid to Providers in 2022.**

We meet Providers where they are on the continuum of VBP arrangements and use the nationally recognized Health Care Provider-Learning Action Network's Alternative Payment Model (HCP-LAN) framework. The framework aligns provider ability and infrastructure with the goal to improve outcomes and, as a result, Providers may take on increased accountabilities in the care delivery decisions as they move to higher categories of HCP-LAN. Throughout their VBP journey from the level of pay for quality, they may move to shared savings, to partial risk, then full risk contracts as they desire. Since 2019, we continue to evolve VBP models by increasing risk for larger Providers like hospital systems, and **offering VBP arrangements to additional provider types, including LTSS Providers, BH Providers, and dental Providers.**

The following table shows a description of each of our VBP arrangements, and the breadth of our VBP programs, which we design to be flexible and optimize payments to Providers, thereby empowering them to move from volume of care to high-value care.

VBP Program	Participating Providers	Populations	Program description	# Providers in Program
Healthier Outcomes	PCPs	All Members, inclusive of	Flagship PCP VBP arrangement with several levels of	All PCPs are enrolled in

VBP Program	Participating Providers	Populations	Program description	# Providers in Program
		children, maternity, Members receiving LTSS services and those receiving BH services	participation designed to improve Member outcomes and meet the needs and capabilities of the Provider	the baseline version of the program; 1,397 Providers are enrolled in advanced Healthier outcomes
CARE and CARE+	BH Providers	All Members receiving BH services from VBP participating Providers	Flagship BH VBP arrangement with measures designed to improve Member outcomes by supporting BH and physical health integration, tobacco cessation, and SDOH	26 CMHC/ CCBHCs are enrolled
Dental VBP	Dental Providers	All Members, inclusive of children, maternity, Members receiving LTSS services, and those receiving BH services	Encourages timely preventive oral health care and establishment of a dental home for the Member	To start in 2024
Employment Support	LTSS Providers serving Members with IDD	Members with IDD	Encourages Providers to develop sustainable employment programs for Members with IDD to improve quality of life	One provider in pilot program; expansion in 2024
Better Value, Better Care	Inpatient Hospital Services	All Members receiving acute inpatient hospital services	Encourages appropriate discharge to community settings with effective transitions of care to avoid readmissions and improve Member outcomes	One provider in pilot program; expansion in 2024
Better at Home	LTSS Providers	Members receiving waiver services and others receiving LTSS	Encourages safe transitions to home from inpatient settings with proper care transitions support to avoid readmissions and improve Member outcomes	To start in 2024
Holistic Health Care Coordination	Providers experienced in managing complex care, including Foster Care Providers	High Complexity Members with multiple health issues crossing BH and physical health, including Foster Care	Supports complex care management and care transitions for populations with complex physical and behavioral health needs to avoid readmissions and improve Member outcomes	One provider in pilot program; expansion in 2024

Timely Claims Payment

Our priority is to pay claims in a timely manner while reducing administrative burden for Providers. We meet timely claims payment standards, paying clean claims within 30 days 100% of the time. We understand the frustration Providers have with delayed or inaccurate reimbursement, and we know that some provider types cannot afford to experience delays in payment. [redacted]

[redacted]

Approach to Enabling Providers: People, Processes, and Technology to Reduce Administrative Burden

We focus our Provider Engagement Model on processes to reduce provider burden. Our people, processes, and technology are designed to reduce provider burden and promote retention and provider satisfaction.

People Addressing Provider Burden: PRRs, QPLs, and Care Coordinators

PRRs are the single point of contact and trusted partners for all Provider interests and concerns. They are in the field delivering training, orienting new Providers, and resolving and escalating claims payment and other issues as needed. Providers can reach out to their dedicated regional PRR who will lead the path to quick resolution of all issues. Within the local Kansas-based Provider Relations team, we support the provider network with a staff of 17 PRRs who will be dedicated by provider types: HCBS, BH, LTSS, and Medical Providers. We scale PRRs and engagement activities based on KanCare membership. All Providers also have interactions with clinical leadership and care management support, as well as in-person and virtual visits with knowledgeable staff as needed. PRR responsibilities include:

- Recruitment and Provider contracting
- Supporting escalated prior authorization concerns
- Supporting claims processing, addressing denials, and claims payment
- Solving enrollment/eligibility determination issues
- Resolving credentialing and recredentialing issues

PRRs deliver new provider orientation training as well as additional training as needed or requested. PRRs are a key element in overall provider satisfaction. **In 2023, we saw a 9% increase in provider satisfaction with their PRRs. Digging deeper, Providers appreciated the PRR's ability to answer questions and resolve issues, significantly contributing to the positive year-over-year results we gained**.

QPLs, also in the field, support Providers to achieve success in closing quality measure gaps and earning value-based payments. Providers earn payment as part of our VBP program

for achieving high performance on specific preventive care and chronic care measures, including BH measures. The measures are approved by KDHE and align with KDHE health outcomes priorities. The goal of the QPL program is to partner with Providers to identify areas to improve quality of care and increase patient satisfaction by closing gaps in care. QPLs help in the following ways:

- Provide trainings and information on HEDIS measures, best practices, and provider incentive programs
- Work in tandem with the Provider's Office team to optimize use of quality reports as a tool to maximize VBP earnings on key quality measures
- Help with submitting HEDIS data electronically from their electronic health records to supplement claims data
- Support in answering questions and removing barriers to promote better health outcomes
- Schedule recurring meetings, virtual or on-site, at the convenience of the Provider's team

Care Coordination Staff Specialists. Care coordinators facilitate Member connection to our diverse, multi-disciplinary staff specialists including social workers with foster care experience, health equity expertise, BH medical directors, licensed BH specialty care managers, CHWs, and specialized care advocates. These specialists provide Members with expert care coordination, guidance, and support related to their health and social needs. Providers can refer Members with complex needs to our Care Coordination team to help manage the Member, thereby relieving provider burden and confirming the Member is connected to the care they need. The Care Coordination team also helps HCBS Providers with the Electronic Visit Verification (EVV) application to support accurate claims adjudication and timely claims payment.

> **"We have a weekly collaborative meeting to discuss patient discharge planning. This has helped with knowledge of community resources… There is communication between hospital CM and Aetna CM to transition our patients to the community with follow-up when needed… This has had a positive impact on discharge planning so that the patients will have continued support in the community."**
> ***– Community Based Organization (CBO) Providers.*** 060g.KS23

Processes to Address and Minimize Provider Burden

We have Provider-facing processes to minimize provider burden as well as systematic ways we track and trend provider concerns and operationalize solutions. Early identification of issues through these tools and processes allows for remediation of the issues before they escalate, which takes the burden off the Provider to bring these issues forward and proactively addresses persistent issues. The following table shows the key strategies we deploy to elevate and address service experience opportunities.

Strategy	Solution
PEAT	Comprehensive dashboard used as a sole source of truth to create actionable insights that improve the provider experience
Digital Utilization	Targeted effort to systematically identify and outreach to Providers with lower rates of digital adoption to understand key drivers and provide helpful coaching and support

Strategy	Solution
Provider Engagement Models	Provider experience operating model has a cross-functional support team inclusive of PRRs, QPLs, claims analysts, Provider leadership staff and input from Provider Committees oriented around a 360° view of the Provider to reduce provider burden by proactively addressing high frequency concerns
Claim Denials and Appeals	Using established insights from PEAT, jointly identify, to resolve root causes to minimize unnecessary denials and appeals and streamline the provider dispute process

In addition to the initiatives depicted above, we formed the **Medicaid Operational Excellence Initiative (MOXI) to establish a process to confirm root cause analysis associated with Medicaid Provider issues is consistently applied.** MOXI uses a streamlined governance process and the standard Six Sigma/LEAN methodology to inform root cause analysis on prioritized provider issues. For example, if there are provider complaints about claims payment, the MOXI process brings together key functional leads to assess the complaints, identifying root causes that may lead to inaccurate claim payment. Teams then institute immediate solutions and stringent validation with ongoing process improvement.

Our systematic approach to evaluating concerns and operationalizing solutions has resulted in several Provider-facing process improvement initiatives to ease burden as described below.

Ease of credentialing. Our credentialing process runs in parallel with the contracting process, for greater efficiency. In addition, we use the State's provider database as the source of truth for provider information when credentialing. **This confirms matched records and a smoother transition to the future of centralized credentialing in Kansas.** We look forward to collaborating with KDHE on the transition to centralized credentialing.

Simplifying Prior Authorization (PA) requirements. The Aetna Medicaid Medical Policy Committee (MMPC) is comprised of physicians and clinical leaders from Kansas and other markets. They are charged with continually reviewing PA policy and updating it to appropriately monitor utilization while alleviating burden on Providers as appropriate. Aetna's MMPC **removed PA requirements for a total of 319 services in Kansas in 2022 and 2023.** For example, in November 2023, the **MMPC implemented auto-approval for 38 admission diagnosis codes for acute admissions with participating Providers in Kansas.** Evidence-based preventive services such vaccines and cancer screenings never require PA. In the past year, we also removed or revised the PA requirements to provide automated approval for DME costing under $500 and eliminated the PA requirement for physical, occupational, and speech therapies ordered by in-network Providers.

Dedicated Provider Services Line**.** Our provider services line is a single call resolution source for all Providers with questions, concerns, or complaints. To confirm our team is ready to help Kansas Providers, team members undergo a seven-week training specific to KanCare

requirements and health plan policies and procedures. We empower and equip our team to respond to a variety of questions about claims status, credentialing, our provider portal, and general information about claims denials and edits. Additionally, team members help other departments with Provider-related issues such as updating demographics, network participation status, care management inquiries, and appeals status. After regular business hours, our interactive voice response capabilities enable Providers to access claims information, auto-fax explanation of benefits/remits, check prior authorization status, check Member enrollment, and access frequently asked questions 24/7 year-round. **In 2023, First Call Resolution (FCR) met or exceeded 92%.** The industry FCR standard is 70-80%.

Technology to Address and Minimize Provider Burden

We use technology in a variety of ways to reduce provider burden and optimize the ability for Provider teams to access services via self-service modalities. We use **Availity** as our secure provider portal; a one-stop shop for Providers to access interactive claims status information, Member panel reports, and quality reports, including practice profiles. Payers often have separate applications for these functions; having them in one place reduces the time Providers spend to get their questions answered. Our reporting and analytics platform offers Providers comprehensive tools to manage their quality metrics and VBP arrangements. Our **Provider Analytics Reporting Suite (PARS)** is a user-friendly companion platform within Availity that allows our Providers easier access to review and download their VBP and HEDIS-related performance dashboards. PARS shows our Providers their gaps in care, clinical data such as a daily census, quality performance, and cost and utilization data. PARS also provides access to Member-level information from health screenings/risk analyses (including identifying SDOH priorities for individual Members), and distributes real-time Admission, Discharge, and Transfer (ADT) notices to Providers. Availity's capabilities show gaps in care, clinical and cost data for all VBP Providers. It also supports data sharing with current Member data while showing trends at the Provider level.

Availity's self-service functionalities, including the "Contact Us" feature, prior authorization request functionality, and provider education and communications functions are continually enhanced. **Web-based inquires decreased by 50% year-over-year and virtual communication strategies increased across the provider community, indicating increased use and provider satisfaction with the portal**. Additionally, Providers receive up-to-date data to earn the maximum quality and shared savings VBP earnings through the Availity web-based provider portal. Availity is agnostic to line of business, which means Providers in both the Aetna Inc. commercial and KanCare networks will see all information in one place.

Dental Provider Portal Dental Hub: Dental Hub is a single provider portal for all dental Providers in the network and will be available in 2024. It supports the following activities in a one-stop-shop format:

- Claims and billing
- Eligibility verification
- PA requests
- Care coordination and continuity of care across Aetna customer service and care management
- Calculating co-insurance at the time of the visit

SDOH Z Code training. Aetna partnered with the Mid-America Mental Health Technology Transfer Center of the University of Nebraska Medical Center to develop a statewide webinar series focused on SDOH and Z Codes. **All KanCare Providers can access the training on**

KDHE's Kansas TRAIN website. Webinars follow a case study family and, for each topic, educate on how the issue might present in clinical settings, which Z Codes would be relevant, and the impact we might see on the family, as well as a link to community resources.

Based on a list of codes we identified as being related to SDOH, we requested and **funded an appendix on Z Code use in the KDHE Billing and Coding Resource Guide, which is distributed to public health agencies.**

Tools and Technology are key to reducing administrative burden for Providers and enhancing quality of care for Members. Our robust IT infrastructure facilitates data integration across system platforms, reducing provider administrative burden and offering enhanced support to PCPs in rural areas.

Our strategy to reduce Provider burden is comprehensive and evolves, based on Provider feedback and needs. We constantly consult with Providers via one-on-one meetings, in formal committees, in town halls, and on listening tours to improve the service we deliver to Providers. **Recently, our chief executive officer completed a listening tour and received great feedback on our progress in addressing provider concerns as an organization, leading to new processes and new partnerships. As a result, we partnered with Starkey, Inc. on our recent Caring Hearts Job Fair to increase the number of direct care workers for Members receiving LTSS services**.

Approach to Incorporating Provider Input

We solicit and act on Provider and stakeholder input on performance and Quality Assurance and Performance Improvement (QAPI) activities to promote appropriate care, appropriate utilization, and health equity. Through a combination of innovative payment strategies, trusted provider partnerships, evidence-based clinical strategies, and care management models, we continually collaborate with Providers on initiatives and outreach effectiveness to improve performance, close care gaps, and optimize the Member experience. Our presence in Kansas and strong relationships with Providers statewide encourages open dialogue and feedback on opportunities for quality initiatives and expansion of existing successful programs.

Committees are an opportunity to consult with Providers on how best to serve, engage, and retain Providers, as they formalize Providers' stake in the decision-making process. We incorporate Provider input through recurring formal committees and advisory councils, including the following committees which each have at least one network Provider representative.

Provider Executive Advisory Committee (PEAC): PEAC is a new advisory body that will include Aetna executive leadership and network Providers. They review QAPI performance quarterly and approve the annual QAPI program and provide feedback and advice to the Aetna Executive team. The strong leadership-level partnership of PEAC inspires broader conversations on provider recruitment, retention, and support, inclusive of addressing administrative burden and evolving VBP arrangements.

Joint Operating Committees (JOCs): The JOC is a decision-making body to facilitate communication and teamwork between key stakeholders in our large hospital systems, including University of Kansas Health System, Children's Mercy, Pediatric Care Network, and Wheat State; and the Provider Relations, Data Analytics, Claims, and Network Management teams.

Quality Management Committee: Decision-making body with representatives from Aetna's executive and clinical leadership and network physicians, among others. Reviews Member outcomes evaluation data and the annual QAPI and quality work plan.

Credentialing Committee: Decision-making body, responsible for reviewing and recommending appointment, reappointment, and Provider-type practice limitations. Provides peer review for potential quality of care concerns. Members include representatives from our Provider network and Aetna quality, clinical, medical, and legal leaders.

Provider Advisory Committees (PACs): PACs are a formal quarterly venue through which we hear firsthand from our network Providers on what they need from us to assist in serving Members. We incorporate this input into the quality improvement programs, strategies, and initiatives we develop to support improved health outcomes and Provider experience. We have four specific PACs to address the unique needs and solutions of each Provider type: 1. PCPs, Specialists and Hospitals, 2. BH, 3. LTSS, and 4. Ancillary Services and DME. In 2020 we added credentialing as a PAC topic and received and implemented provider feedback on our credentialing letters.

Additional Provider Feedback Pathways: We keep Providers informed about and engaged in quality management activities, including the following:

- Periodic communication of quality management goals, objectives, activities, and results
- Town halls and other forums used to disseminate information and solicit feedback
- Ad hoc workgroups and committees to address and resolve persistent provider issues
- Provider newsletters and other periodic communications, which include topics such as program benefits, authorization procedures and guidelines, and clinical practice guidelines

Approach for Transparent Communication and Responsiveness

Aetna values Providers as partners and our PRRs communicates with Providers via email, phone, webinar, and in-person visits. **These are two-way provider engagement opportunities to work with Providers on issue resolution, share data, solicit Provider feedback, and communicate issue resolution. We completed over 15,000 communications with Providers in 2023.** Transparent communication has built trust throughout our provider relationships, as reflected in the comprehensiveness of our Provider network and the willingness of Providers to openly communicate concerns and propose solutions.

Our multi-channel provider communications, including the provider manual, provider materials, and provider website, contain relevant policy and procedure information. **We updated the provider website to facilitate ease of navigation in 2023, and since then we have had more than 11,000 hits on the landing page.** The provider manual, updated annually, aligns with all requirements defined in the **Scope of Services Section 7.6.1**, and we confirm Providers have the manual available to them within 30 days of their contract effective date. We post the manual electronically with hard copies available at the Provider's request. We submit all materials meant for distribution to Providers to the State for review and approval in advance of distribution.

We have a multichannel approach to distributing educational material to our Providers that includes email, provider portal and public website. Our provider communication campaigns include Aetna bulletins, KMAP bulletin links, and newsletters that can be emailed weekly to providers who select that option.

Aetna has the expertise, experience, innovative strategies, methods of approach, and capabilities necessary to advance the KanCare vision and goals to expand Provider network participation and improve provider experience and we are strongly aligned with the KanCare vision and goals for this RFP.

Topic Area 6: Provider Network

26. Describe the bidder's experience with developing and implementing value-based purchasing (VBP) arrangements designed to promote service quality, value, and outcomes over volume. Describe how the bidder will leverage its experience to successfully develop and implement VBP arrangements to improve the quality of care and Member health outcomes in KanCare. Include the following in the bidder's response:
   a. The bidder's priority areas for VBP (e.g., Providers or populations) and anticipated outcomes.
   b. The bidder's proposed alternative payment models (APMs).
   c. The bidder's approach to identifying and supporting KanCare Providers to implement VBP arrangements.
   d. The bidder's strategies to reduce administrative burden for participating Providers.
   e. How the bidder will measure, monitor, and evaluate the effectiveness of the payment arrangements and outcomes.

Aetna's Value-Based Purchasing (VBP) arrangements have **grown exponentially,** benefiting both Providers and the Kansans they serve. Our VBP arrangements generate positive results. We continually evolve our VBP models to **target priority populations and Kansas Department of Health and Environment (KDHE) goals, improving health outcomes, including improving Member and Provider experience, reducing health care disparities, expanding the Provider network, using cost-effective strategies to impact quality, and using data to promote continuous improvement,** while growing the ability for Providers to take more risk and earn more dollars. Our VBP experience, in Kansas and through affiliate health plans across 15 markets, makes us well-suited to drive positive results with all levels of VBP arrangements.

Since 2020, we paid $1.36 million in value-based payments to KanCare Providers in various VBP arrangements (Figure 26-1). All Aetna KanCare Members are part of a VBP program and nationally, Aetna Medicaid supports 1.2 million Members through VBP arrangements. We have a strong commitment to initiating and evolving our VBP arrangements. Since inception, we have moved 98.7% of PCPs into VBP programs. The number of Providers and Members impacted by VBP arrangements has grown exponentially from 2020-2023.

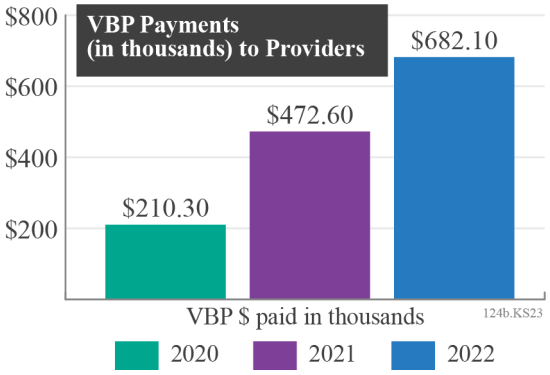

Figure 26-1: VBP Payments to KanCare Providers. *Our value-based programs payments to Providers. Payments increased by 69% since 2020.*

We meet Providers where they are on the continuum of VBP arrangements and use the nationally recognized Health Care Provider-Learning Action Network's Alternative Payment Model (HCP-LAN APM) framework. The framework aims to align Provider ability and infrastructure with the goal to improve outcomes and, as a result, Providers gradually earn more in upside payments while assuming greater risk. Since 2019, we continue to evolve VBP models by increasing risk for larger Providers like hospital systems, and **offering VBP arrangements to other provider types, including LTSS Providers, Behavioral Health (BH) Provider, and dental Providers.**

Our VBP arrangements encompass performance measures across all dimensions of quality defined by timeliness, efficiency, effectiveness, equity, and patient-centeredness. Our VBP strategy and VBP plan is updated annually following Continuous Quality Improvement (CQI) cycles. **We use the following principles to develop our VBP approach:**

- **Value creation**. We design VBPs that impact quality and enhance value to Providers, Members, and the State. As quality and cost goals are attained, Providers earn more revenue.
- **Integration.** We supply actionable data to Providers through bi-directional communication about quality improvement.
- **Holistic care.** We offer VBP incentives that support holistic, integrated care approaches to quality improvement.

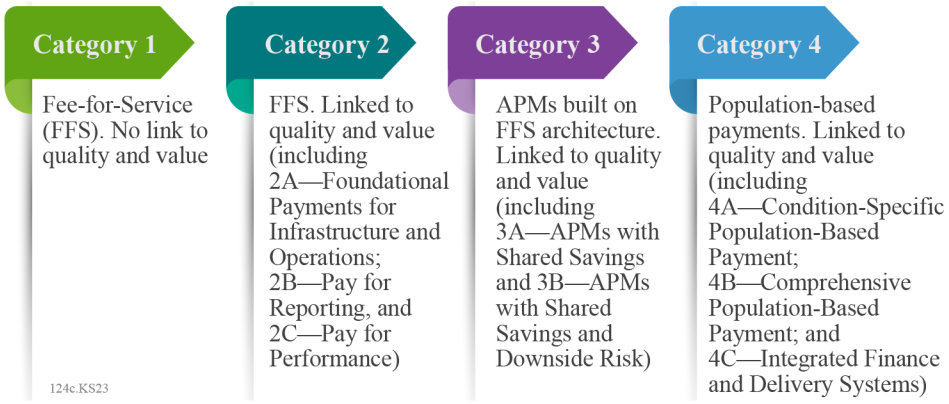

Figure 26-2: HCP-LAN APM Framework. *Our VBP arrangements align with the HCP-LAN APM Framework and include VBP arrangements along the following continuum.*

Today we meet all provisions in **Scope of Services section 7.7**., including addressing all elements of the VBP framework and using standardized quality measure sets.

a. Priority Areas for Value-Based Purchasing and Anticipated Outcomes

Priority Areas

Our VBP program encompasses PCP, BH and LTSS provider types and prioritizes all Members receiving services from those provider types, inclusive of children, Members receiving LTSS services, individuals in Foster Care, and those receiving BH services. We link priority populations to anticipated outcomes using standardized quality measure sets and nationally accepted strategies for measuring changes in utilization and overall cost of care. **Our VBP measures match KDHE priorities and were approved by KDHE for inclusion in the program. One hundred percent of Members that seek care from a PCP are included in the program.**

Our **priority populations for VBP arrangements** are shown in the table below.

VBP Program	Priority Providers	Priority Populations	Anticipated VBP Outcomes
Healthier Outcomes HCP-LAN Category 2C - Deemed Program	PCPs	All Members, inclusive of children, maternity, Members receiving LTSS services and those receiving BH services	• Improved performance on select preventive and chronic care measures • Improved SDOH screening

VBP Program	Priority Providers	Priority Populations	Anticipated VBP Outcomes
3A and Above - Advanced Healthier Outcomes			
Pediatric Care Network (PCN) HCP-LAN category 4	PCPs	Pediatric Members living in certain geographic areas	• Improved performance on select preventive and chronic care measures • Improved efficiency of care
CARE and CARE+ HCP-LAN category 2C	BH Providers	All Members receiving BH services from VBP-participating Providers	• Improved performance on BH medication management • Improved rates of tobacco cessation counseling • Improved SDOH screening • Reduced cost of care for Members in the program
Dental VBP HCP-LAN category 2C	Dental Providers	All Members, inclusive of children, maternity, Members receiving LTSS services, and those receiving BH services	• Timely, age-appropriate preventive care • Establishment of a primary source of dental care for the Member
Employment Support HCP-LAN category 2C	LTSS Providers serving Members with IDD	Members with IDD	• Long-term employment retention for Members with intellectual or development disabilities
Better Value, Better Care HCP-LAN category 2C and above	Inpatient Hospital Services	All Members receiving acute inpatient hospital services	• Reduced readmissions • **Proper utilization of intensive care**
Better at Home HCP-LAN category 2C and above	LTSS Providers	Members receiving waiver services and others receiving LTSS	• Reduced readmissions • **Improved member experience**
Holistic Health Care Coordination HCP-LAN category 2C	Providers experienced in managing complex care, including Foster Care Providers	High Complexity Members with multiple health issues crossing BH and physical health, including Foster Care	• Improved performance on medication management measures • Enhanced care coordination • **Improved member experience**

Anticipated VBP Outcomes

We design **VBP programs to improve Member health outcomes, promote CQI, improve service delivery efficiency, improve Member and Provider experience, and deliver value.**

We have observed an exponential increase of the number of Providers advancing from the deemed program to higher level VBP programs with more accountabilities in the past three years. As we achieved this quantitative evolution of Provider's involvement, we also observed

that **VBP Providers are making significant improvements in key quality measures compared with non-VBP Providers.**

In 2022, Providers participating in advanced Healthier Outcomes VBP arrangements showed better quality of care results than Providers in the deemed Healthier Outcomes program. The table below shows the difference in performance between the deemed and advanced Healthier Outcomes practice performance, as well as the anticipated outcomes for 2024.

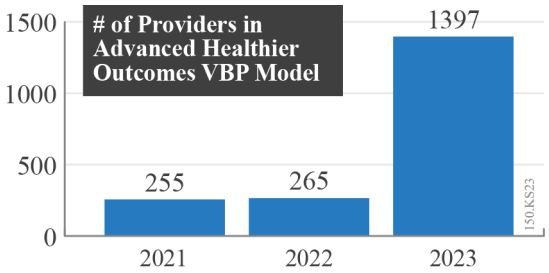

Figure 26-3: *Shows the number of Providers transitioned to the more sophisticated versions of Healthier Outcomes.*

Measure	Deemed Healthier Outcomes 2022 Result	Advanced Healthier Outcomes 2022 Result	2024 Anticipated Outcome Advanced Healthier Outcomes for VBP Practices
ADD medication initiation	37.5%	59.2%	We anticipate continuous improvement of at least 1%-2% per measure in 2024 for advanced Healthier Outcomes practices and, where applicable, CARE and CARE+ CMHCs.
ADD medication maintenance	50.3%	64.5%	
Well child visits	42.5%	44.7%	
Adolescent immunizations	26.2%	29.1%	
Lead Screening	46.8%	49.1%	
Follow-up care after emergency department (ED) visit for alcohol use	16.5%	20.7%	
Follow up care after visit for high-intensity care for substance use	38.3%	52.5%	
Follow up care after ED visit for a primary mental health reason	58.6%	82.0%	
Follow up metabolic testing for people taking an antipsychotic	74.2%	75.3%	
Breast cancer screening	32.3%	37.3%	
Cervical cancer screening	45.0%	47.5%	
Timely prenatal care	34.2%	39.0%	
All-cause readmissions	12.1%	11.0%	

Note: Measurement year 2022 is reported in 2023. Measurement year 2023 is reported in 2024.

We align the measures for the different value-based programs with KanCare program desired outcomes as well as Healthy Kansas 2030 priorities.

b. Proposed Alternative Payment Models

We offer a variety of VBP arrangements across multiple HCP-LAN APM categories that align with KDHE VBP goals of improving health outcomes, developing cost effective strategies, reducing health care disparities, and improving Member experience and satisfaction. The goals for each of the VBP programs were established based on: (1) population needs; (2) key measures, which need improvement; (3) provider practice scope and existing capabilities; and (4) mutually

beneficial priorities. We design all VBP programs to meet Providers where they are along the HCP-LAN continuum. As described in the examples below, our VBP arrangements offer flexibility and Provider-friendly strategies to deliver value over volume-based care.

APM Model #1—Healthier Outcome

Our overarching program, Healthier Outcomes, is an evolving PCP program which addresses the quality side of the value equation, and addresses Provider practice efficiency through reduced Emergency Department (ED) and Inpatient (IP) utilization driven by timely preventive and chronic care. Providers may participate in the deemed pay for quality version of Healthier Outcomes or they can participate in the advanced program, which has more accountabilities with increased financial benefits. Advanced versions of Healthier Outcomes span the continuum of the HCP-LAN APM framework to include APM categories from 2C to 4B.

We have observed significant performance advantages as the result of the Healthier Outcomes program, while participating Providers in the advanced Healthier Outcomes program are outperforming in multiple measure categories. In 2024, we will enter a new iteration of deemed Healthier Outcomes, which will offer more systematic support and structured incentives. The program will be fully aligned with all KDHE pay for performance measures and reward providers for meaningful improvements based on the characteristics of the population they serve.

APM Model #2—Pediatric Care Network Capitated Risk Payment

Aetna executed a capitated risk agreement with Children's Mercy Integrated Care Solutions (Pediatric Care Network or PCN). Within this Agreement, some services are delegated to PCN, including medical management, utilization review, concurrent review, and discharge planning. Aetna is responsible for adjudicating claims submitted by Providers providing care to PCN Members. PCN Members are 21 years old or younger and resides in the counties of Johnson, Wyandotte, Leavenworth, Miami, Douglas, and Franklin. The agreement does not include children using HCBS Waiver services. This is an HCP-LAN APM category 4B model.

Since the implementation, we have observed significant improvement in several key pediatric preventive care measures. For instance, from 2021–2022, PCN Members had 3.4% improvement in receiving Chlamydia screening, 8.5% improvement in Childhood Immunization Combo 10, 2.8% improvement in Adolescent Immunization Combo 2, and 6.4% improvement in total weight assessment and nutrition counseling. We look forward to expanding this model to similar integrated care networks.

APM Model #3—Better Value, Better Care

The Better Value, Better Care program is designed to improve Member experience with higher intensity levels of care by addressing care efficiency and coordination as well as transitions of care from higher intensity to lower intensity settings. We engaged KidsTLC as our partner in this VBP pilot program to open a new avenue of rewards for Providers specializing in pediatric BH care. This is a new model starting 2024. KidsTLC Inc. offers a continuum of IP services, PRTF services, and Intensive Outpatient (IOP) visits for children with complex BH care needs. **Many of the children they serve come from foster care**. The objective of the program is to invest in successful transitions for children from inpatient settings back to the community and home. Given the uniqueness of the practice scope of KidsTLC Inc., this program is custom designed.

KidsTLC Inc. will receive an increased fee schedule for IOP visits if they can successfully transition 10% of the total PRTF days to IOP days. KidsTLC must maintain a low readmission rate to be eligible for the payment starting contract year 2.

APM Model #4—Employment Support Program for Individuals with IDD

Aetna will launch our LTSS VBP Employment First Support pilot in 2024. This first-of-its-kind APM model supports LTSS Providers serving Members with IDD with incentives tied to the achievement of certain employment milestones, such as 90 days, six months, and one year of sustained employment for the Member receiving IDD services. This Program addresses our shared objectives: enhancing successful employment opportunities for Members with IDD so participants can gain social and economic capability as part of the Employment First State mandate, while creating a gateway to improved quality of life and enhanced independence. A secondary objective is to reduce ED and urgent care visits due to improved quality of life.

APM Model #5—CARE/CARE+

Aetna executed a value-based partnership with Wheat State Healthcare, an Independent Practice Association (IPA) for the 26 Community Mental Health Centers (CMHCs) in Kansas. All 26 CMHC's opted to participate in this APM level 2C program. The Program was designed with several objectives in mind:

- Reduce the silos between physical health and behavioral health services
- Increase the use of Z Codes to capture and act upon health disparities data
- Reduce administrative burden by developing a program directly with the IPA who will engage and support their CMHC membership
- Incentivize the CMHCs for their contributions that move Members to permanent employment and housing.
- Improve health outcomes

> **"By aligning incentives between Aetna and the community mental health centers in Kansas, we are helping to increase smoking cessation and peer support services, and better coordinate housing and employment supports. All of these factors help improve the health of our clients and promote recovery."**
> *– Colin Thomasset, CEO Wheat State Healthcare*
>
> 124d.KS23

Since the onset of this model in Q3 2022, we saw that 30 day follow up appointments after a BH-related ED visit went up 6% for KanCare Members. Among rural and frontier KanCare Members, we saw a 24% increase in depression screenings per 1000 rural Members, a 49% increase in the percent of rural Members with at least one prescription to treat depression, and prescription adherence for depression medications up 17.1% for rural KanCare Members. We have observed some preliminary improvement in the seven-day follow-up after ED visit for an alcohol or other drug misuse condition measure, which has improved from 13.6% in 2022 to 32.9% in YTD 2023.

APM Model #6 —Dental APM Pilot

Aetna's dental contractor, SKYGEN, provides the oral health care network and manages the dental health benefit from prior authorization to claims payment. The objective of the VBP model is to address oral health disparities and encourage quality of care while adhering to a value-based model with an emphasis on patient-centered care, preventive services, and improved oral health outcomes. Providers are rewarded for exams and other preventive care for the

Members on their panel, thereby encouraging the Provider to build a "dental home" relationship with the Members on their panel.

We will develop and pilot an HCP-LAN APM 2C model that pays for performance on preventive service measures as well as payment for high complexity care, like for Members needing sedation dentistry. We will target dental Providers serving adults, pregnant Members, children, children in foster care, and Members living with IDD. This is a new model set to start in 2024. Our metrics for success include performance improvement on selected preventive care measures and increased access to dental care for complex Members and we will expand the pilot as we begin to see results.

APM Model #7—Better at Home

HCBS agencies are on the front line of providing care to the EPSDT and LTSS populations and offer essential services to create sustainable lifestyles for LTSS Members who would otherwise likely be institutionalized. We recognize that HCBS agencies have often faced staffing challenges to meet population needs during and after COVID, especially in underserved communities. Aetna realizes the value of establishing VBP for HCBS Providers as they provide life sustaining services for KanCare's most medically complex Members.

Minds Matter and Aetna have jointly committed to investing in the caregiving workforce and enhancing the quality and accessibility of care. Together, we launched an innovative value-based partnership in 2023 with the following objectives: 1. Empower and train the Direct Care Workers (DCWs); 2. Support career advancement and earning potential for DCWs; 3. Promote care coordination and in-home clinical oversight; 4. Improve access and timeliness of care; and 5. Enhance quality of care and improve patient outcomes. The APM increases HCBS reimbursement rates in exchange for the organization maintaining adequate staffing levels, inclusive of both wage and benefit increase strategies. Aetna's investment to support the HCBS workforce will help agencies pay higher wages to retain current DCWs and potentially attract new DCWs.

Aetna will lead the way with VBP models for HCBS Providers with several prospective partners, including Midland Inc., Starkey, Wichita Home Attendance Care, etc. Since each HCBS provider serves different populations with different services, we will build flexible models that meet mutual goals, including staff recruitment and retention and improving the quality of life for Members served. By strengthening our VBP model for these Providers, Members will have a better chance of remaining in their home setting, resulting in decreased ED encounters and acute inpatient admissions. These are new models, set to start in 2024.

APM Model #8—Holistic Health Care Coordination

Our Holistic Health Care Coordination program involves use of a tiered fee schedule which is driven by case complexity. Along with the fee schedule, we use a percentage withhold to the capitation fee. If the practice reaches the basic performance threshold, the Provider receives payback of all the withhold. If the practice reaches the advanced level of performance, the Provider receives a bonus for the advancements achieved. Measures used with the program to evaluate performance include: 1. 30-day all cause readmission; 2. IP utilization; 3. ED utilization; and 4. Clinical indicators regarding progression of the Member's condition. In 2023, we launched our Holistic Health Care Coordination program, a Capitated Case Management

Payment model, with KVC Kansas as our initial partner. KVC Kansas is a private, nonprofit organization that serves over 15,000 children and adults each year. They provide family strengthening and preventative services, parent training, foster care case management, family reunification services, foster family recruitment and support, adoption, aftercare, outpatient therapy, and more. This is a new model set to start in 2024.

This VBP model was offered in an affiliate Aetna Better Health market. The pilot program, which engaged Members aged 16–29 with emotional and behavioral difficulties, showed positive results with reduced ED use and inpatient admissions. Successful Providers focused on engagement and skill-building through a person-centered approach. So far, Providers achieved 100% of performance measures with zero BH IP admissions and no crisis services use. We plan to expand this model to similar Providers as we see results and refine the model to align with populations served.

These incentives encourage Providers to fulfill a care coordination role and actively develop and execute the treatment plans in coordination with the Member's PCP and other specialists. Other potential gains from effective care coordination include reduced duplication of tests/prescriptions, higher likelihood of applying the proper level of care, and improved timeliness of follow-up. This VBP model has applications with both complex physical and behavioral health conditions.

c. Identifying and Supporting KanCare Providers to Implement VBP Arrangements Earnings

Identifying KanCare Providers for VBP Arrangements

Our assessment and recruitment approach evaluates provider capacity and ability to execute on the proposed VBP arrangement. This approach helps determine provider readiness to succeed under a VBP arrangement and supports our goal to position Providers for long-term VBP success.

As we deploy our VBP models, we determine provider readiness to succeed under a VBP arrangement through our proprietary assessment and recruitment approach that evaluates provider capacity and ability for all proposed VBP arrangements. Positioning Providers for long-term VBP success is our goal. Before we launch our VBP model, we validate readiness assessment results with the potential Providers through collaborative discussions focusing on the Provider points of view. As Providers succeed with VBP arrangements, we further evaluate their capabilities to advance along the continuum of models in the HCP-LAN APM framework. Our Provider Relations team works with the practice to build a pathway to success, while monitoring the pace of the improvements, trend of practice maturity, surfaced concerns, and growth in both technological and financial capabilities. Assessing the overall needs for VBP arrangements beyond the deemed Healthier Outcomes program is based on population health needs, care gaps, and KDHE quality strategies and priorities.

Supporting KanCare Providers to Implement VBP Arrangements

Aetna shares quality, utilization, cost, and outcomes data with Providers to support them to implement and optimize earnings in their VBP arrangements. Aetna uses provider-facing platforms and Secure File Transfer Protocol (SFTP) to collaborate bi-directionally with Providers

and supply them with detailed, actionable data for their VBP arrangements. We will continue to add more bi-directional data sharing capabilities to increase efficiency for Providers and reduce administrative burden related to VBP models. Our Provider Analytics Reporting Suite (PARS) is a user-friendly companion platform within Availity that allows Providers easier access to review and download their VBP and HEDIS related performance dashboards. In addition to the Availity data, PARS provides access to member-level information from health screenings/risk analyses (including SDOH priorities), and distributes Admission, Discharge, and Transfer (ADT) notices to Providers. The table below describes our standard VBP reports.

Report	Description	Aetna APM Models	Frequency
Pay for Quality Performance Report	Provider performance profiling at the organizational, group, and individual Provider level. Includes Member-level gaps in care on HEDIS quality measures	Healthier Outcomes, CARE/CARE+, Dental VBP, Holistic Health Care Coordination	Monthly
Key Performance Indicator Report (IP and ED)	Insights on performance at the organizational, group, and individual Provider level on key utilization measures (ED visits, generic dispense rate, admissions, readmissions) among assigned panel	Healthier Outcomes, CARE/CARE+, Better Value, Better Care (IP/ED/readmissions), Better at Home (readmissions)	Monthly
Shared Savings Reconciliation Report	Insights on performance at the organizational, group and individual Provider level on the medical loss ratio among their assigned enrollee panel	Advanced Healthier Outcomes	Annually

We take a **people, process, and technology approach** to supporting Providers implement and manage VBP arrangements. Our people include Provider Relations Representatives (PRRs) and Quality Practice Liaisons (QPLs). Processes to support Providers to implement VBP arrangements includes our innovative tool, Stellar Health, which guides and compensates Providers for actions they take to earn VBP dollars. Our technology is inclusive of data aggregation and bi-directional data sharing using tools that deliver timely and actionable information for Providers that helps optimize VBP earnings. Through our pilot with Aetna Medicare markets, we have observed, on average, a 5% improvement in HEDIS performance for Providers equipped with Stellar Health than for Providers without Stellar Health support.

People Innovation: Practice coaching from QPLs. Our QPLs use comprehensive VBP performance data to deliver high-touch support to Providers in VBP arrangements. They also help providers better understand the data and tools we provide and make recommendations to impact cost, quality, clinical, health equity, and health risk assessment impacts. QPLs advise Providers on best practices to implement practice flow changes to support high quality care for KanCare Members. QPLs educate Providers about our population health program offerings, performance improvement activities, VBP model requirements, reporting processes, and our Community Resource Directory, which lists resources to help Members address their social determinants. **We provided practice coaching to 99 Provider groups, inclusive of 6,000+ Providers in 2023. We completed a pre and post-analysis of the impact of the QPL program on women's health quality metrics and, for the top 5 Providers, we saw an increase of 6.5%**

in cervical cancer screening and a 15.8% increase in chlamydia screening within 60 days of introducing QPLs into practices.

> **"This [Stellar Health] is really great, we haven't gotten this from other payors and it will really make getting these measures closed much easier. It's really nice seeing where we are at performance-wise too because this is the first time we are seeing numbers like this."**
> ***– Kansas Provider's Director of Quality***
>
> 124e.KS23

Process Innovation: Stellar Health. Through our partnership with Stellar Health, Aetna supports our Provider network with an EHR-based point of care checklist that assists in care gap closure for Members. While Availity is a self-service platform for Providers to gauge their progress toward quality goals, Stellar Health is a point of care workflow tool that includes supportive outreach to Providers and outbound calls to Members to encourage them to get their preventive care. The objective is to improve the quality of care for Members by engaging Providers to excel in their quality based VBP arrangements with a tool that gives real time, actionable information. There are four prioritized measures tracked by the pay for action feature of Stellar Health: lead screening in children, chlamydia screening, cervical cancer screening, and childhood immunizations. Stellar Health's tool is designed to be easy to use with minimal clicks needed. Many actions available on the platform can be completed by support staff at a practice, which reduces clinician administrative burden and encourages staff to operate at the top of their license.

Technology Innovation: Bi-directional Information Exchange. Aetna understands that clinical success depends on the accuracy and completeness of information, and quality information exchange is where our Provider support begins. We established two-way data sharing processes with Providers who have existing capability to ingest our clinical data.

We are moving toward bi-directional data sharing using Health Information Service Provider (HISP) technology. As a HSIP-enabled health plan, we will be an active partner to intake provider EHR data and marry it with data available in our HISP, inclusive of Health Information Exchange (HIE), ADT data, clinical values data, SDOH data and status updates, clinically coded Health Risk Assessments (HRAs), pharmacy data, and individual service plan and claims data, including diagnosis codes. **This means EHR-enabled Providers and their patients will have access to the most comprehensive data inventory available in the market.** Once Provider HIE and HISP data are combined, the Provider accesses our supplemental data solution to retrieve reports, including:

Value-based Provider Groups Reports from Availity		
HEDIS Report	Member profile report (via other reports above as part of drilldown)	Prioritized Member list report
ED Utilization Report	Full gaps in care report (via HEDIS report)	VBP pay for quality performance report, group level (2024)
IP Utilization Report	Member panel report	Cost and utilization dashboard eiekccllvibjkjnlittddbjjghltlfkkfgtrdhuekndk (2024)

Value-based Provider Groups Reports from Availity		
Prescription Utilization Report	Daily census report	Combo 3 vaccines report (2024)
Contract Summary Report	Prioritized Member List report	

HISP data are available in accordance with 42 C.F.R. §§ 438.242, Section 6504(a) of the Affordable Care Act (ACA), and Section 1903 of the Social Security Act.

d. Reducing VBP Administrative Burden

To reduce administrative burden for Providers taking part in VBP arrangements, Aetna makes the data reporting process as seamless as possible to avoid having the Provider extract data from their EHR whenever possible. In the deemed Healthier Outcomes program, Aetna uses claims data to determine provider performance on measures. For more advanced Healthier Outcomes and other APM models, we use claims data whenever possible, as well as the bi-directional data sharing model described above to extract data from more advanced EHR systems. Avoiding having Providers report their data to the health plan alleviates the most burdensome part of VBP arrangements for Providers. In addition, Aetna does the following:

- **Resource Collaboration.** We offer resources to Providers to support VBP initiatives, which are often hard to implement due to lack of resources on the Provider side. Aetna has identified several clinical priorities, such as BH integration. We have developed tools and resources that can support these goals in alignment with VBP priorities. We encourage Providers engaged in 2C APM arrangements to select at least one incentive-based quality measure focused on standardized screening instruments for BH conditions, such as depression, anxiety, and SUDs. We collaborate with providers who lack resources to close gaps in care, such as supplying temporary administrative support and/or clinical resources. For example, our affiliate health plan in Virginia's partnership with MedZed in Virginia offers temporary clinical support for PCPs in providing care to hard-to-reach populations as well as assistance with administrative tasks like appointment scheduling and support for telehealth opportunities. With a focus on decreasing ED and hospital utilization by addressing SDOH, year-to-date **IP admissions were reduced by 31% and ED visits were reduced by 20%** in the Virginia population of focus.
- **Process Integration.** We regard VBP as an alignment mechanism between payer and Providers, rather than merely an alternative payment tool. Some of the performance measures in our VBP models demand a higher level of process integration and coordination. For instance, our capitated risk payment model with PCN includes a case referral process where our discharge planners alert PCN when we identify a Member needing care transition support. This referral process plays an indispensable role in improving the performance of all plan cause readmission measures with a reduction from 11.6% in 2022 to 10.4% year to date 2023 among PCN Members. Similarly, we built a referral process to effectively connect our Care Coordination team with the Provider’s Care Management team to make certain the PCP does not miss the opportunity to take the best course of action for their Members.
- **Access to performance data.** Our Provider Analytics Reporting Suite (PARS) is a user-friendly companion platform within the Availity provider portal that allows our Providers easier access to review and download their VBP and HEDIS related performance dashboards.

PARS shows our Providers their gaps in care, clinical data such as a daily census, quality performance, and cost and utilization data. In addition, Stellar Health provider point of care gaps in care data via the Provider's EHR. The HISP will serve enhanced data to Provider EHRs used to gauge performance. Finally, QPLs are also a great resource for performance data.

- **Administrative support.** Our QPLs help VBP Providers review VBP-related reports and discuss how best to use the data to maximize VBP payments to Providers.

Additionally, we continue to assess the effectiveness of our VBP programs and refine them as needed based on Provider feedback and changing program requirements.

e. Measuring, Monitoring and Evaluating the Effectiveness of our VBP Arrangements and Outcomes

Measuring the Effectiveness of VBP Arrangements and Outcomes

We evaluate the performance of our VBP programs through three dimensions: structure, process, and outcome, as described in the table below.

Structure: Is the program targeted to the correct Providers to yield desired outcomes?

Structure Measures:

- Provider’s readiness to succeed, as indicated by their collaborative engagement in the negotiation process
- Financial stability - the program generates financial results that drive value for both Aetna and the Provider
- Operational consistency - the program is not operationally burdensome for either party, including reporting requirements, excessive meetings, or required use of multiple technologies

Process: Will the program have a positive impact on the participating Providers and Members?

Process Measures:

- Number of engaged Providers
- Number of VBP contracts signed annually
- Number of Members impacted by the program
- Payment penetration: of the available dollars, amount the Provider earned

Outcome: Will we achieve better quality of care and more efficient utilization?

Outcome Measures:

- HEDIS measure performance
- Collection of social determinants data via Z Codes
- Utilization efficiencies (e.g., fewer ED visits, greater access to primary care)
- CMS core measures performance

Monitoring the Effectiveness of VBP Arrangements and Outcomes

Aetna monitors each VBP program for effectiveness and shares information with our Provider partners as part of a dynamic monitoring process so both parties can track progress toward payment goals. The table below describes the standard monitoring reports Aetna reviews and Providers in VBP arrangement receive.

Report	Description	VBP Model
Pay for Quality Performance	Monthly provider performance profiling at the organizational, group and individual Provider level. Includes Member level gaps in care for quality measures	Deemed Healthier Outcomes, Advanced Healthier Outcomes, Shared Savings and Shared Risk
Key Performance Indicator (Inpatient/Emergency Department)	Monthly insights on utilization performance at the organizational, group, and individual Provider level	Advanced Healthier Outcomes, Shared Savings and Shared Risk
Shared Savings Reconciliation Report	Annual insights on utilization performance at the organizational, group and individual Provider level, including medical loss ratio	Shared Savings and Shared Risk

Precision reporting from Stellar Health, Availity, and claims reports allow us to observe trends and act if needed to correct course if negative trends are noted.

QPLs and PRRs are the eyes and ears of the VBP program, consistently checking in with practices to confirm they are supported as they move toward their VBP arrangement goals. Additionally, we host Joint Operating Committee meetings for our larger Provider partners that are in shared risk arrangements to share data, elevate barriers, and mutually agree on measures and evaluation strategies.

Aetna's quarterly Health Equity Council monitors quality metrics to identify breakdowns by different regional, racial, ethnic, and linguistic categories. Reviewing these measures through an equity lens allows us to assess the impacts that race, ethnicity, language, and disability factors have on communities. We evaluate VBP arrangements annually and make changes as needed.

Evaluating the Effectiveness of VBP Arrangements and Outcomes

We focus the evaluation of the arrangement/program on following aspects:

- **Increased practice efficiency and appropriate utilization of services.** This measure will use utilization and cost of care information for services rendered within the performance year. As our VBP arrangements mature, we anticipate reductions in avoidable admissions and readmissions and increases in use of PCP and other outpatient services, yielding a decrease in cost of care and an increase in overall quality of care.
- **Increased equity.** We evaluate this measure in two ways—first, social determinants assessment is a required measure for Providers to have access to the incentive pool. Second, many of the HEDIS measures are reported by ethnicity groups. The performance difference among different ethnicity groups will reflect the level of health care equity. **In 2023, we observed a notable increase of 53.9% in distinct Aetna Members identified with Z codes, along with a 25.4% increase in distinct Providers since 2020. The increase in Members identified with Z codes indicates our Providers are more effectively recognizing the SDOH factors impacting patient health and health equity.**
- **Increased screenings.** We evaluate the performance trend in women's health screenings and childhood lead screening measures. **Advanced Healthier Outcomes practices did 5%**

better than deemed Healthier Outcomes practices in lead screening for children and 14% better in breast cancer screening.

- **Increased vaccination.** We evaluate the performance trend in childhood and adolescent vaccination measures. We are first among KanCare MCOs for the childhood immunization Combo 3 measure, and we saw a 5% improvement from 2020–2021.
- **Holistic maternal care.** We evaluate the performance trend in timely prenatal and postpartum, prenatal immunizations, and postpartum depression screening measures. **Advanced Healthier Outcomes practices did 13% better in prenatal care than deemed Healthier Outcomes practices.**
- **Integrated BH care.** We evaluate the performance trend in screening measures and measures for follow up after ED visits and hospital admissions and medication monitoring. CARE and CARE+ CMHCs did better in three different follow up after ED measures:
  - 21% better in follow up visit after ED for alcohol overuse
  - 29% better in follow up visit after ED for a mental health reason
  - 27% better in follow up visit after ED for high intensity substance use
- **Improved medication adherence.** We evaluate the performance trend in medication monitoring measures. **Advanced Healthier Outcomes practices did 37% better in Attention Deficit Disorder (ADD) medication initiation processes and 22% better in ADD medication maintenance processes.**

Overall, program data is used to inform systematic analyses of the strategies contained in the future KanCare contract, providing valuable insight into future strategies for improved clinical outcomes.

As Providers succeed with a VBP arrangement, Aetna further evaluates their capabilities to advance to the next categories of HCP-LAN APM framework. Once a Provider enters a VBP arrangement, we assign a QPL to partner with the practice to build a pathway to success, by monitoring the pace of improvements, trend of practice maturity, surfaced issues, and growth in technological and financial capabilities.

Since 2020, our first measurement year in Kansas, we made extraordinary progress in introducing VBP arrangements and supporting Providers' success within the arrangements. The benefits to Members are evident and our experience in Kansas and throughout the nation continues to help us evolve models tailored to Kansas's needs and the KDHE's priorities.




Topic Area 7: Case Scenarios

Tab 7g

Topic Area 7: Case Scenarios - Juanita

27. The bidder's Member services line receives a call from Maria, the mother of a twenty-two (22)-year-old, Hispanic, female KanCare Member named Juanita. Maria's and Juanita's primary language is Spanish. Juanita delivered a baby boy approximately two (2) weeks ago. Maria is calling out of her concern for the well-being of her daughter and grandson.
Maria shares that the Member has been living temporarily with her until Juanita finds employment, transportation, child care, and housing. Maria states while Maria works, she has been struggling to make ends meet and at times has been unable to buy groceries. Maria shares that she has recently noticed significant and increasing changes in Juanita, including bouts of crying, lack of appetite, listlessness, and frustration with caring for her baby. Maria reports that Juanita has not been sleeping much and is struggling to produce enough breast milk to meet the baby's needs. Maria thinks that the baby may be "colicky" because the baby "cries a lot" and is difficult to soothe. Maria stated that Juanita missed the first postpartum well check because the baby was finally sleeping, and Juanita did not want to wake the baby. Maria immediately called the Member services line when her daughter told her, "I can't do this anymore."
Describe how the bidder will handle the call from Maria, and the bidder's approach to meeting the needs of Juanita and her baby.

Introduction

A valued Member at Aetna Better Health of Kansas Inc. (Aetna), Juanita and her newborn son are currently living with her mother, Maria, in Olathe, Kansas, located in Johnson County. When we receive a call from Maria about Juanita, our team jumps into action. At Aetna, we are passionate and relentless in building and implementing our **One Team, One Member** integrated model of care throughout Kansas to help to meet the needs of Juanita, her son, and other Members like them.

Our holistic, member-centric integrated strategy is designed to help Juanita improve her overall health outcomes through seamless coordination and delivery of physical health, behavioral health, and by identifying and addressing SDOH needs. This team is composed of dedicated staff licensed in Kansas as behavioral health clinicians, registered nurses, physicians, and includes Community Health Workers (CHW). Our care coordination approach is fully integrated into the Olathe community, local to Juanita and her family. Aetna does not carve out or delegate behavioral health services and is proud of our holistic model which places Juanita's voice and choice at the forefront of her care.

Juanita and her son's whole health is the priority throughout the entire care process, from initial call to sustaining support. Aetna recognizes the complex nature of Juanita's health and well-being as we **assess** all areas of her situation, **empower** her to take control of her wellness, **incentivize** sustained independent improvement, **educate** on all Aetna has to offer, and **oversee** her holistic care. The unifying value of **One Team, One Member** is integration built on strong relationships, trust, respect, and an appreciation of the diversity of thinking, language, and culture of our Members. This comprehensive approach aligns with Aetna's commitment to not only address immediate concerns, but also guide Juanita and her son toward long-term health and well-being.

Identification and Needs Assessment

Crisis Response Timeline

Upon receiving the call, a member services representative will **establish a language preference,** verify the Member's name and contact information, and warm transfer the call to a bilingual, **Spanish-speaking,** Registered Nurse (RN) care coordinator, Rosa, who has crisis training. Rosa will speak to Maria, assess for crisis and safety, and will attempt to speak with Juanita.

If Juanita cannot or is unwilling to come to the phone, Rosa gathers crucial information from Juanita and her mother. She engages with Maria to obtain necessary information such as location, status, and safety of Juanita and her child. In cases where the existence of crisis is confirmed or if the status is unclear, a call to the police will be made for immediate intervention and wellness check for Juanita and her son. Rosa conducts a crisis assessment and provides crisis intervention, including active listening, problem-solving, calming strategies, and safety planning. Crisis situations always prompt a three-way call with 911 or a 24-hour crisis line.

When we can speak with Juanita, Rosa gathers crucial information from Juanita and her mother, confirming Juanita's safety and overall security. Rosa quickly assesses the situation from Juanita’s perspective. Rosa supports Juanita using empathy, understanding, and open-ended questions, which assess Juanita’s risk of harming herself or someone else. This includes inquiring about any specific plans or means for harm. Keeping Juanita engaged throughout this process is essential, encouraging her to stay on the line while making sure necessary steps are taken. If no immediate danger to her or others exists, Rosa will create an interim safety plan and, with Juanita's consent, review it with both Juanita and Maria. If danger is present, the 911 emergency responders would transfer Juanita to a hospital and her care coordinator would follow up with her and work with the facility case managers at that location.

Emphasizing urgency, Rosa confirms Juanita is connected to emergency services while maintaining continuous contact and support. The immediate goal is addressing Juanita and her son's pressing issues during the first crisis call, avoiding any delay.

Post-Crisis Care

Once Rosa feels that Juanita is either no longer in crisis or determined that the original call was not a crisis, she will move to the next phase in Juanita's care. In the first 1–2 days, the RN care coordinator, Rosa, conducts an in-person assessment of Juanita, addressing the baby's health including his colicky symptoms, breastfeeding, postpartum depression screening, and ongoing crisis identification and safety planning. The goal is to understand Juanita's challenges and to meet her needs and that of her son.

This process includes completing the Health Screening Tool and Maternal Health Program assessments to provide Juanita with seamless coordination of referrals and follow-up/continuing care as well as supporting her as she cares for her son. In the initial follow-ups, Rosa will help Juanita schedule her next OB/GYN appointment on a three-way call. She will also connect her with Johnson County Mental Health, a Certified Community Behavioral Health Clinic (CCBHC), securing an urgent behavioral health appointment, in addition to making sure the baby has appropriate pediatric and well-baby visits scheduled.

Juanita's Care Coordination team works with her and Rosa to build a comprehensive safety plan considering her strengths, support systems, community resources, and potential triggers. Monitoring these aspects prevents provoking a crisis response and call to the police or Johnson County Mental Health. If another crisis status arises, her clinical Case Manager, Jasmine, would seamlessly work together with Rosa to get Juanita the best care. Rosa also provides Juanita and Maria with education regarding the 988 line and Aetna's 24/7 crisis line.

Juanita's Interdisciplinary Care Team (ICT) includes Rosa, behavioral and physical medical directors, pharmacist, a Spanish-speaking CHW, a licensed mental health professional care coordinator, care advocate specialist and Social Impact team. This approach integrates medical, maternal, behavioral health, SDOH, and postpartum expertise for a holistic response including extending support to Juanita's mother, Maria, throughout the care journey. Rosa uses a trauma-informed care approach, employing Motivational Interviewing while actively assessing the situation. The ICT supports Rosa as they help Juanita identify her whole-person goals, create her care plan, and monitor her progress.

Rosa counsels Juanita on the importance of therapy and that it would be key to Juanita's improved health. Rosa and Juanita's assigned CHW, Jasmine, help Juanita find a Provider of choice. Because Juanita would prefer not to have to arrange child care, the team helps Juanita select a Spanish-speaking telehealth Provider. Rosa would also provide information about all the options available to her to empower Juanita a self-directed, healthful future.

Person-Centered Service Planning

Engage

Juanita, her RN Care Coordinator, Rosa, and members of the ICT engage collaboratively to develop a person-centered service plan, which is an integrated solution spanning physical health, Behavioral Health (BH), and SDOH. Central to this approach is our commitment to Juanita's well-being, recognizing the interconnected nature of her diverse needs and prioritizing her own interests and directives. We know Juanita is more likely to stay engaged in her health improvement when she develops her own goals with our support of her voice and choice.

Shedding light on available resources and highlighting incentives for new mothers, the plan focuses on her immediate medical and BH needs and those of her baby by including her Providers in all conversations. Rescheduling Juanita's postpartum appointment with her OB/GYN is the first step on the road to stable health. We offer Juanita the option to request Jasmine's, her CHW, presence in this appointment for support and to coordinate recommended follow-up care. Rosa will also connect Juanita with lactation nurse to address her concerns regarding breastfeeding and her son's health.

We address Juanita's depression with a holistic approach, which includes completing an Edinburgh Postpartum Depression screening, offering resources and support to engage her to participate in Johnson County Mental Health Clinic therapy, counseling, and supporting her and her family’s participation in support groups of her choosing to follow proper psychiatric evaluation. Swift connection to Jasmine, a case manager at Johnson County Behavioral Health, is imperative following Juanita’s crisis. Aetna provides comprehensive support and assistance in

arranging transportation to these appointments, acknowledging challenges Juanita has shared with her team.

Social support is a crucial aspect of engaging Juanita for her care. After confirming that Juanita has sufficient technology available, Rosa can introduce Juanita to **Pyx Health** to help Juanita address loneliness and isolation. Pyx provides 24/7 digital companionship for Members 18-and-older and offers support intervention via a mobile platform to address Juanita's needs as they arise. She will also have direct access to the Pyx Health Compassionate Support Center, which is staffed with individuals trained to support her one-on-one when they screen as lonely, depressed, anxious, or indicate any social need.

Educate

In alignment with **the State's objective of enhancing the public's ability to make well-informed and suitable health care decisions,** we provide comprehensive care education for Juanita and her family. Our focus includes providing Juanita comprehensive information about available local benefits and services in a timely and guided manner. Helping Juanita navigate the health care system and improving her health literacy is crucial for long-term health.

As Juanita gets more confident, Rosa supports her by helping her and her family increase their capacity to live a self-determined life through selected programs and their services. This starts with programs that support Juanita as a new mother who is providing for her family. Rosa will provide vital educational resources like those available from the **Kansas Department of Health and Environment (KDHE)** for perinatal depression prevention and support. Listening to Juanita's priorities, Rosa recommends programs that Aetna partners within Kansas such as the following:

- **The Service League for Healthy Families Kansas**, which provides family support services to help families during times of hardship. A prime example being their caregiver/parent-led support system designed to assist in developing Juanita's leadership skills to cultivate a sense of empowerment.
- **Text4Baby** is a free app companion and text messages for Juanita to get health and safety tips.
- **Women, Infants, and Children (WIC)** is a program that provides nutrition and health education, healthy food, and other services to Kansas families.
- **Child Care Aware of Kansas** is a resource for locating accessible, affordable, high-quality child care.
- **Postpartum Support International** which Juanita can participate in online. Their groups facilitate community in recovery for new mothers and can help Juanita feel connected to a larger community online of women in the same situation who empathize.
- **Moms-to-be and Moms**, the National Child & Maternal Health Education program is a program that can help Juanita understand postpartum depression and anxiety.

As Juanita works with her ICT to choose which programs to use, we collaborate with local Kansas initiatives to arm her with the knowledge and resources needed to make well-informed health care decisions, contributing to her overall well-being. Juanita will also have many Value-Added Benefits (VAB) at her disposal. Rosa will make sure she knows all about VABs and can use VABs when she needs them. These programs include:

- **Kansas Home Visiting** connects Juanita to programs that support families and children with a trained family support specialist that can visit the home and introduce programs that support healthy babies, healthy families, and connect to resources for child development. This will help Juanita care for her son and feel more confident about her own abilities.
- **Birth to Three** introduces Juanita to programs and services such as WIC, Early Head Start, the Parents as Teachers program, and other early intervention services.
- **Maven** would provide doula coverage for one year postpartum to Juanita and help to address her concerns about breastfeeding and infant care. Maven is an evidence-based mobile app and perinatal solution that provides 24/7 access to a national network of International Board-Certified Lactation Consultants and doulas via live video consultation. Members can get the information through their Care team, via the Member Real Engagement and Community Help line, or member services.
- As Juanita still needs a crib for her infant son, her RN Care Coordinator, Rosa, assists her with participating in the **Crib Benefit Program** which could provide Juanita with a crib if she has completed at least two prenatal appointments.
- **Enhanced Transportation Coverage** supports all of Juanita's postpartum appointment travel needs. This benefit is unlimited from the time of delivery through the duration of Juanita's postpartum care. It includes free rides for Members going to the pharmacy, WIC eligibility appointments, and all related postpartum appointments, classes, or on-site training support. With up to 12 roundtrips per year, Juanita can use this service to complete a job training course and attend two interviews, one of which results in a job offer she accepts. She also uses the benefit to get groceries to stock her new apartment.

Incentivize

For all Kansas Members **deliveries with PCP follow-up within 90 days has gone up 25%** during the most recent rolling 12 months (July 1, 2022–June 30, 2023) over the prior rolling 12 months (July 1, 2021–June 30, 2022).
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As Rosa gets to know Juanita, they build a trusting relationship and Juanita shares some of her other concerns with Rosa. She indicates she is sometimes nervous about being a good mom and she wants to provide a bright future for her son. She shares with Rosa that some of her immediate needs are coaching around breastfeeding and a crib for her son, but that she ultimately wants to get a better paying job and her own apartment. To help Juanita take an active role in her physical, mental, and social well-being, we will provide her information on Aetna's VABs, including:

- **Maternity Matters (formerly the Promise Pregnancy Program) encourages** Juanita to make early postpartum visits. She can earn a $75 incentive card by completing a postpartum visit within 84 days of delivery.
- **The Healthy Rewards Incentive Program** would give Juanita $25 for her son's well-child visit and $10 annually for immunizations. In addition, she can either receive a $25 or $35 incentive card when she completes her own wellness activities based on Kansas Quality Metrics such as: vaccines, yearly checkups, cervical cancer screenings, and more.
- **No Place Like Home Grant** can benefit Juanita in her search for her own apartment. Juanita can use this emergency assistance program which provides up to $5,000 to help pay for her choice of housing and its related costs such as initial rent assistance, items to purchase for the new home, and other needs such as housing application fees, deposits, first month’s rent, past due utilities, furnishings, and housewares. **As of Oct. 31, 2023, we supported 36 unique Members with a total spend of over $81,882.**

Rosa helps Juanita use her plan benefits based on her interests and to further incentivize her to continue her wellness journey.

Empower

As Juanita becomes more confident in her new role as a mother and works to address her postpartum depression, she is empowered by Aetna's support through Rosa who supports her so she can self-direct her care.

Juanita is interested in local doula support for help with her postpartum challenges around her emotional well-being and breastfeeding challenges. Rosa can fulfill Juanita's request for a doula thanks to our collaboration with Mama Glow to provide comprehensive education and training for our care coordinators in Kansas about the benefits of doulas. This initiative creates tools to better support Juanita when she wants a community-based doula present across her journey. This program will begin in 2024 and seeks to improve maternal health outcomes of all Members, including Juanita, by advancing care manager intercultural competence and supplying the tools our care coordinators need to provide Juanita with safe, dignifying, affirmative, trauma-informed, community-centered care.

For daily, personalized timely support for her care coordination management Juanita participates in our innovative **Aetna Advice** campaigns. This can support her in tailored ways, sending her helpful tips and reminders about her own care. This tool uses proprietary data (e.g., medical claims, pharmacy claims) and predictive analytics, based upon more than 20 metrics, to tailor messages and communication channels to Juanita. These campaigns leverage a range of customizable channels (e.g., mailer, email, text, phone call, digital messaging) to inspire action and involvement with her care plan. Campaign messaging can be anything from reminders for postpartum visits to promoting early childhood well visits and more.

Having told us she wants to find a job and be able to move into her own apartment, Juanita is also concerned about finding qualified day care. Juanita's team identifies **Level Up KS** which connects prospective students with in-demand careers through associate and technical degrees. Rosa would also suggest **Workforce Partnership of Johnson County**, another local organization that can assist Juanita in her search for employment. Rosa would then recommend **Child Care Aware** to assist Juanita with resources and information on licensed child care options near her to prepare for her new working life. Aetna also supports **Rewarding Work,** a resource online directory Juanita has access to that is designed to help individuals and families find and recruit caregivers to assist them on their wellness journey.

Rewarding Work provides an accessible and easy-to-use online directory and job board designed to help individuals and families recruit, find, and hire caregivers and for job seekers to match with caregiver jobs.

Aetna supported Rewarding Work with a $17,000 sponsorship investment.

Rewarding Work also offers access to free Respite Care Provider Training, a nationally recognized training that provides a certificate upon completion. This training will bring more trained individuals into the DCW workforce.

153b.KS23

Through Juanita's care **Aetna is building a healthier workforce** by providing access to job training, resume services, and more at our local **CVS Workforce Innovation and Talent Center (WITC)** that Juanita can access with ease. Rosa will engage an employment care advocate specialist for Juanita's team to make sure Juanita has what she needs at every step of her job

hunt. Juanita's employment specialist is responsible for developing and managing a continuum of vocational, employment, and business development services so Juanita achieve her employment goals.

We share KanCare's goals to **reduce poverty and spread prosperity to every corner of the State.** Acknowledging the link between health, education, and employment, we have developed a targeted program to empower Juanita toward self-sufficiency. These programs are integrated into Olathe, Kansas, delivering health evaluations and assessments through staffed FQHCs, like the **Health Partnership Clinic**, job training, transportation assistance with NEMT. Additionally, Juanita is provided interview support services, including clothing, resume writing, and mock practice sessions. Our workforce kitchen provides cooking and serving training and serves free hot meals to Juanita's community as well. Juanita is supported and feels more confident that her life is moving forward again with new skill sets that she can use to provide for herself and her son.

Juanita was concerned with overwhelming tasks in her new life so Rosa addresses those at Juanita's own pace, demonstrating how Aetna is aligning with **the State's objective to advance integrated health care delivery, encompassing medical care, BH, and social services.** Aetna is redefining convenient access to care for Kansans, using community-based initiatives, offering in-person services at CVS Health retail locations, and using digital tools to connect with Juanita wherever she may be. Juanita and her son have access to various programs, and her RN care coordinator Rosa will collaborate to identify those that align best with her needs and preferences to empower her to make her own self-directed choices.

Care Monitoring and Oversight

As Juanita's personal care journey progresses, Juanita is introduced to these key community programs and resources, fostering her long-term health and stability. Rosa will cover all her areas of concern as directed by Juanita, such as employment, housing, transportation, and child care support. We share Kansas' goal **to improve the public's capacity to make informed and appropriate health care decisions.** This includes Rosa scheduling follow-up appointments with her OB/GYN and other specialized care. Juanita's progress is measured and followed carefully to allow Juanita to voice any requests or concerns to Rosa along the way.

Rosa conducts regular check-ins to relay comprehensive information about Juanita's Medicaid benefits and explores available resources for her and her family's future well-being. We emphasize individual-focused support for recovery from crises to sustained health and prosperity.

Juanita’s success will be monitored through her claims review, face-to-face visits, and continued support with accessing community resources facilitated by her RN Care Coordinator, Rosa. Addressing the intricacies of postpartum care, behavioral health and infant care, our ICT provides seamless support to Juanita. Juanita and her mother, Maria, are confident and delighted in the diverse range of value-added benefits, integrated suites of resources and local programs all tailored to meet their needs facilitated with the responsiveness of Rosa and her team.

Outcomes

Our Member Juanita, her son, and her mother, Maria, will be seamlessly connected to various care programs through Rosa and her Care Coordination team, plus connected to a robust care community specific to her cultural and physical needs in Olathe. This holistic approach creates confidence for Juanita on her journey toward well-being with support from every angle integrated into her community. We share the State's goal to **reduce health care disparities** across all socioeconomic and demographic populations, including Spanish-speaking populations. Juanita is supported through her Care Coordinator, Rosa, and her ICT every step from crisis call to self-directed confident stability and wellness.

Our integrated approach combines linguistic and cultural community sensitivity with a comprehensive suite of programs and services. The focus is not only on immediate needs but also on empowering Juanita to take proactive steps toward her well-being and that of her newborn. Through this collaborative effort, we aim to provide meaningful support and guidance throughout her postpartum journey.

Our affiliate Aetna Better Health of Texas targeted maternity Members with Pyx and here is what they found:

- Mothers using Pyx also had a **51.5% increase in completion of physician-administered postpartum depression screenings** (5.9%) versus those not using Pyx (3.9%)
- Mothers using Pyx had a **14.8% increase in completing their necessary prenatal and postpartum care** (73.3%) versus not using Pyx (63.9%)

From July 2022 through to July 2023:

- Postpartum care for Pyx-supported Members up 35.4% as of July 2023 (58.3%) over non-Pyx supported (43.1%) 153c.KS23

Upon case closure, Rosa documents that Juanita reported she is feeling much better and is grateful not only for the extra resources provided by Aetna, but also for the meaningful connections she has created in her community. She is regularly attending therapy sessions at Johnson County Behavior Health, her son's growth and development is on track, and she has found sustained success on her own, knowing that she has Aetna's support anytime she needs it.

Topic Area 7: Case Scenarios - Shanice

28. Shanice is a twenty-three (23)-year-old, black, female KanCare Member who was brought to the Emergency Department (ED) by police due to injuries sustained during a fight with another person in a downtown homeless shelter. While her injuries do not appear to be life threatening, Shanice sustained injuries around her face and head and exhibits odd behavior. Shanice has a history of opioid use disorder, benzodiazepine use disorder, and stimulant use disorder in addition to co-morbid schizoaffective disorder and major depression disorder with psychotic features. Her drug screens at the ED are positive for opioids and benzodiazepines. Shanice has been receiving services through a CCBHC but has been inconsistently engaged in treatment and has presented to the ED multiple times for either drug intoxication or withdrawal in the past year. She is unstably housed and lacks any form of Transportation. Tests conducted during the ED stay indicate that Shanice is pregnant.
Describe the bidder's approach to addressing Shanice's needs.

Introduction

Shanice, a 23-year-old Black female KanCare Member from Wichita, Kansas, is facing the challenges of homelessness, pregnancy, and complex health issues. Aetna's commitment to her well-being is supported by our expertise and experience in providing case management and service coordination to Members who are living with complex mental illness and SUDs.

Our Aetna **One Team, One Member** approach prioritizes whole-person care coordination focusing on the integration of physical health and behavioral health and addressing Shanice's SDOH needs. Our dedicated team values Members' voice and choice, and our initial efforts will focus on building engagement, rapport, and choice with Shanice, understanding her needs and goals.

In collaboration with COMCARE, the local Certified Community Behavioral Health Clinic (CCBHC), and their subsidiary Mental Health Association of South Central Kansas (MHASCK), other health care Providers, and stakeholders, we establish a supportive network that empowers Shanice to actively participate in her health care decisions. Our weekly collaboration meetings with MHASCK will enhance our ability to coordinate Shanice's care, problem solve any gaps in care, and address her SDOH needs. For Shanice, her primary SDOH need is to secure stable housing and continuity of care. Through these weekly meetings with MHASCK, our Care Coordination team monitors Emergency Department (ED) use among our Members, and we coordinate with numerous housing providers to identify stable housing options.

When Shanice arrives at Wesley Medical Center ED following a fight at a homeless shelter, our integrated care coordination system will receive an alert via a secure Admission, Discharge and Transfer (ADT) feed from the Kansas Health Information Network (KHIN). Our Care Coordination team are informed of the admission and will initiate an urgent response due to the high priority of this case. This alert will mark our first notification of Shanice's presentation, including pregnancy, and we will stratify her as a high-risk Member, which will trigger our complex case rounds protocols, and our ICT will create a PCSP to support her complex needs.

Considering Shanice's complex situation, our approach involves the critical role of Bridget, our Transition of Care Coordinator (TOCC), a member of our Care Advocate Team (CAT).

Monitoring ADT alerts throughout the day, Bridget also recognized Shanice as a high-risk Member, who has been challenging to contact historically. Upon receiving the alert, Bridget reviewed Shanice's file and immediately notified our hospital-embedded Case Manager, Susie. This step is part of our protocol for high-risk Members, providing comprehensive attention to immediate and long-term care needs.

Susie, who was scheduled to be on-site at Wesley Medical Center, reached out to the ED social worker to schedule an in-person meeting with Shanice at the ED, demonstrating our commitment to minimal service disruption, where possible. Using a trauma-informed approach and her skills with Motivational Interviewing, Susie began establishing rapport with Shanice, emphasizing empathy and unconditional support. She gathered information regarding Shanice's support system, including family members and the father of the baby, to better understand her social context. Susie also inquired about Shanice's interest in having them be part of her care plan, recognizing the importance of a supportive network in her journey.

Our initial response is multifaceted, focusing initially on addressing Shanice's immediate health issues. Her injuries were addressed in the ED, where she received a thorough assessment, including screenings for head trauma, a mental health assessment, and a drug panel to assess her drug and/or alcohol content levels. The ED team followed concussion protocols and conducted a CT scan, which showed no severe injuries. Additionally, they treated a minor laceration that did not require stitches. While Shanice was receiving this care, Susie collaborated with the ED social worker to jointly develop a discharge plan for Shanice.

Identification and Needs Assessment

After Shanice is identified in the ED, our Interdisciplinary Care Team (ICT), led by COMCARE, and MHASCK, was mobilized. Simultaneously, our CAT housing administrator, who regularly coordinates with hospital discharge teams, implemented a 'Housing First' strategy to secure stable housing and transportation for Shanice, which is essential for her prenatal care. This included coordinating with the United Way of the Plains for Shanice's entry into HUD-funded supportive housing. These efforts also included creating a budget for the 'No Place Like Home' program and adding Shanice to our weekly case conferencing with MHASCK.

During this same period, we started a preliminary PCSP to address Shanice's physical health and pregnancy-related needs, including the scheduling of an immediate OB/GYN appointment within 48 hours of her ED discharge, as per our protocol for high-risk pregnancies. This comprehensive plan, which also addressed her substance use, mental health issues, and SDOH needs, is developed with her health care Providers, family and additional support systems, and is focused on prioritizing Shanice’s immediate health needs while laying the groundwork for her sustained recovery and well-being.

Beyond the hospital setting, we focused on maintaining engagement with Shanice. Susie collected detailed information about Shanice's medical, social, and housing needs, which we used to inform our PCSP. Susie also connected Shanice to a PCP to conduct necessary evaluations and assisted her with scheduling the first appointment.

As part of our broad collaboration efforts, we engaged behavioral health/SUD specialists at COMCARE, Peer Support Specialists (PSS), and a qualified physician, to address Shanice's Opioid Use Disorder (OUD) and pregnancy, advocating for an integrated medication management plan that includes treatment for her mental illness and Medication-Assisted Treatment (MAT) as a critical care component and educating Shanice about its benefits to support her informed decision-making and active participation in her treatment. During our initial assessment phase, we also emphasized creating a safety plan for Shanice, exploring her strengths, coping skills, potential triggers, and connecting her with local resources. Upon completing our initial assessment, we were able to secure free housing for Shanice at a CKF Level 2 intensive outpatient program (IOP). Shanice accepted this referral, as this program will provide Shanice with temporary housing while she attends the on-site addiction treatment program.

Additionally, we involved our Kansas SDOH team and our community resource directory, which is a key resource we use to address Shanice's broader social and environmental factors. We engaged law enforcement and local social service agencies for additional information and support, including personal safety planning in response to her recent altercation. We also provided her with immediate support options like the 988 hotline and the Aetna crisis line.

Identifying these social factors is crucial in bridging gaps in Shanice's care and in promoting her integration into community support networks, which are critical elements for making a successful transition from an acute care setting to a stable community living environment.

Person-Centered Service Planning

Engage

Our integrated planning and care coordination activities reflect an active collaboration with Shanice by members of our Interdisciplinary Care Team (ICT) to support every decision-making step of this process. Our hospital-embedded Case Manager, Susie, reached out to Tamara, Shanice's care coordinator, to coordinate a smooth transition. Our ICT, led by Tamara, is the cornerstone of our support. Tamara, who is a licensed mental health professional and skilled at managing and supporting complex needs, is Shanice's primary point of contact. Our ICT, which also includes our embedded Case Manager, Susie, COMCARE and MHASCK representatives, behavioral health clinicians, PSSs, recovery specialists, and housing and transportation experts, creates a PCSP. This plan describes how the ICT collaborates to address Shanice's immediate stabilization needs and aspirations for her long-term well-being.

Week 1: At this point, we increase our collaboration with COMCARE and MHASCK, leveraging our expertise in care coordination. While Shanice is participating in the CKF residential IOP, Tamara focused her efforts on identifying and integrating behavioral health specialists and PSSs, which are vital for addressing Shanice's specific needs related to her mental illness and history of substance use. In addition, our already established weekly case conferences with MHASCK have been instrumental in coordinating our care efforts with Shanice. Tamara also helped her schedule her first prenatal care visit, advised her OB/GYN on the value of recommending prenatal vitamins, such as low dose aspirin to prevent preeclampsia and MAT for her OUD, all in consideration of her pregnancy and to provide her the most effective care.

Beyond acute care, our priority was to maintain Shanice's active engagement in her health journey. Tamara conducted an in-depth assessment of her social support system, including the involvement of her baby's father and other family members. Our housing specialist, now with additional time available, started the process of linking Shanice to the HUD Continuum of Care Homeless Assistance program and coordinated transportation services. In addition, the MHASCK's Operations Community Integration team, supported by our housing administrator and transitions of care coordinator, began drafting a request and budget for the No Place Like Home (NPLH) program.

Week 2: Expanding on the foundation laid during our initial week, we shifted our focus to tracking the progress and timeliness of securing her housing placement through the HUD Continuum of Care Homeless Assistance program, a critical factor in providing her with a stable and safe living environment. By this week, we approved the NPLH budget for Shanice, which not only covered her housing deposit and new furnishings but also, as an exceptional measure, the first three months of rent. This decision aimed to alleviate pressure on Shanice and reassured the housing provider of Aetna's commitment, given her history of eviction and property damage. An additional $500 was also set aside for unforeseen expenses. We also prioritized the consistent coordination of transportation services, making certain Shanice had reliable access to all her medical appointments, including a follow-up prenatal visit and other necessary services.

In our collaborative efforts with COMCARE and MHASCK, Tamara reviewed and supported their existing treatment plan for Shanice. Recognizing the changes in her situation, especially her pregnancy, we advocated for the inclusion of MAT in her regimen. Furthermore, acknowledging Shanice's past challenges with consistent engagement with the CCBHC, Tamara initiated a dialogue with both Shanice and the COMCARE and MHASCK team to identify and address the factors that led to these issues. Her focus was on building a more durable and effective connection between Shanice, COMCARE and MHASCK, and the care coordinator, arranging a more successful and sustained engagement in treatment going forward.

Week 3: Our efforts in Week 3 shifted toward the development and integration of a more personalized substance use treatment plan for Shanice. This plan was aligned with her preferred SUD treatment and mental health care, and incorporated regular consultations with a psychiatrist and therapist, reinforcing the comprehensive care approach and consideration of trauma-informed care in response to the complexity of her situation related to her substance use and mental illness. In addition to these health-focused efforts, Shanice has been enrolled in a permanent supportive housing program for people with disabilities, to further stabilizing her living situation. As part of the state-supported Operation Community Integration program, Shanice is also receiving intensive support services to improve her independent living skills and to manage her symptoms, and she has shown notable engagement, especially with support from one of MHASCK's peer support specialists (PSS).

Additionally, and in line with making sure Shanice has all the tools she needs for successful communication and engagement, Tamara helps Shanice obtain a cellphone during this first month, which is intended to enhance Shanice's connectivity and independence. Tamara also assists Shanice download and use the Maven app, a resource that supports her in managing appointments, accessing health information, and maintaining consistent communication with her

care team. These combined efforts are needed to help empower Shanice, facilitating her active participation in her health journey and keeping her connected with the support she requires.

Month 1: Tamara, our care coordinator, takes a proactive role in Shanice's ongoing care. She establishes regular telephonic follow-ups to regularly monitor the effectiveness of the interventions laid out in Shanice's PCSP. During these calls, Tamara not only tracks Shanice's attendance at the CKF IOP and other scheduled appointments but also conducts an interval assessment and reviews the care plan. This process allows for necessary adjustments to be made in real time, making certain that the care plan remains aligned with Shanice's evolving needs.

Month 2: We focus on strengthening Shanice's social support network. Tamara continues her diligent telephonic contact with Shanice, completing another interval assessment and reviewing her care plan. These regular check-ins are key to making sure Shanice’s care remains relevant and responsive to her needs.

During this period, Shanice has been consistently attending her monthly prenatal visits with her OB/GYN, a crucial part of her care due to her high-risk pregnancy. The positive impact of these visits is evident in her adherence to appointments and the ongoing management of her pregnancy. Simultaneously, Tamara is working to enhance Shanice's connection to community resources and support groups. We track her level of engagement with these services, noting the expanding breadth of her support network.

Additionally, Shanice has been prescribed MAT and she reports this approach has been effective in managing her cravings and, importantly, she has not used opioids or other substances since learning of her pregnancy. This achievement is a significant milestone in her journey, reflecting the success of the integrated approach in addressing her SUD in conjunction with her pregnancy.

Month 3–6: Tamara continues to review and adjust the PCSP making sure it responds to Shanice's changing needs, particularly since she successfully completed the CKF treatment program. In our approach, Tamara frequently evaluates Shanice's pregnancy progress, including conducting a maternal health trimester screen, and monitoring her prenatal visits to confirm both the mother and child are progressing well. Shanice is connected to Baby Talk, a program available through Aetna designed to support healthy pregnancies. We also continue to monitor Shanice's mental and physical health status, whether she is maintaining sobriety, her engagement with support services, and her overall satisfaction with the care she received. Our goal is to provide a seamless continuum of care that adapts to Shanice's health and health care requirements.

We also explore the option of connecting Shanice with a community doula program. This initiative aims to provide her with a prenatal doula, who would offer additional support and guidance tailored to her specific needs during this crucial phase. The involvement of a doula can significantly enhance Shanice's experience by providing emotional, informational, and physical support, thereby complementing the medical and therapeutic care she is receiving.

Months 6–12: Regular evaluations are conducted to review her progress, with the aim of setting further health and recovery goals. These evaluations focus on supporting Shanice's delivery and related outcomes, such as full-term birth and infant wellness at delivery. At the same time, we will confirm Shanice participates in postpartum visits and care, along with arranging a well-child visit to monitor the baby's development. Additionally, we arrange for breastfeeding counseling through our Promise Pregnancy program, providing her with vital information and support for successful breastfeeding.

We learned that the $500 we had reserved for potential damages in Shanice's housing situation has gone unspent. MHASCK requested permission to use these funds to purchase a crib and other essential baby supplies for Shanice, a request we approved. Along with these activities, we schedule a well-child visit to closely monitor the baby's development, making certain that the child receives the necessary care and interventions for a healthy start. We also make sure Shanice receives and understands information regarding family planning and contraception, discussing these options both before and during her postpartum visits. This is a crucial aspect of her care, allowing her to make informed decisions about her health and family planning.

Our long-term efforts are centered on Shanice's sustained sobriety, improved mental health management, and her consistent use of prenatal services, all contributing to her preparation for a successful delivery and postnatal period. Our integrated care model is designed to provide support to both mother and child, providing for their well-being throughout their journey.

As we advance Shanice's PCSP, our focus is not only on preventing relapse or acute crisis in the context of her substance use, but on providing continuous care through smooth transitions between Providers. This coordination considers her pregnancy, mental health, SUD, housing challenges and SDOH needs.

Incentivize

Recognizing Shanice's unique challenges, including progress in substance use rehabilitation, her pregnancy, and mental and physical health needs, we offer value-added benefits to enhance Shanice's quality of life.

Value-Added Benefit	Scope of Benefit
Enrollment in the No Place Like Home (NPLH) Program	Emergency assistance up to $5,000 for housing-related costs including rent assistance, utilities, furnishings, and housewares. Year-to-date in 2023, we supported 36 unique Member households with a total spend of over $81,882.
Pyx Health	An app for combating loneliness, offering screening for loneliness, anxiety/depression, SDOH needs, and medication adherence. Chats, 24/7 live phone contact, and resource help are available.
Promise Pregnancy program	$75 reward for timely prenatal and postpartum visits, plus a $10 dental checkup during pregnancy.
University of Kansas Cribs Personal Pregnancy Services	Provides insurance and service information, 1:1 education, screenings, interventions, and referrals for various health issues.

Value-Added Benefit	Scope of Benefit
Services offered through MAVEN	Doula support during pregnancy and postpartum, plus 24/7 access to lactation consultants and doulas via a telehealth app.
Legal Services for Housing	Access to legal services and education for housing issues, including eviction, tenant issues, record expungement, and more.
Extended Transportation for all Postpartum Appointments	Free transportation for pharmacy visits, WIC appointments, prenatal classes, postpartum appointments, job-related activities, and community health services.
Referrals to the Baby Talk Program for Early Childhood Development	Six two-hour classes on pregnancy, infant care, and postpartum issues, available in English and Spanish, primarily for those without access to prenatal education.
Over-the-Counter (OTC) Items	$25 per month for OTC items including diapers, wipes, and prenatal vitamins. For fiscal year 2020 through Oct. 31, 2023, we supported 12,577 unique Members with a total spend of over $3,150,473.

Care Monitoring and Oversight

Our oversight activities, in line with the KanCare vision and our current contract, is to confirm the provision of high-quality, comprehensive care for all Members, particularly those with complex needs like Shanice. We emphasize the critical roles of our ICT members, like our transition of care coordinator, our embedded case manager, and our care coordinator. Our Clinical and Quality Assurance teams monitor and evaluates the impact of our interventions on Shanice's long-term engagement and wellness. We prioritize early intervention, integrated service delivery, and continuous quality improvement in following areas.

Medical/Physical Care: Providing proactive maternal care forms the cornerstone of our monitoring efforts for Shanice. We focus on scheduled prenatal visits and educational support for a healthy pregnancy and post-delivery and emphasize postpartum care and well-child visits. This includes the potential referral to Ouma, a maternal fetal medicine telehealth Provider, signifying our commitment to holistic, integrated service delivery.

Maternal Care: During Shanice's pregnancy, our monitoring efforts will make sure Shanice's maternal care is proactive, with scheduled prenatal visits and educational support that fosters a healthy pregnancy. Post-delivery, we will emphasize the importance of postpartum care and well-child visits to monitor both the mother's and baby's health, which may include a referral to Ouma, a maternal fetal medicine telehealth Provider.

We will also offer and encourage Shanice to participate in our Maternal Health/Maternity Matters program, which provides integrated care management to all pregnant women during their pregnancy for a minimum of 12 months postpartum. Throughout this period, we will routinely screen Shanice for postpartum depression using the Edinburgh Postnatal Depression Scale. This screening will occur following her discharge from delivery, and then again at six weeks, six months, and 12 months postpartum. Should any of these screenings indicate potential concerns, we will promptly refer Shanice for a behavioral health evaluation to make sure she receives the necessary support and treatment.

Mental Health: Our care coordination efforts are intended to empower Shanice so she can direct her own treatment plan. Through regular evaluations, in partnership and collaboration with her Psychiatric Care team, we will facilitate necessary modifications to her mental health treatment, making sure these services align with her evolving needs during and after her pregnancy.

Substance Use: We will confirm that Shanice's SUDs are managed as part of an integrated treatment plan. We will monitor her engagement with counseling, group therapy, and MAT, while promoting her autonomy in care as part of the Self-Direction program.

Social Network and Employment: We address social isolation by confirming Shanice's active participation in community support groups and educational programs. Additionally, we will explore referrals to employment providers or training programs, enhancing her pathway to economic stability and recovery. This approach aligns with Shanice's PCSP, which focuses on strengthening her support network and independence.

Environmental Factors: Access to stable housing, reliable transportation, and healthy food choices are essential components of our care plan. We make sure Shanice connects with relevant housing programs and transportation services, maintaining uninterrupted access to care, and support her in making nutritious food choices.

Medicaid Knowledge: Tamara is well-versed in Medicaid services and regulations, will maintain an active relationship with Shanice, making sure she is informed about her rights and access to benefits, consistent with Medicaid policies.

Outcomes

We evaluate the effectiveness of Shanice's care using a data-driven methodology, making certain that we are responsive to her immediate needs while also laying the groundwork for sustainable, long-term health and well-being. Leveraging a continuous quality improvement strategy, we are dedicated to refining our services to best support Shanice's evolving circumstances.

Short-term Evaluation Activities

We will assess and support Shanice's progress in several domains through the following short-term evaluation activities, which are is crucial for Shanice's overall well-being and integration into a stable and healthy lifestyle.

Medical Stabilization: Monitoring recovery from injuries, prenatal care progression, and pregnancy-related complications.

Pregnancy-Related Care: Evaluating adherence to prenatal care plan, including visit attendance and vitamin regimen compliance.

Substance Use Rehabilitation: Measuring withdrawal management progress, treatment adherence, and completion of detox milestones.

Mental Health Interventions: Evaluating mental health support effectiveness through symptom checklists, appointment attendance, and medication adherence.

Housing and Transportation: Gauging housing stability and timely health care appointment attendance and access to consistent transportation services.

Social Network Reintegration: Quantifying community support through engagement with groups and interaction frequency

Vocational and Income Support: Assessing vocational rehabilitation and income support effectiveness through engagement and income changes.

Long-term Evaluation Activities

We will monitor longer-term activities to support Shanice's sustained progress in the following aspects of Shanice's life, focusing on the effectiveness of our interventions in health management, mental health support, and vocational advancement.

Health Management: Monitor with near-real-time systems and regular check-ups; track health visits, changes to health indicators, and adherence to disease management plans.

Pregnancy-Related Care: Focus on postpartum recovery, baby's well-being, and mental health; supporting lactation, contraception planning, and mental health adjustments

Mental Health Support: Measuring long-term medication management, therapy, and treatment efficacy using mental health stability and satisfaction assessment results.

Housing and Transportation: Assessing housing stability by duration in the same residence and access to reliable transportation.

Social Network Reintegration: Monitoring social reintegration and strengthening of family ties through regular assessments of community engagement and family interactions.

Vocational and Educational Advancement: Tracking training program participation, certification or degree attainment, skillset expansion, and job placement post-training.

We are committed to providing Shanice with the highest standards of care coordination, acknowledging the complexities in her journey. We meet her in her current life situation, partnering at every step to uphold her rights and facilitate her recovery through a comprehensive, data-driven service delivery system. Our commitment reflects our whole-person care approach, making sure that Shanice is supported by a cohesive, integrated care system that aligns with KanCare's goals. This approach is not only effective but also cost-efficient, reflecting our dedication to optimizing resources while maximizing positive outcomes.

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Topic Area 7: Case Scenarios - Robert

29. Robert is a twenty-five (25)-year-old, white, male KanCare Member with Cerebral Palsy enrolled in the IDD HCBS Waiver. He is currently being treated in an acute care hospital for an upper respiratory infection and is nearing discharge. In addition to having a limited ability to meet his basic personal care needs, Robert is wheelchair dependent and requires an augmentative communication device. Robert is currently living with his grandmother, Betty, who has been providing the majority of support for his personal care needs.
Betty recently learned that she has stage 4 rectal cancer and is gravely concerned about her ability to continue to care for Robert when he is discharged, and anxious about who will take care of him when she dies. There are no additional family supports for Robert.
Robert is very intelligent and close to getting a bachelor's degree in computer programming. He would like to live independently, complete his schooling, and obtain employment.
Describe the bidder's approach to supporting the hospital discharge planning process and to initiating and managing Robert's follow-up care to assist him in meeting his short- and long-term needs and personal goals upon discharge.

Introduction

We will work with Robert and his grandmother, Betty, to improve their health outcomes, engage with them on their needs and goals, and educate them on their options. We will coordinate with Kyle, the community-based Targeted Care Manager (TCM), on home visits; health and safety monitoring; referrals to community and non-Medicaid resources; and supports for his education, employment, and housing. We will also partner with the Community Developmental Disability Organization (CDDO) for counseling on Robert's choices.

In alignment with KanCare's vision to realize program excellence and optimal health outcomes for Members, Aetna will leverage its experience, innovative programs, and key personnel to support Robert's hospital discharge planning process and meet his short- and long-term needs and personal goals upon discharge. Our strong relationship with Robert gives us valuable insights into his health conditions, Betty's cancer diagnosis, and his lack of family supports, informing our approach to caring for them both. While continuing to support Betty with her illness, and in partnership with Kyle, **we will empower Robert to self-direct his managed care journey, honor the choices that he makes, and help him achieve health, wellness, and independence along with his personally defined goals for education and employment.**

Identification and Needs Assessment

Aetna established a strong, trusting relationship with Robert before his hospitalization and is aware of his background through his KanCare membership. Because he is enrolled in the IDD HCBS Waiver, Aetna has assigned Robert to an **LTSS Care Coordinator, Brian.** In accordance with **Scope of Services section 7.4.7**, Brian is a registered nurse licensed in Kansas with a bachelor's degree in nursing and two years of full-time experience working with HCBS IDD Waiver Members; he has also completed the **University of Missouri-Kansas City Institute for Human Development's Charting the LifeCourse™ (**CTLC) coursework and the overall integrated care management training of 160 hours. The tools and principles in CTLC help Robert strengthen his self-determination and achieve his goals. Using CTLC helps confirm that Robert's voice is the driver of all services.

Our holistic, member-centric Care Coordination model complements Robert's choice of a community-based TCM, Kyle, through options counseling from the CDDO. Kyle acts as the hub and touchpoint for community resources and is Robert's and the Care team's **primary and single point of contact.** He communicates with the CDDO for counseling, checks whether Providers have openings, and continually collaborates with Brian.

Robert has been our LTSS Member since 2019 working with Kyle and Brian. Before his admission, Kyle and the team completed an interRAI, other supplemental assessments, and the Person-Centered Service Plan (PCSP) to identify and assess Robert's needs and wants. **As of Dec. 15, 2023, our LTSS Members initial interRAI completion is 92.75%.** Brian and Kyle have been actively exploring options with Robert regarding his long-term goals in interdisciplinary team meetings to avoid duplication of services. Kyle has been having monthly touchpoints with Robert, Betty, and Brian via either telephone calls or face-to-face visits; during these, Kyle continues to explore informal support options for Robert. Collaborating with Brian and the CDDO, Kyle has also informed Robert and Betty of the Careforth program—an online telephonic platform that offers caregiving support and info—as well as family resource networks and support groups for their needs. Aetna has coordinated, and will continue to coordinate, all physical and behavioral health services, as well as the following LTSS and IDD waiver resources available to Robert:

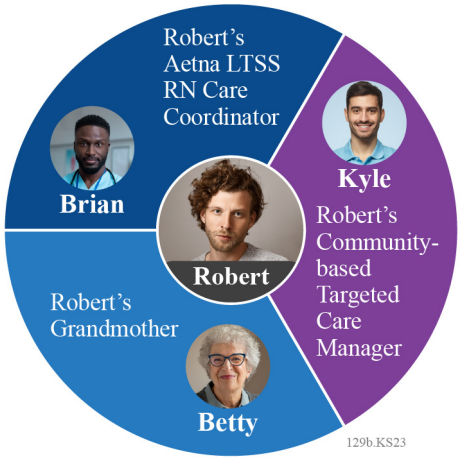

Figure 29-1: Robert's Support Team. *Brian, Kyle, and Betty make up Robert's main support team.*

- Personal Care Services (PCSs), including assistance with Instrumental Activities of Daily Living (IADLs)
- Home-delivered meals
- Emergency alert system services
- Day services and residential support, including independent living programs
- Therapeutic services, including physical, occupational, and speech therapy
- Respite and family support services for Betty, if needed
- Assistive technology and DME, including augmentative communication devices, nebulizers, respiratory masks, and grab bars

In offering these services to Robert before, during, and after his illness, we retain continuity of care, enable consistent and seamless access during Robert's transition, and are better prepared to accommodate him during his convalescence and discharge, **supporting the State's vision for realizing optimal health outcomes for Robert and our Members.**

Coordinating Care with the Hospital

When Brian receives an inpatient alert about Robert's hospitalization for an upper respiratory infection, he notifies Kyle and coordinates a meeting with Robert at the hospital. Robert expresses that his most important goal after recovering from his upper respiratory infection is to return home with his grandmother. Brian also notifies the CDDO and Robert's current HCBS Waiver Providers of his admission. Brian shares with Kyle, Robert's reason for admission and his

expected discharge date, which helps Kyle complete the State-required Adverse Incident Report (AIR). In a meeting that involves Kyle, Brian, Robert, and Betty, they discuss long-term planning, the support that Betty needs, and potential living and rehabilitation options for Robert. During this process, Betty expresses concern about her own health needs and her inability to care for her grandson the way she had before her illness; **Brian reassures her that she and Robert will receive the support and care that they need.**

Brian coordinates hospital-discharge planning with the transition of care coordinator and IDD program manager from the Care Advocacy Team, both from Aetna, to facilitate Robert's return home with needed services and supports. The discharge-planning process is initiated with the Interdisciplinary Care Team (ICT), including the Concurrent Review Nurse (CRN), Kyle, service Provider, social worker, case worker, and Aetna medical directors. Brian communicates frequently with the hospital staff about Robert's needs, any gaps in his care, and the supports he will have at home. After Robert chooses a home health agency, Brian connects with that Provider to coordinate the therapies to be delivered at home. Brian provides education on services, benefits, value-adds, and community-based services so Robert and Betty can make informed decisions. **For example, Robert will receive up to two meals per day for up to seven days for members 21 years and older with a medical need who have been discharged from an inpatient stay after seven days in the hospital as part of his value-added benefit**. Before discharge, Brian collaborates with Kyle to make sure Robert’s wheelchair and augmentative communication device, as well as any additional DMEs, are in place and meeting his needs. Brian assists in locating PCSs and hands-on caregiving support to relieve Betty of day-to-day caregiver responsibilities. Brian recognizes Robert and Betty's concern with receiving services once discharged home: he schedules a visit with Robert and Betty on the planned discharge date. Brian has coordinated with Kyle and the PCS Provider to attend the visit together, confirming Robert and Betty have their questions answered once returning home.

Collaborating Through Complex Case Rounds

To determine future care planning and interventions, Aetna’s ICT monitors Robert’s clinical progress and makes recommendations for meeting his discharge goals based off the feedback of the hospital care team and the results from the diagnostic tests. The team reviews clinical notes and the recommendations from consultants in gastroenterology, neurology, pulmonology, and nutrition, as well as in physical, occupational, and speech therapy, to evaluate Robert’s readiness for discharge and formulate his discharge plan. The CRN continually shares their findings with Kyle and Brian.

During Robert’s hospital stay, Kyle and Brian engage all those involved in discharge planning and lead weekly complex case rounds with the ICT and Aetna staff to discuss Robert's immediate needs and formulate a plan of action; **Robert's voice and choices are at the forefront as Kyle and Brian guide these conversations.** Kyle and Brian routinely interact in person with Robert and his circle of support, including Betty, community agencies, the college disability services liaison, the home health agency, and the ICT to address all his health and social needs; by doing so, they build rapport with Robert and those involved in his life and show their devotion to delivering the best care. Kyle and Brian facilitate a contingency plan to anticipate and mitigate the risk of potential disruptions to the delivery of authorized services. To serve Robert best, Aetna hires from within the community to provide services that are sensitive to and informed by

disability culture. Care management staff are responsible for assessing and documenting Robert's overall functional, physical, and behavioral health status at each review.

In addition, we assist Robert in connecting with and contacting his PCP. To coordinate care and prevent duplication of services and activities, we share the results of any identification and assessment of Robert's needs with Kyle and other Providers serving him. Kyle and Brian reevaluate and update Robert's care and service plans continually. **The NCQA standards that we follow allow us to be more comprehensive in our service planning approach.**

Performing Reassessments

When Robert is discharged, Brian, using Motivational Interviewing techniques, conducts a new assessment based on his recent admission, then a whole-person reassessment to identify Robert's current physical, behavioral, and social needs and promote him to a higher level of care. We confirm he has appropriate accommodations during these assessments, including assistive tools and necessary technologies for his mobility and communication. We test the functionality of Robert's augmentative communication device and fully integrate his adaptive tools into the screening process; we also confirm that his home is wheelchair accessible, give him extended time for tasks, and use visual supports to enhance his participation and understanding. Brian encourages Robert to share his strengths, needs, and goals; with Robert's permission, we also obtain input from his grandmother to broaden assessment information. **Honoring Robert's individuality, independence, and self-determination, we make sure through this person-centered approach that Robert's discharge plan aligns with his choices.**

Updating Robert's Service Plan

Robert, in collaboration with his ICT, created and approved his PCSP, which incorporates the person-centered and behavior support plans developed by Kyle. Kyle, collaborating with Brian, continues to monitor Robert's goals, progress, and the status of the PCSP; Kyle has been recording strategies and interventions in this written document to help Robert meet his goals and improve his health. Robert has been the center of and leads the service plan. We **engage** him by promoting self-determination and building trust. If Robert disagrees with an aspect of the PCSP, Kyle works with him to adjust it. We also coordinate with the ICT—composed of professionals with expertise in community living and person-centered service delivery—to assess and update the PCSP. Robert, Betty, and the relevant Providers signed the PCSP before initiating his services.

The PCSP includes Robert's short-and long-term goals; his discharge and transition plan, including the process for a warm hand-off to Betty and community supports; and an emergency plan, including power backup for Robert's Augmentative and Alternative Communication (AAC) device. Based on Robert's reassessment for his hospitalization and upper respiratory infection, Kyle, in coordination with Brian, revises the PCSP to reflect his current care needs, reviews the timeline for meeting his goals, and asks Robert what changes he would like to make. Kyle has risk-stratified Robert to Level II because of his enrollment in the HCBS Waiver and his chronic long-term needs. To avoid duplication of services, Kyle coordinates with Brian, requests copies of documentation, and invites him to all meetings, reducing Robert's abrasion.

Person-Centered Service Planning

Robert's Short-Term Needs and Goals

Robert and Betty both decide that they want to stay together during her cancer treatments and for the near future; however, Betty's deteriorating condition expedites the need to explore interim and long-term housing solutions as options. In collaboration with the LTSS housing services and supports specialist, Brian assists with connecting Robert to the CDDO, which serves as a single point of entry for coordinating options counseling, residential community options, and other services. We discuss Robert's options for in-home care and Personal Care Services (PCSs) to ease his grandmother's mind and assure them both that they will have the support they need while continuing to live together.

Considering Betty's limitations, Brian discusses the option of transitioning Robert's personal care to a formal agency to reduce caregiving burdens on his grandmother and alleviate her anxiety over his future care. As an alternative, Robert's guardian, Betty, has the option of hiring staff whom Aetna would help pay for their support. Brian helps Betty complete and continually reevaluates the HCBS Needs Tool to adjust PCS hours based on Robert's needs, delineating the services provided. As Betty continues to get sicker, Brian would ask the agency to increase their supplemental day support and PCSs and replace Betty's self-direction with attendant care services, helping to relieve her of her responsibility. Throughout these discussions, **Brian treats Robert and Betty with compassion and, as a unit, listening attentively, reconciling their desires, and allowing them both the opportunity to voice their preferences and concerns.**

Brian assists with access to a mental health Provider to alleviate Robert's worry and grief over the potential loss of his grandmother and only family support. We do a behavioral health referral to support Robert through the emotional circumstances of his grandmother's cancer diagnosis as well as to address anticipatory grief and the impending change in Betty's caregiver role. We help find a therapist who has experience supporting people with disabilities and augmentative communication devices. We discuss and offer grief and bereavement counseling for Robert and his grandmother should they want it to provide them support for the traumatic and life-changing events that they both are facing. We refer Robert to community mental health centers, certified community behavioral health centers, and peer support.

Robert's Long-Term Needs and Goals

Robert has communicated to us that his long-term needs and goals are to live independently, complete his schooling, and obtain employment. Brian documents these in the PCSP for the awareness of the ICT and works with Robert to make certain that all his goals align with the care plan and are **SMART—specific, measurable, achievable, relevant, and time-bound.** Robert has established the timeframe and cadence for these goals and drives them.

Achieving Robert's First Goal: Living Independently

Although Robert has decided to stay with his grandmother, independent living programs allow him to pursue the option of living on his own while reducing the burden of care on his grandmother as her condition worsens. We discuss the possibility of safe, affordable, and accessible housing through our No Place Like Home (NPLH) value-added benefits, which would support Robert in establishing, accessing, and maintaining his new home in the community; the

$5,000 fund from the NPLH grant provides one-time emergency housing assistance that can help Robert pay for first month's rent, furnishings and housewares, and other fees and items. Brian's knowledge of Robert's gaps in family support informs his approach to finding peers and a circle of friends with whom he can share his feelings and develop as a person. In exploring housing options, Brian discusses with Robert to gauge his interest in the possibility of living with a roommate—potentially a fellow student— as an alternative to independent living, to ease his transition into the community as he comes to terms with Betty's diminishing role as his caregiver.

Should Robert decide in the future that he wants to live on his own, we will assist Robert in filling out housing applications and, with written permission from the homeowner, in completing any necessary structural home modifications for physical needs and other conditions through the HOME program. After evaluating the home environment for potential barriers to mobility, we would plan to include ramps, wide entryways, grab bars, and height-appropriate furniture and applications to accommodate Robert's wheelchair usage and reach. Key PCSs would include assistance with IADLs, such as bathing, dressing, grooming, and meal preparation, as well as support in transferring Robert from his wheelchair to his bed or other areas. **Throughout the home planning and modification process, we listen to and implement Robert's preferences.** Brian will make a referral for Robert to the local Aging and Disability Resource Center for further assistance in obtaining access to information and services. We collaborate with the Kansas Association of Centers for Independent Living, which serves as the collective voice for Centers for Independent Living in Kansas and can share resources with and offer skills training and peer counseling to Robert. **These services and partnerships will promote Robert's independence and involvement in the community.**

Achieving Robert’s Second Goal: Completing His Schooling

Because Robert would like to continue his schooling, our team will provide support to help him complete his degree in computer programming. Kyle implements a PASS (Plan for Achieving Self-Sufficiency) plan and connects with university supports to make certain accommodations are in place for Robert; for example, we use VR technology for support during the education process. We engage with LTSS for educational support programs and leverage the WORK program and STEPS pilot upon Robert’s graduation as a bridge to review and provide feedback. We make referrals to community resources for educational needs, such as value-added benefits for Lyft Learning, A Better You, and laptop assistance.

Program or Benefit	Description
Lyft Learning online instruction platform	(Beginning 2025) $25 benefit card for each module completed: communication, resiliency, getting/keeping a job, personal finance and independent living
Over-the-Counter (OTC) benefit	$25 monthly allowance to order OTC drugs and supplies delivered directly to Robert's home
No Place Like Home	Up to $5,000 to support Members like Robert with one-time costs like tenant application fees, security deposits, and first/last month’s rent **Aetna has spent nearly $82,000 on home modifications for our members.**
STEPS	Program available to Kansans living with disabilities to obtain and maintain employment.

Program or Benefit	Description
WORK	Program that allows Kansans living with permanent disabilities to work and keep their health care.

We further support Robert's wish to complete his schooling by referring him to and maintaining his vocational rehabilitation program, which includes educational support services such as the **CampusEd** value-added benefit and **ABLE accounts.** CampusEd offers online education and support to Robert for resume-building and other academic needs. An ABLE account is a savings account for people with disabilities that allows Robert to bypass his $2000 resource limit and save up to $100,000: he can use this money for living, disability, education, and transportation expenses.

Achieving Robert's Third Goal: Obtaining Employment

Our LTSS employment services and supports coordinator, with Kyle's help, refers Robert to vocational rehabilitation and the STEPS pilot, which assists with all elements of the job search and employment, including resume-building and interview skills. It provides access to employment-oriented benefits counseling to educate Robert on the impact that employment has on his SSI and SSDI, including information on the 300% Federal Benefit Rate limit that could affect his HCBS Waiver eligibility. The benefits specialists and the STEPS program manager inform Robert of programs for which he qualifies as well as resources and support for his education and transportation needs. Kyle and Brian coordinate with STEPS to make certain Robert can travel to and from his interviews and his eventual place of work. Within 12 to 18 months of having a steady job, Robert could then transition into the WORK program, which offers all the benefits and services of STEPS.

We also assess Robert for impairment-related work expenses, include him in PASS plans in the workplace and at university, and pursue his eligibility for the Kansas Working Healthy Medicaid buy-in program, which allows him to keep his Medicaid coverage as he enters the workforce. We engage with LTSS for employment support programs and make referrals to community resources for employment needs.

Care Monitoring and Oversight

Kyle and Brian will follow up within 48 hours to complete a face-to-face post-discharge questionnaire for Robert's comprehensive reassessment process, which they initially began with him in the hospital. During the questionnaire, Kyle will confirm that Robert is receiving all authorized and planned services and ask him if he would like to make any changes or additions to the PCSP. Kyle will also review Robert's discharge instructions and confirm the following occur:

- Review of and follow-up on speech therapy, physical therapy, and occupational therapy services
- Enforcement of therapeutic actions to prevent future aspiration if indicated
- Review of Robert's understanding of discharge, nutrition, and medication instructions
- Medications have been received and instructions are being followed
- Formulation of a new care plan, with Robert's signature shared with his Providers
- Follow-up care as directed in the discharge plan

- Assessments of Robert's wheelchair and AAC device
- Completion of the **HCBS Needs Tool** to help determine any change that may need to occur for Robert's attendant care hours

Ongoing Support

We will regularly monitor, reassess, and coordinate with Robert post-discharge. In accordance with **Scope of Service section 7.4.2.3,** Kyle and Brian will reassess Robert's need for services at least 365 days from the date of his last assessment; however, if a significant change in condition occurs, Kyle will reassess Robert within three days and update his PCSP to include new required goals, interventions, or service authorizations, obtaining signed consent from Robert, his authorized representative, Providers, and other relevant parties.

We will continually collaborate and partner with Robert to advance his goals and maintain his independence and well-being. After they have facilitated a smooth transition for Robert from the hospital back home, Kyle and Brian will monitor Robert's home health care and therapy services as well as provide ongoing education and information to Robert and Betty on their conditions and on community resources they can access to manage their health. Brian and Kyle will hold weekly follow-ups with Robert until he is stabilized for a successful discharge, then visit him monthly thereafter. Brian will continually communicate any changes in Robert's health status or care needs to his Providers. As his advocate, Brian will promote Robert's centrality and decision-making in the PCSP.

After being discharged from the hospital, Robert will have options and supports in place for any contingencies. Kyle, in collaboration with Brian and Aetna, will continue to advocate for Robert in his self-directed journey toward recovery and the completion of his goals.

Topic Area 7: Case Scenarios - Billy

30. Billy is a thirty (30)-year-old, white, male KanCare Member currently residing in a skilled nursing facility (NF) as a result of injuries sustained in an automobile accident, including a traumatic brain injury. Billy has been living in the skilled NF for the last 14 months. Billy receives physical and speech therapies but continues to struggle with slurred speech, coordination, and balance. He is eager to move back into his home, eventually go back to work, and “get his life back”.
Billy recognizes that he may still need assistance in order to manage basic needs in his home, but finds being in a “nursing home” is depressing and lonely. In addition to his physical and speech challenges, Billy is overweight and developed a stage 3 pressure ulcer. He also experiences periodic incontinence.
Describe how the bidder will assist Billy in planning for and implementing Billy’s transition, including monitoring post-transition and assisting him to achieve his personal goals.

Introduction

Aetna is member-driven and member-focused as we guide Members through successful transitions from Skilled Nursing Facilities (SNFs) to the community. We are dedicated to helping Billy "get his life back." His ability to transition from his current SNF setting back to the community is crucial to meeting his goals. We are committed to Billy and coordinating the transition from the SNF to Billy's choice of community setting, while encompassing all of Billy's input, needs, and desires throughout and after the transitional process. We **engage, educate, incentivize, and empower Billy** in his health care decision making.

Aetna addresses Billy's whole-person care by evaluating his physical, behavioral, and social needs. Together with Billy, a comprehensive person-centered service plan (PCSP) will be developed that will encompass all of Billy's goals of returning to his home, eventually going back to work, and getting his life back. The PCSP will include goals to support other identified medical needs, such as his slurred speech, issues with coordination and balance, depression and loneliness, weight, stage 3 pressure ulcer, and periodic incontinence. Billy achieves his **goal of returning home through services, benefits, and community resources.** We incorporate his short-and long-term goals and his support system into the service planning process. We will work diligently with the **Interdisciplinary Care Team (ICT),** including Billy's physician, discharge planner, therapists, nurses, Aetna care coordinators, and any friends and/or family that Billy would like to include to plan a smooth transition from the facility to the community. The Member's voice and inclusion in the development and implementation of any care plan/delivery of coordination is included, encouraged, and championed.

Identification and Needs Assessment

Billy was involved in an automobile accident and sustained significant injuries including a traumatic brain injury that has impacted his life significantly. As a result of the sustained brain injury, Billy requires SNF level of care assistance with his daily needs and has resided in a nursing facility for the past 14 months. Our Care Coordination team continuously screens, assesses, stratifies the Member's risk. Our team implements, follows up, communicates, and evaluates Billy's needs, goals, and interventions throughout the care coordination/case management process. The Aetna LTSS registered nurse care coordinator, Amy, is embedded in the SNF and understands the complexity and unique challenges of Members like Billy who

reside in an SNF. She visits Billy in person at least twice a month or more when requested by Billy or the SNF team. She also visits if changes to Billy's condition that warrant additional reassessment exist. Amy attends internal case rounds at the SNF on a weekly cadence. Billy's transition planning started on day 1 of his admission to the SNF.

Upon his admission to the SNF, the local **Aging and Disabilities Resource Center conducted a Brain Injury (BI) waiver assessment.** Since Billy has been in the SNF for 14 months, the original BI waiver assessment is outdated. Amy sends a referral for a new assessment after discussing waiver options with Billy and confirming his decision to pursue BI waiver approval with services in place as part of the transition and post transition plan. Amy, along with the transition of care coordinator, Susan, collaborates with the Kansas Department for Aging and Disability Services (KDADS) with a confirmed discharge date. Once KDADS approves the BI waiver, Amy will initiate **transitional funding** for Billy. These transitional funds are for direct costs incurred by the member accessing the NF diversion program. Billy can use these funds to pay for cover and utility deposits; the purchase of basic furnishings; and other basic living costs.

Amy conducts an **interRAI assessment, health screen tool, health equity assessment,** and a **HCBS Needs Tool.** She completes the assessments with Billy and updates his progress needs, so that appropriate services are in place upon discharge to support a successful transition.

Amy is determined to close any gaps and alleviate barriers to meet Billy's needs and successfully transition Billy back to the community safely. He continues with physical and speech challenges, including slurred speech, poor coordination, and imbalance, and he experiences periodic incontinence. Before Billy's return to the community, the BI Waiver therapy Provider, the Member, care coordinator, and SNF Therapy team will collaborate to assess what therapies Billy will need in the community setting. The BI waiver offers the following therapies to Members:

- Skilled Nursing, including Wound Care
- Personal Care Services
- Home Delivered Meals
- Personal Emergency Response System
- Home Modification
- Transition Living Skills
- Physical Therapy (PT)
- Occupational Therapy (OT)
- Speech Therapy (ST)
- Behavioral Therapy
- Cognitive Therapy

Amy understands that proper treatment of the pressure ulcer is critical to Billy's overall health. Addressing the underlying factors, such as weight and mobility issues, can exacerbate the pressure ulcer or cause more to form. It is imperative to evaluate and address his current complex medical needs, and SDOH needs, to promote a safe and effective discharge transition plan to the community. Due to his slurred speech, he requires a communicative device to assist with communication. Billy requires DME to aid in basic tasks such as bathing, dressing, grooming, and transferring. Billy's home may require modifications for his safety. He also needs incontinence supplies to address his periodic incontinence.

Person-Centered Service Planning

Engage

Billy continues to experience slurred speech, balance and coordination issues, periodic incontinence, and complications from the pressure ulcer at the SNF. Due to these complex needs,

Aetna assigns Lyndsey, a registered nurse, as a secondary case coordinator. Amy explains Lyndsey and her role to Billy, and she assures him that Amy will continue to be his primary point of contact, while he receives in-person and telephonic support from both clinicians. **Amy meets with Lindsey monthly to confirm continuity of care.**

Amy will remain assigned to Billy for a minimum of 30 days post-discharge to assist in a smooth transition for Billy between care coordinators. This process allows for a warm transition in care coordinators, and Amy and Lindsey can collaborate on Billy's needs and work toward a smooth transition from the SNF to the community. The Aetna care coordinators, Amy**,** and Lindsey, also work with the transition of care coordinator, who is also involved with Billy's discharge planning. The Aetna Care Coordination team communicates regularly with the SNF team during the weekly collaborative discharge planning meetings. Collaboration and brainstorming occur during these meetings to also address barriers, gaps in care, progress, housing needs, funding needs, and informal/formal supports.

Amy will update the person-centered care plan based on the reassessment or reevaluation of Billy's needs together with Billy and any other Care Team participants that is part of Billy's ICT. Amy will coordinate with the service Providers to arrange services according to Billy's choice. She will evaluate all supports available, such as family and friends who will serve as informal and formal supports. Due to his current medical condition, Billy will likely require **Personal Care Services (PCS) assistance** with bathing, dressing, grooming, transferring, and mobility due to his continued poor balance and coordination. He will also require **skilled nursing, specifically wound care,** to address his stage III pressure ulcer. Amy educates Billy on his wound care, such as turning frequently, at a minimum of every 2 hours, using pillows when laying down to relieve pressure to prevent further development of the pressure ulcer, and assist in promoting healing. Amy will also discuss how his periodic incontinence could hinder his wound healing and the importance to stay clean and dry with immediate changing of any soiled briefs. Amy will provide written education materials so Billy can review further as needed. He may benefit from **Home Delivered Meals (HDM)** if he is unable to stand for long periods of time, which would make meal preparation difficult. Billy would also need a **Personal Emergency Response System (PERS)** if he lived alone in case of an emergency like a fall.

As the embedded SNF Care Coordinator, Amy discusses the stage III pressure ulcer with the SNF Care team. She submits a potential quality of care concern since Billy developed the pressure ulcer while residing at the SNF. **Amy will collaborate and communicate with the ICT at the SNF in conjunction with HCBS Providers to provide a seamless transition from the SNF to community-based services.** Amy understands that taking a holistic approach in the development of the person-centered service plan includes assessing Billy's mental state and addressing his voiced concern of "depressing and lonely" in conjunction with his physical or medical needs. Amy references Billy's SDOH and uses motivational interviewing to further assess and understand Billy from a biopsychosocial/holistic perspective. This aids Amy's understanding of Billy and his goals, readiness for change, values, and beliefs to develop a holistic care plan together with Billy.

Amy will also evaluate Billy's needs for any DME based on his current needs at the SNF as well as Activities of Daily Living (ADL). During the weekly collaborative discharge planning with the ICT team, Amy will initiate a discussion about Billy's DME needs and determine which is

most appropriate. Billy also has coordination and balance issues and may require assistive devices like a walker, Hoyer lift, shower chair, and/or a bedside commode to aid with mobility and transfers. Due to his pressure ulcer, Amy will also work to secure an air flow mattress for Billy to alleviate the risk of pressure ulcers and aid in his healing. Billy continues to struggle with slurred speech, so a communicative device would assist him with communication at home with friends, family, and Providers.

Amy will complete a comprehensive transition assessment including transition funding, services needed to remain safely in a home, and housing needs. If housing is needed, Amy will engage the LTSS housing services and supports coordinator to help Billy and his support system secure housing for him. If Billy is returning to the home in which he previously resided, Amy will consult the therapists from the SNF to assess Billy's home for any home modifications, which could include grab bars, widening of doorways, and a ramp for the home's entrance. Depending on whether Billy owns or rents the home, Amy may require a written approval from the property owner. The home modification work will also require additional approval.

Additionally, Billy has expressed feelings of depression and loneliness in the nursing facility. He also still requires assistance to manage his basic needs, which is a change in his level of care post-accident. **For this reason, Amy will conduct a mental health assessment to identify Billy's Behavioral Health (BH) needs.** If appropriate, Amy will make a **BH referral** for Billy to support him through the emotional circumstances of his change in health and to address his feelings of depression and loneliness. Amy may refer Billy to **psychotherapy for processing and coping skills.**

Educate

Amy will continue to meet with Billy **at least twice a month** while he is in the SNF to review discharge plans. She will educate him on the services available to him once he returns home. They will explain the duties of the PCS aide who will assist him with his ADLs. Amy will **review a contingency plan** with Billy in case there is a gap in care with PCS staffing. She will include his support system in the conversation, so all involved are aware of the backup plan. She will also educate him on **how to contact emergency services** through his PERS in case of emergency.

Amy will discuss **healthy eating and nutrition** with Billy and educate him on the connection between a good diet and healing of a wound. Wound care will assist with dressing changes and monitoring the pressure ulcer. Amy will also discuss the importance of movement in the healing process and the Therapy team who will conduct PT, OT, and ST in the home weekly. His PCS and informal support system can also help encourage Billy to be as active as he can be safely in the home.

The Careforth app services direct caregivers with coaching, resources, and emotional support to help them better care for their loved one by taking care of themselves.

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Billy would benefit from a conversation about **advance directives.** Amy will explain and provide education materials on advanced life planning, which includes advanced directives and/or guardianship, and encourage Billy to speak with his informal support system about a plan. Guardianship may also be an option for Billy if he is unable to make informed decisions for himself. If applicable, Amy will discuss guardianship with the internal discharge planning team. **Education**

on Careforth will be shared with Billy's support system. The Careforth app and caregiver-centric platform that provides support through health coaches, serves as a resource on various issues and conditions, and connects caregivers to support one another. This HIPAA-secure, mobile, platform is easy to use and available 24/7. It focuses on increasing caregiver engagement on the Member's behalf and reducing caregiver burnout. As the complexity of the Member and burden of caregiving responsibilities increase, caregivers rely more heavily on coaching supports and move to higher intensity program tiers.

Incentivize

To incent Members like Billy to take an active role in their physical, mental, and social well-being, we offer several free and incentive-based programs.

Amy will connect Billy with **Pyx Health, a Value-Added Benefit (VAB)**, to support his BH needs. Pyx Health is a mobile solution that helps to identify and reduce loneliness and social isolation. It connects our most vulnerable Members to critical and timely interventions, as well as addresses SDOH. Billy may also benefit from an age-appropriate support group in his area to build a network of friends.

Billy is overweight and Amy will review options to support weight loss to increase his mobility. Aetna offers a **VAB through Weight Watchers,** a 12-week membership to a weight management class from the University of Kansas Weight Management program addressing healthy eating, exercise, and behavior change that could assist Billy with **healthy eating** and **weight loss.** Billy would have access to the Weight Watchers Weight Management program, in addition to the HDM that he would receive weekly.

Should Billy need additional financial assistance, after using transitional funds, he is eligible for our **No Place Like Home VAB**. This one-time emergency assistance program **provides up to $5,000** to help pay for housing costs such as initial rent assistance, items to purchase for the new home, and other needs for our Members such as: housing application fees, deposits, first month’s rent, past due utilities, furnishings, and housewares.

Empower

Amy will educate Billy on the **Self-Direction Program** and how he can direct his care. Billy would be able to make decisions about the services he received and the individuals who would provide them, including having a choice over who, what, when, and where he would receive services. Amy will expand his knowledge of his options for care so he can make independent and informed decisions. **Amy will also educate Billy on self-advocacy and how he can have autonomy over his care and how his voice can be heard.**

Throughout the discharge planning process, the ICT will include Billy in the discussion and confirm that he has the resources and supports he needs to be successful in the community. Person-centered care is the focus of the planning process. Billy is the decision maker of his care. The ICT will meet with Billy weekly to review the discharge plan and make any necessary adjustments, as warranted.

Care Monitoring and Oversight

Billy has both short-term and long-term goals Amy will address. She will prioritize the goals and plan, the appropriate interventions to meet the goals as well as a timeframe for completion. The goals are member-centric and focused on whole-person care.

Billy's Goals	Aetna's Services and Interventions
Safety	SNF Transition
Family Supports	Caregiver Support
Educational and School Supports	Work VAB and Employment Supports

Short-Term Goals

Billy's **short-term goals revolve around his desire to return home.** He wants to make the transition successful as soon as possible with at least 30 days' notice to the State. Amy will complete the following before or at the time of discharge from the SNF:

- Engage in complex discharge rounds depending on barriers to discharge planning.
- Coordinate with the SNF and Billy's PCP to confirm that all prescriptions will be ready for Billy to take home with him and schedule a follow-up appointment with Billy's PCP.
- Coordinate with the Therapy team to transition PT, OT, ST, behavioral therapy, and cognitive therapy from inpatient at the SNF to in home therapy, provided several times a week.
- Schedule the following HCBS services to start the day of discharge, so there is no gap in care.
  - Skilled Nursing, including Wound Care
  - Personal Care Services
  - Home Delivered Meals
  - Personal Emergency Response System
  - Home Modification
  - Transition Living Skills
  - Physical Therapy (PT)
  - Occupational Therapy (OT)
  - Speech Therapy (ST)
  - Behavioral Therapy
  - Cognitive Therapy
- Confirm that any DME required will be delivered before Billy's return home.

Long-Term Goals

Billy voiced his desire to return to work and "get his life back." Lindsey will help Billy meet these long-term goals over the next 12 months through the following interventions:

- Engage **the adult and employment specialists** to help with goal planning. She will also consider employment strategies as options for continued support, as requested. These provide updated access to all VABs assisting the Member.

Follow-up and Ongoing Reassessments

The care coordinator who is embedded at the SNF, Amy, will remain assigned to Billy for the first 30 days post-discharge. During this time, Amy and Lindsey will continue to collaborate on Billy's care. **A face-to-face comprehensive assessment is completed within 48 hours of discharge from the SNF.** Another assessment will be completed within 30 days of the discharge to confirm that the care plan and service plan meet all of Billy's needs.

Upon a successful transition, Lindsey will relieve Amy as the primary care coordinator. Billy will be stratified as an intensive member for six months post-discharge. Lindsey will maintain contact with Billy monthly to confirm any unmet needs are addressed timely to avoid readmission.

Lindsey will continue to monitor Billy's successful return to the community through face-to-face visits and claims monitoring. She will provide continued support for Billy to access community resources and employment, with a potential move from Medicaid plans.

Outcomes

A positive health outcome is Billy remaining safe in the community setting following a discharge from an inpatient setting, addressing his **whole-person care**. The Care Coordination team will assist with **scheduling routine well visits, promote preventive health measures, and proactively update the care plan** to meet his current and ongoing needs. The success of our Care Coordination team is based on the Member's health outcomes.

A transition from the SNF to the community is a complex operation. It requires a partnership with the SNF staff, well-planned coordination between the Aetna Care Coordination teams, and dedication to the Member's well-being. Health outcomes are improved through exceptional care management, and that is what we provide.

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Topic Area 7: Case Scenarios - Mary

31. Mary is a twenty-eight (28)-year-old, white, female who is incarcerated at a correctional facility serving a two (2) year sentence for a felony conviction. Her estimated release date is in two (2) weeks. Prior to her incarceration, Mary was enrolled in KanCare; however, her KanCare enrollment was suspended upon incarceration. Mary will be a Member of the bidder's plan upon release.
Mary has a history of schizoaffective disorder and substance use (marijuana and alcohol). She has been receiving medication for her mental health condition (Abilify and Depakote) throughout her incarceration but has not received treatment for substance use. Mary does not believe she has had or has a problem with substance abuse, though her prior usage led to her inability to maintain employment and housing.
Mary has “burned bridges” with her family and friends and will not have a place to live upon her release. She is, however, optimistic about her future and is willing to do “whatever it takes” to get back on track.
Describe the bidder's approach to planning for and addressing Mary's needs to support her successful re-entry into the community.

Introduction

After completing her term at the Topeka Correctional Facility, Mary is about to face a series of health care challenges and social issues. Mary's voice will be central to the development of her care coordination plan tailored to her history of schizoaffective disorder and substance use. Our interdisciplinary care team (ICT) prioritizes her choice, and autonomy for making informed decisions based on her self-expressed goals, needs, and preferences.

We are ready to guide Mary through her transition with Charting the LifeCourse, Aetna's whole-person, person-centered planning framework that helps people like Mary develop a vision for a full and meaningful life. Our collaborative path with Mary is built on self-direction, with support from our dedicated Care Advocate Team (CAT) and representative specialists. Our process for supporting Mary through her transition includes the following key resources and approaches:

Primary point of contact: Our Case Manager, Bridget, will serve as Mary's primary point of contact during her discharge and transition process. This role involves close coordination with the Kansas Department of Corrections (KDoC) discharge planner to facilitate a smooth transition from incarceration to community life. Upon Mary's release and initial transition to the community, we will transition the primary point of contact role to Susan, our care coordinator. Susan is a licensed mental health clinician with expertise in behavioral health and SUD, has a strong relationship with community partners, and brings specialized experience in working with individuals reentering society from correctional facilities.

Creating PCSP: Mary's optimism and active engagement play a key role in her recovery and in creating PCSP. Our approach leverages these strengths to develop a care plan with Mary that meets her unique needs and is holistic in scope. Working with Mary, prioritizing and integrating her natural and informal supports, which will be essential for enhancing Mary's long-term prognosis. We will help connect her with community-based resources, including 12-step programs and support groups specifically designed for females with justice involvement.

Integrated Behavioral Health and Physical Health: Together with Mary, we will guide her through a continuum of care, help her manage her medical needs, and prepare her for future challenges. Our approach acknowledges the unique dynamics of the correctional environment and includes early engagement to coordinate the resources needed to support Mary.

Connections to community services: Our PCSP is tailored to assist Mary in securing stable housing, identifying employment opportunities, and connecting her with community-based support services. We will also focus on linking Mary with organizations in Topeka, Kansas, specializing in reintegration support for individuals leaving correctional facilities.

Mary will be initially supported in Level III Care Coordination using **our One Team, One Member** model. Her team includes a pharmacist, medical doctor, BH medical doctor (psychiatrist), registered nurse, Community Health Workers, and CAT specialists, all specifically skilled to align with Mary's unique history with her aspirations.

Pending the warden's approval and Mary's agreement, we will arrange for a face-to-face or virtual planning meeting with Mary to begin coordinating services that will meet her needs upon her release. These efforts align with our commitment to providing Mary with a stable foundation as she embarks on her recovery journey.

Identification and Needs Assessment

Intake

Upon receiving notification of Mary's release by the Topeka Correctional Facility, we initiate our intensive pre-release planning meeting with Mary and begin coordinating services as much as possible before her release. We will assign a case manager to coordinate Mary's discharge planning with the KDoC Discharge Planning team and participate in all transition planning meetings. At this point, our primary goal is to quickly establish a rapport with Mary and support her transition from the facility and integration into the community. In line with our experience and success with Oxford House and CKF Addiction Treatment, we will help Mary access transitional living arrangements and introduce her to the concept of a sober living environment.

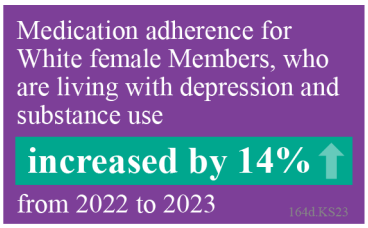
Consistent with our comprehensive care philosophy, we acknowledge the pivotal role that a recovery-oriented living situation plays in reducing Mary's risks and increasing her chances of improving her health. Our ICT will actively support Mary as she explores her living options, assisting her in the application process for suitable sober living arrangements. We will make sure Mary's input is central to every step of the planning process, addressing the stigma and risks related to a female returning to the community from incarceration.

Assessment

As Mary steps into her chosen community of Topeka upon her discharge, our ICT will prioritize a thorough health risk assessment to identify Mary's needs, aligning with her goals and preferences across various domains, including medical, behavioral health (BH), housing, and employment. This comprehensive assessment, conducted at the beginning of her reentry process, is critical in understanding and addressing all of Mary's goals, needs, and priorities. We will introduce Mary to a Provider like **Valeo Behavioral Health Care in Topeka, a Certified Community Behavioral Health Clinic (CCBHC),** while emphasizing her autonomy in

choosing Providers. This approach reinforces that Mary is fully informed and comfortable with her mental health care options and reinforces her ability to make independent choices. Further, our assessment process is grounded in building trust and rapport with Mary, respecting her wishes and perspectives on her recovery journey. This detailed assessment, will give us a deeper understanding of Mary's unique situation, allowing us to tailor our support and services to her specific circumstances. We will focus our efforts on identifying Mary's needs, linking her to Providers, providing her with high levels of support and encouragement, and reinforcing that change is possible.

In consideration of Mary's treatment history and respecting her autonomy, values, and choices, we will present her with an array of treatment options. We will facilitate a discussion for Mary to explore the possibility of using a long-acting injectable regimen with her BH physician, presenting it as one of several options to support her consistent adherence to her medication management plan. Our approach supports and empowers Mary to make informed decisions regarding her treatment, a critical component in helping her manage her schizoaffective disorder. Simultaneously, we will use Motivational Interviewing to work to understand and address Mary's substance use. These techniques have been shown to help people like Mary acknowledge and understand her substance use issues, fostering a more receptive attitude toward treatment and support related to her marijuana and alcohol use.



Peer support will also be a critical element of her recovery, offering Mary a relatable and well-structured support system. We will help build and encourage Mary to use a peer support program that includes individuals with similar experiences and structured meetings and one-on-one mentoring. This support will be foundational as she moves toward stability and health. Peer support specialists, particularly those who share similar backgrounds and experiences will support Mary in locating, engaging, and staying connected to the local recovery community.

To complete our assessment, we will evaluate the need for metabolic monitoring, as well as actively involve Mary in discussing and understanding the importance of this monitoring to her overall health. This approach will help us identify and respond to potential health concerns and empower Mary with knowledge to support her active participation in her health care.

Person-Centered Service Planning

As Mary prepares to leave the Topeka Correctional Facility, we have already assigned Bridget, a female case manager, with the assistance of our CAT (e.g., transition of care coordinator, housing specialist, recovery/resiliency administrator, and adult administrator) to begin planning and identifying services that will help Mary transition into the community. Bridget will collaborate with the KDoC transition team and Mary's parole officer to prepare for Mary's discharge. This preparation involves identifying and documenting Mary's risks of recidivism and needs associated with reentry. Bridget will facilitate a seamless transition by working closely with Mary and our ICT. In addition, we will incorporate key elements of evidence-based practices from SAMHSA into Mary's treatment plan, as outlined in the following bullet list, to further support her successful reintegration into the community.

- **Medications for Opioid Use Disorder and Alcohol Use Disorder:** Explore potential medication options, emphasizing informed choice in her treatment plan.
- **Care Coordination:** Continue with the detailed approach, focusing on tailored care and coordination across different service Providers.
- **Peer and Patient Navigation:** Implement a peer support program with regular meetings and personalized support, aligned with Mary's preferences.

Pre-Release Preparation (Two Weeks Before Release)

Typically, our in-reach and reintegration planning will start a few months in advance of release. However, given the shortened timeframe of two weeks before Mary's release, we will intensify our efforts and make sure Mary is actively involved in the decision-making process. Once we have been notified of Mary's release date by the KDoC, we create an Interdisciplinary Care Team (ICT) to initiate in-reach services and thoroughly assess Mary's health status, skills, educational background, and social needs. We will partner with Mary to develop strategies and coping skills to manage her BH symptoms and ways to increase her motivation to engage in community-based recovery services. We will also formulate a plan to address her SDOH needs and cultivate a supportive social network that aligns with her values and choices with a goal of building a robust natural support system. This collaboration will include discussions about her past experiences, current interests, and aspirations, which are critical for creating an effective reentry plan. This team will also start their coordination efforts with our housing CAT specialist to identify a transitional living space, actively involving Mary in selecting her living environment to meet her needs and preferences. We will also assist Mary in arranging NEMT, so she has reliable transportation to all necessary post-release appointments, while actively involving her in the planning to support her sense of independence and agency. Finally, this process will include a strong focus on Mary's SDOH needs and supported by our Kansas SDOH team to confirm a comprehensive approach to her reintegration.

Release Month

Week 1: Immediate Post-Release Transition

The first week following Mary's release is a crucial period for her to establish stability and avoid relapse. Bridget, who has been actively involved in Mary's pre-release discharge planning with the KDoC Transition team on all areas of Mary's transitional needs, facilitates a smooth transition from the Topeka Correctional Facility. This seamless transition is further supported as Mary transitions from Bridget to her new care coordinator and ongoing point of contact within Aetna, Susan, confirming continuity in care without any break. This change is a planned part of Mary's reintegration process, designed to provide specialized post-release support.

Together, Susan and Mary confirm Mary's choice to transition into the Oxford House sober-living home that provides a recovery-supportive environment. Susan coordinates medication pickups and works with Mary to make sure she understands and is comfortable with her medication regimen. Simultaneously, our CAT housing specialist, in collaboration with Susan, works with Mary to connect her to Oxford House and provide the necessary support to help Mary connect with and succeed in this program.

Week 2: Establishing Health Care and Support Systems

By the second week, with Mary's input, our ICT is expanding our focus on Mary's health care needs. Before Mary's release, we jointly discussed and then we scheduled several appointments to support Mary's continuity of care. Immediately upon her release, we introduce Mary to a peer support worker and connected her with peers who have been formerly incarcerated, recognizing the importance of these connections right from the start of her reintegration journey. In addition, these appointments include a meeting with a mental health provider, chosen based on Mary's preferences. We expand upon Mary's peer support by confirming she has a dedicated Alcoholics Anonymous buddy from Day One, reinforcing her commitment to sobriety and providing immediate, relatable support. Furthermore, with guidance from our CAT recovery/resiliency administrator and discussions with Mary, we facilitate her entry into a structured outpatient substance use program. We support Mary's involvement in this entire decision-making process and for joining 12-step support groups, reinforcing her commitment to sobriety and mental health stability. We also work to enhance Mary's peer support by introducing her to Pyx Health, which includes a mobile app and a compassionate call center, to support her emotional well-being. This approach makes sure Mary has a comprehensive, relatable, and supportive network.

Week 3: Vocational Planning and Skill Building

As Mary settles into her new routines, week 3 shifts the focus to her future. Susan and our CAT employment specialist assist Mary with exploring vocational counseling and employment services and completing an online application with Vocational Rehabilitation. Together, they identify career paths and training opportunities that align with Mary's interests and aspirations. This collaborative approach is designed to establish a path for Mary's economic independence, making certain that her strengths and preferences guide her professional development.

Week 4: Consolidating Gains and Planning Ahead

In the final week of the month, as part of our Level III Care Coordination, we look to reinforce the gains Mary has made. These efforts include a monthly interval assessment and PCSP review, by our ICT, to confirm the plan's ongoing effectiveness and relevance. During Mary's regular follow-up sessions with Susan, we pay special attention to Mary's emotional well-being, verifying that her treatment plan is responsive to her current emotional state. In addition, our CAT employment specialist provides referral resources and helps Mary effectively use community-based resources, including workshops for resume-building and interviewing skills. These resources are proposed to Mary to improve her professional skills and to strengthen her emotional resilience and support network. This week is about reinforcing her support network and preparing Mary for her long-term stability and health, with a particular focus on confirming her emotional needs are met and that she feels supported every step of the way.

Month 2: Strengthening Foundations

During the second month, we will facilitate a person-centered face-to-face visit between Mary and Susan or a documented contact with Mary from a member of our ICT every 60 days to maintain consistent and personalized support. Mary also continues to participate with her chosen substance use treatment program, collaboratively working on developing coping strategies for triggers and stress management. In her vocational training, which is tailored based on her interests and aspirations, she is investigating internships and part-time work to gain valuable real-world experience. Additionally, Susan introduces Mary to the Consumer Credit Counseling

Service and their online financial education resources, empowering her to learn and manage her income effectively and plan for her future with guidance and support related to her needs.

Month 3: Evaluating Progress and Addressing Challenges

During month three, Susan continues to collaboratively evaluate Mary's progress while making sure Mary's voice is central to the assessment. Susan focuses on supporting Mary's unique recovery journey, prioritizing physical health and behavioral health integrative service coordination, and promoting the development of Mary's robust social support system. Early in the month, Mary encountered a significant but common challenge in her recovery journey—a relapse. This relapse occurred despite her committed participation in regular 12-step meetings and consistent peer support.

Upon learning of this relapse, our ICT, led by Susan, responded swiftly with understanding and compassion. Recognizing relapse as a potential part of the recovery journey, our ICT worked with Mary to identify her relapse triggers and reinforce her coping strategies. Susan uses active, empathetic listening to convey her understanding of Mary's unique struggles and normalizes to Mary that relapse is often a part the process of achieving sustained, long-term recovery. In a collaborative meeting, Mary and the ICT reassessed her treatment plan, with emphasis on understanding and support while reframing the relapse as a learning opportunity to better inform Mary's overall recovery journey. In addition, Susan reached out and collaborated with the KDoC team and Mary's parole officer to coordinate additional supports, services, and other resources to prevent Mary's reincarceration due to any potential and future parole violations.

Month 6: Midterm Review and Adjustment

Halfway through the year and building on Mary's progress, Susan and Mary jointly lead a review of Mary's care and recovery plan, with participation from the ICT and other stakeholders, including Mary's parole officer. This process involves celebrating Mary's achievements and addressing any setbacks. Together, the group collaborates to adjust her current goals and to set new goals, confirming that these new goals align with Mary's aspirations and needs. They jointly assess her employment status, the effectiveness of her health management strategies, and her satisfaction with the support she is receiving, actively involving Mary in the decision-making process. This collaborative review serves as a critical checkpoint to confirm that Mary's journey toward sustainable independence is on track and aligns with her evolving goals.

Month 12: Annual Evaluation and Planning

At the 1-year mark, Mary plays a central role in our annual evaluation, which is conducted with Susan and her ICT. Together, they measure long-term outcomes such as Mary's sobriety, mental health status, and vocational progress. Throughout the year, Mary has discovered a keen interest in graphic design and has successfully completed a certification course in this field, with help from Vocational Resources and a grant from Level Up Kansas. This new skill set has led to her initial success in securing part-time employment at a local design studio, a significant step toward her vocational aspirations. Based on this collaborative assessment, incorporating Mary's aspirations such as further developing her graphic design skill and exploring career advancement opportunities within the creative industry and transitioning to independent living if appropriate. The plan also includes making certain Mary has a robust relapse prevention strategy in place and understands how to access support whenever needed, thereby maintaining the positive

momentum she has built throughout the year. This evaluation and planning process emphasizes Mary's active participation and self-directed choices, confirming her empowerment and alignment with her personal goals.

Incentivize

Susan, our care coordinator, will guide Mary in accessing and utilizing her value-added benefits, making sure they are integrated into her daily life and support her recovery and community reintegration. These benefits will help, which are listed in the following table improve her well-being and to support her care needs.

Value-Added Benefit	Scope of Benefit
No Place Like Home (NPLH) Program	Provides up to $5,000 for housing-related costs including rent, utilities, furnishings, and housewares.
Pyx Health	An app offering chats and resources to combat loneliness. Since the 2022 inception of Pyx Health in Kansas, 1,924 Members have been onboarded to Pyx Health with Aetna contributing over $238,000 to support these Members.
Over-the-Counter (OTC) Items	$25 monthly allowance for select OTC items available for order and home delivery.
CampusEd	Access to over 3,000 job skills resources, resume assistance, and access to a local employer network. As of Dec. 1, 2023, Aetna has contributed $45,612 for 181 units of CampusEd services.
Legal Services for housing	Legal aid for housing issues like eviction, tenant problems, and record expungement.
Lyft Learning	Online learning modules with $25 incentives covering key life skills.
Laptop	Provides laptops for Members entering the workforce and/or completing continuing education.

Care Monitoring and Oversight

Our ICT, under Susan's leadership, is committed to empowering Mary in her reintegration. Through engagement with Mary, we understand her preferences and aspirations. Utilizing insights from the stakeholders and our ICT, including CAT specialists, we provide a personalized approach that integrates physical, mental, social, and environmental aspects focusing on quality, whole-person care. This approach fosters Mary's autonomy and supports her identified need for a supportive circle, an essential element of her successful reintegration into the community.

Physical Health: In collaboration with Mary, Susan conducts a comprehensive health assessment the first-week post-release to address Mary's immediate health concerns and they jointly review her medication regimen, including Abilify and Depakote. We monitor and support her uninterrupted access and adherence to medication through coordinated pickups, confirming Mary's active involvement in managing her medication. Susan and our ICT monitor and support Mary's medication compliance and any needed metabolic testing due to her specific medication regimen. Additionally, we track her attendance to scheduled health appointments, facilitated by NEMT services, while verifying Mary's active engagement in her health care decisions.

Mental Health: Understanding the importance of mental health in Mary's reintegration, we collaborate with her to maintain regularly scheduled appointments with mental health professionals of her choice. Together, Susan and Mary track these appointments to support her access to consistent and personalized care. An initial assessment, actively involving Mary, is administered in the second week post-release to evaluate her mental health needs and align them with her preferred treatment for schizoaffective disorder.

Substance Use: We will work with Mary to manage her substance use within an integrated treatment framework, supporting her choices and engagement in counseling and group therapy. We will support her in the use of medication-assisted treatments, with a focus on empowering her to make informed decisions and take an active role in her care.

Social Network: Recognizing Mary's need for a social support system, we will partner with her in rebuilding and strengthening both her family and community relationships. Soon after Mary's release, our CAT specialists will facilitate and guide her involvement in peer support groups and use community-based resources, confirming Mary is integral in the selection process. Additionally, Mary will benefit from Pyx Health's Compassionate Call Center and mobile app, offering personal emotional support that complements her community and peer engagements. These efforts align with her preferences and comfort levels while fostering her independence. In line with the Kansas Department of Corrections' risk reduction and reentry strategies, we focus on the critical role of social networks in successful reintegration.

Environmental factors: Mary's immediate need for stable housing stands as a priority within our oversight plan. Working collaboratively with Mary, we will identify and coordinate with transitional housing resources of her choice to make sure she has a secure place to call home. We will also connect her to community-based supports that align with her reintegration goals and preferences, thereby bolstering her efforts toward a successful reintegration. Our focus includes supporting Mary in all aspects of maintaining stable housing.

Outcomes

In the evaluation of Mary's reintegration plan, we will utilize multiple metrics to inform our measures of success. These metrics are not only tied to the activities outlined in the integrated planning and coordination efforts but are also closely aligned with Mary's own stated goals, needs, and priorities. Earlier in the planning process, we identified and documented Mary's personal objectives, which include her aspirations for social reintegration, vocational achievements, and mental health stability. These metrics and measures reflect our commitment to Mary's progress and our accountability to the state of Kansas. They are designed to be ambitious yet achievable, confirming we provide a high standard of care coordination that is deeply centered on Mary's active participation and evolving personal goals. Regular review of these metrics in collaboration with Mary will allow us to adjust our strategies as needed to align with both Mary's evolving goals and aspirations, and the State's expectations for quality care delivery.

Evaluation Metrics and Measures

Medication management: We measure Mary's adherence to her medication regimen, while confirming her understanding and comfort with the regimen. Our measure of success, collaboratively determined with Mary, is maintaining a 90% adherence rate within the first three

months, indicating consistent medication intake and her active participation. Long term we aim for an 85% adherence rate to all scheduled health care appointments over six months.

Mental health engagement: Our metric, developed in consultation with Mary, is the attendance rate at scheduled mental health appointments. The corresponding measure, reflecting Mary's involvement in her care, is her participation in 80% of her planned mental health evaluations and therapy sessions within the first month, confirming that these appointments align with her preferences and needs. We evaluate Mary's long-term adherence to her PCSP by involving Mary in setting and maintaining these goals,

Substance use recovery: We will work with Mary to manage her substance use within an integrated treatment framework. Our metric involves monitoring her involvement in counseling and group therapy of her choosing and supporting her use of medication-assisted treatments. In line with our commitment to providing comprehensive care, we will recommend Mary consider using telehealth services as part of her recovery process. Should Mary choose this option, we will facilitate access to CKF Addiction Treatment's telehealth services, which offer support for individuals managing addiction and substance use. The goal is her commitment to attend at least one activity or group session per week over the course of the year.

Social and community integration: This metric, based on Mary's comfort and choices, is the number of peer support meetings she attends. Our target measure, agreed upon with Mary, is her involvement in at least two peer support activities per week by the end of the first month, making certain these activities resonate with her social preferences and recovery goals. Our long-term target is a 50% increase in her social interactions by the end of the year, making certain these activities are meaningful and supportive of her recovery.

Housing stability: Our metric, reflecting Mary's choice of living situation, is the duration of stay in transitional housing. We measure this by aiming for no unplanned moves within the first three months, making certain that the housing aligns with Mary's needs and provides a stable and supportive environment.

Employment and economic independence: We measure the acquisition of employment or active engagement in vocational training, making certain these opportunities align with Mary's career aspirations. Our goal is to support Mary in securing a job or internship within six months that resonates with her skills and interests.

Concluding Remarks

Our yearlong whole-person, PCSP, represents a dynamic and evolving process, aligned with Mary's personal journey and changing needs. Using regular assessments and feedback, and particularly Mary's self-reports, we confirm our approach aligns with her evolving needs. Mary's active participation and dialogue with Susan have made her feel supported, empowered, and heard. By working together, Mary overcomes her substance use challenges and avoid reincarceration. We consistently use evidence-based practices, such as those available from Substance Abuse and Mental Health Services Administration to make certain Mary receives the highest standard of care. It is our unwavering commitment to service enhancement that allows us to adapt our strategies to meet Mary's needs as she grows in self-reliance and health.

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Topic Area 7: Case Scenarios - Pedro

32. Pedro is a seventeen (17)-year-old, Latino, male KanCare Member living in foster care. Pedro was diagnosed with asthma at four (4) years old and uses an inhaler to manage his symptoms, with varying success.
At his last health care visit, Pedro and his foster mother shared with Pedro's Primary Care Provider (PCP) that Pedro is having more difficulty breathing and more frequent asthma attacks. When the PCP inquired about the precipitating circumstances, the PCP learned that the breathing problems and asthma attacks have been occurring when Pedro is at home — not at school or other locations, leading his PCP to think that there may be an environmental trigger in the home.
Pedro has had four (4) ED visits in the last 12 (12) months due to his asthma. Pedro's case file also states he experienced significant physical and emotional abuse during his early childhood, resulting in his placement in foster care. Pedro was once active in school and extracurricular activities but recently has become more withdrawn, leading his foster parents to suspect marijuana or other substance use, which they have expressed to his PCP.
Pedro's PCP has contacted the bidder's Care Coordination team to request assistance with assessing and addressing the potential environmental trigger exacerbating Pedro's asthma, and to make the care coordinator aware of Pedro's possible behavioral needs.
Describe how the bidder will respond to the PCP's request and how the bidder will support and coordinate Pedro's health needs.

Introduction

Our Member, Pedro, is a 17-year-old Latino living in foster care in rural Kansas. Pedro is on the precipice of many life-changing experiences, including graduating from high school. He has a perceived lack of resources for further education and training. Pedro was diagnosed with asthma at 4 years old and uses a rescue inhaler to manage his symptoms, with varying success.

Upon identifying Pedro's visits in our proprietary ED Dashboard, our Interdisciplinary Care Coordination (ICC) team engaged with Pedro and his foster parents to provide supportive care coordination. Approvals for care coordination services were not previously obtained from Pedro's Foster Care Case Management Provider (FCCMP). As a result of Pedro's visit with his PCP, the PCP's outreaches to Aetna's ICC team for assistance in assessing potential environmental triggers in Pedro's foster home that may be exacerbating Pedro's asthma. The PCP also requests assessing triggers related to Pedro's recent behavioral changes and possible substance use. Pedro, his foster parents, and his FCCMP agree to meet in-person with our care coordinator.

Our goals for Pedro's health and wellness align with the state of Kansas' vision for KanCare including collaboration and partnership between the State, contractors, Members, and Providers to achieve optimal health outcomes for Members, "Partnering together to support Medicaid Members in achieving health, wellness, and independence for a healthier Kansas." Goals for Pedro, in addition to safety and crisis planning, are described in the following table, and align with the State's KanCare goals.

Goals	Plan
Improve Pedro's experience and satisfaction.	• Educate, engage, and empower Pedro to personally define his health and wellness goals. • Proactively solicit feedback from Pedro and his foster family to improve the health care delivery system and Member satisfaction.
Improve health outcomes by providing holistic care to Pedro that is integrated, evidence-based, well-coordinated, and recognizes the impact of SDOH.	• Provide integrated, whole-person health care, including physical health services, Behavioral Health (BH) services, and promote independence and wellness. • Expand the use of evidence-based practices and services shown to provide optimal health outcomes. • Provide appropriate levels of person and family-centered care coordination to support timely access to necessary services, continuity of care, and effective of services.
Increase the use of cost-effective strategies to improve health outcomes and the service delivery system.	• Encourage and incentivize Pedro's engagement in wellness and prevention services to adopt and maintain healthy behaviors and prevent more serious health care conditions.
Leverage data to promote continuous quality improvement and achieve KanCare program goals.	• Consistently and frequently examine quantitative and qualitative data and information obtained through a variety of sources to evaluate the effectiveness of the strategies employed to achieve program goals, identify opportunities for improvement, and adjust strategies to incorporate results and lessons learned.

All care management functions, including requirements specific to the foster care population with complex/high or moderate needs who do not meet the criteria for a HCBS waiver or Serious Emotional Disturbance/BH services, shall be performed by Aetna as described in the KanCare Medicaid & CHIP Request for Proposal (RFP), Attachment L, Item 8.

Identification and Needs Assessment

Our ICC team immediately assigns a care coordinator, Angie to support Pedro's health and wellness. Angie resides in the same community as Pedro and his foster parents, which enhances service delivery by making sure that certain cultural and linguistic preferences are met. Angie has extensive experience working with youth in foster care and demonstrated experience working in the foster care system with Department of Children and Families and FCCMPs. She knows how to obtain approvals and coordinate health care services needed by foster children including physical health, BH services, care coordination, and SDOH to support and promote independence and wellness. Aetna makes sure care coordinators and Community care coordinators who are working with youth in foster care are trained and aware of the responsibilities of FCCMPs versus the foster parent in making decisions on behalf of the child. Angie will use person-centered, evidence-based medical, behavioral, functional, and social assessments to develop a holistic care plan for Pedro that is integrated and recognizes the impact of SDOH.

In accordance with **RFP section 7.4.7 E. and F.,** Angie is a registered nurse with three years' experience as an Aetna care coordinator. We engage Members to amplify their voices. All care coordinators are trained in Motivational Interviewing, trauma-informed care, and Mental Health First Aid to provide them with the tools they need to understand a Member's life experiences and needs. This understanding results in increased Member engagement, treatment adherence, and health outcomes.

Our care coordinators are supported by Aetna clinical experts and professionals, integrated teams, and support staff for consultation, resources, and if necessary, direct engagement with Pedro and his foster parents to support timely access to medically necessary services and supports. Care coordinators partner with local Providers and support systems to quickly address Member needs and integrate cultural humility into our practices. We leverage Aetna's Foster Care Center of Excellence based on its national footprint providing oversight, consultation, and technical assistance to various state-level foster care programs, serves 1.3 million children under 21 years of age, and sets the gold standard for all foster care programs represented by Aetna Medicaid. The Foster Care Center of Excellence provides guidance on proven programs such as transitional care for foster children who are aging out of the program and innovative ideas, such as foster care "toolkits", and trains care management teams that serve foster care members across all Medicaid markets.

Within 24 hours of her assignment, Angie contacts Pedro and his foster parents by telephone to schedule an in-home, in-person meeting for the following evening. She advises them the meeting may take a few hours and will allow them to ask questions, discuss, sign releases of information forms, update Pedro's state-developed Health Screen and Health Risk Assessment (HRA), and identify and complete needs assessments while in the home.

To prepare for the in-person meeting, Angie reviews Pedro's prior Health Screen, HRA, utilization management (UM) and historical claims data in FamilyCare Central, our proprietary member and care coordination portal. FamilyCare Central is accessible to a Member's care circle, including the Member, caregiver, Providers, care coordination and management entities, MCOs, and state case workers. Populations supported include transitional aged and foster youth. The portal also provides easy access to physical, BH, and pharmacy claims, as well as lists of medications prescribed for multiple conditions by all Providers. It shows referrals to community outreach programs based on individualized needs. It provides Member profile pages that include care coordination scoring, stratification, and risk tiering as Members move between care coordination intensity levels based on their needs.

Angie outreaches to collaborate with the FCCMP to improve Pedro's health and well-being. Given Pedro's long history of foster care, Angie emails Aetna's foster care coordinator and Pedro's FCCMP to update them regarding Pedro's circumstances and changing needs. She also asks them to identity Pedro's authorized responsible party. She requests the FCCMPs attendance at the upcoming in-person visit with Pedro and his foster parents. Angie also requests authorization to review Pedro's available records, including any transitional age youth independent skills training records.

Aetna is in a unique position to help Kansas youth prepare to live their best life. Aetna offers our recommendations for Kansas' youth transitioning into adulthood by leveraging experience

gained in nine states: Kentucky, Arizona, Kansas, Louisiana, Maryland, Michigan, New Jersey, Pennsylvania, and Virginia. We support the development of the youths' transitional care plan and develop services and supports that build skills and knowledge that improve the youths' ability to carry out his or her personal plan for their future. We also support Kansas foster youths' growing independence and provide an array of services that will guide and encourage new skills while helping youth develop a cushion of support. It is crucial that youth Members receive support and services to guide them through the transition process well before they leave care, beginning in adolescence or even earlier. Aetna's model for transitional services embodies the understanding that preparing for adulthood does not occur overnight and should not wait until youth are ready to age out to begin transition planning.

Angie, assigned care coordinator, offers education and assistance to the PCP and his staff in navigating Aetna's UM process to obtain authorization for an environmental assessment of Pedro's foster home. Angie requests that the PCP schedule a follow-up appointment with Pedro for consideration of a medication "step-up" to improve control of his asthma, and collaboration in the development of an Asthma Action plan upon completion of environmental testing. Angie discusses the *2020 Focused Updates to the Asthma Management Guidelines: A Report from the National Asthma Education and Prevention Program Coordinating Committee Expert Panel Working Group* with the PCP and provides action plan examples from the National Institutes of Health and the Asthma and Allergy Foundation of America. She offers to connect the PCP with Aetna's chief medical officer in the event he has any questions regarding Aetna's resources and findings. Finally, Angie asks about the status of Pedro's EPSDT screenings, well-child visits, immunizations, and referrals for follow-up care such as dental screenings, BH services and SUD services.

Angie reaches out to Pedro's school counselor to schedule an appointment to discuss how Pedro is doing in school, how his current behaviors may be affecting his academic performance, and the participation of the counselor, the school nurse, and Pedro's teachers on his ICC team. Angie provides a release of information to the school after meeting with Pedro and his guardians.

The next day, Angie, and Pedro's FCCMP, arrive for their in-person visit with Pedro and his foster parents in their home. Angie completes a safety and home assessment. Upon inquiry, no one in the home smokes and the family is careful about the use of cleaning products that may trigger Pedro's asthma. They do not have pets or a wood burning fireplace.

Pedro is soft-spoken. Angie explains the purpose of her visit, describes the benefits of care coordination, and her role in coordinating Pedro's health care. Pedro's foster parents ask a few procedural questions after responding to Angie's questions. Angie begins to ask Pedro and his foster parents questions to complete the health screen. Angie uses motivational interviewing and takes a trauma-informed care perspective to engage with Pedro and his foster parents. She uses active listening, empathy, and unconditional positive regard, and open questions to build rapport and learn more about Pedro and his foster parents' perspective on the family's needs and goals. Angie asks whether Pedro needs any special accommodations for health appointments, for example if Pedro requires interpreter services, or sedation for routine dental care. Although no special accommodation is identified, Angie provides information on how to access accommodations and offers to assist Pedro in arranging accommodations, if needed.

As a result of BH needs identified during Pedro's health screen, Angie is required to complete an HRA during the visit. Angie explains the purpose of the HRA to Pedro and his foster parents. Angie completes the HRA including the HRA elements in Appendix F of the KanCare Medicaid & CHIP RFP. The HRA determines the types of needs assessments (NAs) warranted by Pedro's health status, including a physical health NA for his asthma, a State prescribed tool for the assessment of BH needs, and a Health Care Equity NA. Angie completes the identified assessments in-person during the visit. Angie schedules a follow-up visit to complete additional NAs that target specific populations such as Foster Children and Children with Special Health Care needs including the Adverse Childhood Experience screen, Trauma Screening Questionnaire, and CRAFFT screener (current or history of substance use) within the next 14 days.

After completing the Health Screening Tool, HRA, and NAs, Angie offers health education about asthma; understanding and controlling some of the common pollutants found in homes; avoiding asthma triggers such as mold, dust mites, pet dander, and secondhand smoke; the importance of improving the air in the home through ventilation; the use of air purifiers; and humidity control. She provides Pedro with education materials including health sheets, videos, and prescribed drug reference materials. Angie offers to drop off an air purifier for Pedro's bedroom, she explains that air purifiers are a value-added benefit (VAB) available to Members diagnosed with asthma.

Angie also shares information about wellness services, EPSDT, VAB, and enhanced benefits for SDOH needs, consistent with the State's desire for cost effective interventions. Additionally, she discusses appropriate ED utilization and recommends other resources such as prevention of known asthma triggers, contacting our nurse line, Pedro's PCP, and urgent care as ED alternatives. **Our Aetnalytics Hub provides a centralized and comprehensive library of dashboards and reports that provide informative data supporting Member health outcomes. In 2023, 77% of Kansas Members that used the nurse line were diverted from the ED to more appropriate care options.** Angie recommends connecting Pedro with necessary resources, including transportation assistance to and from health care appointments, and assistance with appointment scheduling, tracking referrals, and

Reduction in ED Use
From July 1, 2022 to June 30, 2023, Care Coordinated Members' ED use considered avoidable was 16% less than the rate of Members not engaged in Care Coordination. 145a.KS23

Angie solicits feedback from Pedro and his foster parents to improve his health care delivery system. Angie shares her commitment to educate, engage, and empower Pedro to personally define his health and wellness goals. Angie emphasizes Aetna's commitment to Member voice and choice; Pedro's choices and health and wellness goals will be respected. Angie describes the possible membership of Pedro's ICC team to include Pedro's PCP, specialists, his choice of community health workers (CHWs), peer support specialists, housing specialists, educators, school counselors, social workers, state foster care representatives, BH Providers, Aetna representatives, his care coordinator, Pedro's foster parents, and other participants selected by Pedro, such as a biological parent. Angie reminds Pedro he can choose ICC team members and his health and wellness goals.

During this conversation, Pedro discloses his use of marijuana. Pedro reveals he is depressed and anxious about his future. He states he has no resources to further his education, fears he will not

be able to find employment after high school, and will live in poverty or become homeless. Tearfully, he shares that smoking marijuana relieves his anxiety and helps him forget about his past and future. He also says after using marijuana he often has feelings of hopelessness and depression, social isolation, impaired memory, and difficulties paying attention during class. He says he has lost interest in activities he previously enjoyed. Pedro also says he thinks marijuana makes his asthma worse. He does not want to continue using marijuana, but it does provide him with a temporary escape. Pedro's foster parents are unhappy with Pedro's choices but express their love and support for Pedro. They do, however, make it clear to Pedro that his continued use of marijuana is not acceptable.

Angie describes steps Pedro can take and points out he is likely self-medicating his underlying depression and anxiety. Angie notes she will connect with Aetna's recovery and resiliency team for support and actively coordinate referrals for Pedro with a local Certified Community Behavioral Health Center (CCBHC) for BH and SUD assessments. Angie also provides additional options for Pedro and his foster parents including Twelve-Step meetings and Al-Anon (for his foster parents). Angie shares recommended pathways to address Pedro's depression and anxiety including counseling with a BH clinician and a psychiatric evaluation to determine the efficacy of psychotropic medication. Angie identifies supports for Pedro's foster parents, including education, family therapy, and community resources. Angie begins creating a comprehensive safety plan with Pedro and his foster parents. It includes Pedro's strengths, social supports, triggers for cannabis use and depression, coping skills, and identification of community resources.

Value Added Benefit: **Air Purifiers**

Since 2020, Aetna supported 183 unique Members with a total spend of over $454,498.

132b.KS23

Angie describes the benefits of care coordination for Members like Pedro in need of more frequent, intensive coordination and support for complex health care needs. For example, **our Aetnalytics' Hub dashboards provide data that shows Members engaged in care coordination have higher rates of medication adherence, and foster care Members engaged in care coordination have lower rates of avoidable ED utilization.** Angie advises Pedro that next steps will include the development of his care plan including service referrals, treatment, and other interventions with his ICC team. The results of the assessments help Angie identify Pedro's strengths, preferences, goals, and care needs. Pedro's immediate care needs include referrals to his PCP and a BH specialist. Service needs include an environmental assessment of the home to identify potential environmental triggers that may be exacerbating Pedro's asthma, health education related to Pedro's asthma and medication compliance, the development of an asthma action plan, communication and coordination with Pedro's school counselor, nurse, and teacher, NEMT, VAB such as an air purifier, and SDOH supports including expanded transportation services and other community-based supports.

Person-Centered Care Planning

Our care planning approach promotes Pedro's self-determination, encourages, and empowers him to lead the care planning process and actively participate in all aspects of his care planning. We support Pedro in the development of a Plan of Service (POS) in accordance with section 7.4.4.1 of the KanCare Medicaid & CHIP Capitated Managed Care RFP. A State approved POS process is used for Pedro. To create a care plan to meet all Pedro's needs, Angie facilitates a

meeting with Pedro and his ICC team ten days after her visit. At the request of Pedro, the team includes his foster parents, FCCMP, his PCP, his BH clinician, school counselor, school nurse, and our CHW, Megan.

The team provides education to Pedro regarding available services to meet identified service needs and encourages Pedro to exercise choice and preference of services and Providers. Based on Pedro's needs, we help him choose Providers (in-person or telehealth) that will benefit him. **Aetnalytics' reports show, compared to the prior year, BH telehealth visits for Members 18 and younger enrolled in care coordination in Kansas increased by 16.4% from July 1, 2022, to June 30, 2023.** The decisions are documented in Pedro's care plan. The following table describes Pedro's needs as identified by the ICC team, and the recommended services and interventions to support Pedro to prevent future ED use and hospitalizations and other complications related to Pedro's asthma.

Needs	Services and Interventions
Control of asthma, asthma symptoms and BH services	• Angie will provide instructions about how to obtain timely medication auto refills and home delivery for Pedro. Megan will provide information about how to arrange for transportation to and from Pedro's medical appointments. • Pedro's asthma action plan for home and school is developed with Pedro and members of the ICC team. • Pedro's comprehensive safety plan includes contact information if his depression worsens including 988 and Aetna's 24-hour Crisis line. • Angie provides medication compliance education and teaches Pedro how to use his inhaler and medications, as well as when to use his rescue inhaler. • The ICC team notes appointments for Pedro with his PCP will occur in two weeks for assessment. They advise Pedro to see his PCP for his annual well-child checks, EPSDT screenings and services, including BH services, SUD services, and lead screenings, as needed, and childhood immunizations as soon as possible. They review which vaccines Pedro needs in the next six months. They confirm Pedro needs a dental screening. • The ICC team notes referrals for Pedro to a local CCBHC/CMHC for BH and SUD assessments. Angie provides additional options for Pedro and his foster parents including Twelve-Step meetings and Al-Anon. • Angie will communicate with Pedro's school to leverage available services and supports, including use of his inhaler and medications with the school nurse and other specific accommodations, supports or services. • Angie identifies supports for Pedro's foster parents, including a referral to the local CCBHC for Family Therapy and targeted case management to address their parenting concerns.
Evaluation and remediation of in-home asthma triggers	Angie will conduct an environmental safety assessment of the home, including water testing and a referral for lead testing, to identify potential hazards or risks that may impact or trigger Pedro's asthma. Angie will provide our VAB that support environmental control of asthma and prevent

Needs	Services and Interventions
	exacerbation of symptoms and make referrals to state agencies to eliminate triggers identified in the home during the environmental safety assessment.
Companionship and social supports	• Pyx Health is a mobile solution that helps reduce loneliness and social isolation. It connects our most vulnerable Members to critical and timely interventions, as well as addresses SDOH. **January 1, 2023, through September 30, 2023, we supported 1,924 unique Members with a total spend of over $238,682. We have also measured a 42% decrease in loneliness since inception.** • Local support groups for Pedro's foster parents.
Health education to prevent future condition-related complications	• Angie provides health education about asthma self-care, the normal progression of asthma, common complications, signs of complications, methods of asthma self-management, environmental triggers for asthma, and nutrition. Pedro and his foster parents are provided information about the importance of working with Pedro's Provider(s) in partnership toward healthier behavior. Angie shares MCG® Chronic Condition Management Member Education material. • Angie provides information to Pedro and his foster parents about the following resources: – Aetna's Asthma Disease Management program and biannual disease management newsletters. – FamilyCare Central for resources, appointments, ID card, health care reminders, and provide autonomy in care. – Referrals to community resources such as: American Lung Association, Asthma and Allergy Foundation of America, American Academy of Allergy, Asthma, and Immunology, National, Heart, Lung and Blood Institute, National Institutes of Health, Centers of Disease Control, and local and state Departments of Health. • Megan, our CHW**,** will schedule appointments for all services in the care plan, schedule transportation to and from appointments, as well as reminders about upcoming appointments, following the asthma action plan, and other SDOH interventions. Megan also provides health condition specific education materials available through Krames and digital content available through the Aetna mobile app and our Member portal.
SDOH	Research shows that social barriers to accessing care, like housing, food insecurity, and transportation, cause intense utilization of services, more so than the severity of illness alone. The following VAB and community-based resources are recommended to support Pedro in improving his health and well-being: • Healthy Rewards Incentive Program. Members receive either a $25 or $35 incentive card when they complete wellness activities based on Kansas Quality Metrics such as vaccines, yearly checkups. **From January 1, 2021, through October 31, 2023, our total spend is $6,882,520.** • Members with asthma can receive an air purifier. **Since January 1, 2020, supported 183 unique Members with a total spend of over $454,498.**

Needs	Services and Interventions
	For the last two rolling 12 months (July 1, 2022– June 30, 2023, and July 1, 2021–June 30, 2022) for Members identified with Asthma. • [redacted] • Aetna's Over the Counter (OTC) benefit provides an allowance of $25 per month per household for certain OTC drugs and supplies from an Aetna catalog. Monthly supplies can be ordered online or by phone and are mailed directly to the Member's home. **For fiscal year 2020 through October 2023, we supported 12,577 unique Members with a total spend of over $3,150,473. Utilization has increased by 4x since inception.** • Access2Care is an NEMT vendor that provides free rides for Members going to the pharmacy, support groups, and 12 round trips per year for going to job interviews, job trainings, shopping for work type clothing, grocery store for food, and getting community health or SDOH services otherwise not covered. **Since January 1, 2020, we supported 4,193 unique Members with a total spend of over $957,186.** • Referrals to community-based organizations using our Community Resource Directory (CRD) to support Pedro and his foster parents with access to local support groups. Our CHW will monitor Pedro's SDOH using the CRD for referrals to support access to community-based supports. • $50 per year for after school engagement programs such as YMCA membership for socialization. **For Fiscal Year 2020 through October of 2023, we supported 1,108 unique Members with a total spend of over $65,265.** • A tablet, and/or laptop computer, and assistance with free wireless services. • Educational and other applications such as iFoster, Connections for Life and Campus Ed. **January 1, 2023, through December 1, 2023, CampusEd supported 181 units of services in Kansas, 50 of whom are actively working on their GED certification and 13 of whom have completed the certification and obtained their GED, with a total spend of over $45,600.** • Charting the LifeCourse, a flexible person-centered tool for transition aged youth to help Pedro explore, problem-solve, make decisions, or plan for his future. • Essential Needs Duffle Bags. • Peer support (community-based services) based on physical health conditions, population type or BH concerns through Mercy Children's Hospital.

Care Monitoring and Oversight

We commit to meeting Members where they are, while adhering to contractual requirements. Angie makes weekly contacts (telephonic or in-person) with Pedro and visits Pedro and his foster parents in-person monthly, exceeding contract requirements. Additional contacts can be made by

any member of Pedro's ICC team. The results of the contact and notes about meetings are documented in Pedro's electronic record. Angie provides her direct telephone number and email address for contacting her during business hours. For after hours, Pedro receives contact info for Nurse Advice Line or after hours service. The ICC team will reevaluate the appropriateness of Pedro's care coordination level, in-person. This will be done at least annually, based on changes in Pedro's needs or circumstances, or upon request of Pedro or his authorized representative.

Angie will confirm Pedro attends appointments with his PCP and BH clinicians and that there are no barriers to compliance with the recommendations, or accessing the services outlined in Pedro's care plan. In addition, Angie will:

- Track and monitor well-child visits and immunizations with Pedro's PCP. Pedro agrees to provide updates regarding his medications, medication compliance and maintenance, and rescue inhaler use.
- Monitor her CEC Dashboard and how Pedro is managing his feelings related to his condition.
- Conduct BH screenings and make referrals to BH Providers and other services, as needed. Monitor admission, discharge, transfers, and our predictive modeling risk algorithm data to identify whether Pedro uses the ED or his risk changes over time.
- Check in with his CHW, Megan, weekly to exchange updates, make sure Pedro and his foster parents have all needed educational materials and obtain information on any emerging needs within the home.
- Continue to facilitate care plan updates and annual reassessments according to the frequency required for Pedro's level of case management, consistently and frequently examine quantitative and qualitative data and information obtained through a variety of sources (e.g., Members, Providers, and other stakeholders) to evaluate the effectiveness of the strategies employed to achieve program goals, identify opportunities for improvement, and adjust the strategies to incorporate results and lessons learned.

Outcomes

Due to our focused interventions to address Pedro's needs following his ED admissions, completion of environmental remediation, ongoing reassessment, and care plan updates by Pedro's ICC team, Pedro is breathing without difficulty. Pedro's mood has improved with his medication changes, and he is enjoying school and after-school activities again. Pedro is committed to following the care plan and feels relieved by the support he continues to receive from Angie, his school, and the local community. His foster parents are thankful for simplified methods of receiving Pedro's prescriptions, transportation to and from Pedro's appointments, referrals including community-based resources like the support groups, VAB, and other supports. Pedro and his foster parents are actively using and following recommendations from Pedro's ICC team along with the educational tools provided by the care coordinator, CHW, and disease management programs.

Improved Medication Adherence
Compared to the prior year, medication adherence for Members 15 to 19 years old with asthma enrolled in Care Coordination **increased by 24.3%** from July 1, 2022 to June 30, 2023.
145b.KS23

Pedro is stable with no return visits to the ED or hospital, demonstrating our commitment to Pedro's improved health and well-being. Our capabilities to drive innovation, operational excellence, and experience are improving ED utilization and medication adherence for asthmatic Members in Kansas.

Topic Area 7: Case Scenarios - Henry

33. Henry is a twelve (12)-year-old, white, male KanCare Member who has complex medical needs, including significant IDDs with co-occurring severe Behavioral Health issues. In recent months, Henry has become increasingly aggressive towards other people and the family pet, with behavioral episodes that are both more frequent and more severe. These episodes have resulted in repeated crisis interventions, visits to the hospital ED, inpatient psychiatric stays, and calls to law enforcement. Henry's most recent episode of aggression resulted in his current stay in a psychiatric hospital.
Henry's mother, Shauna, is a single parent to Henry and his two (2) younger siblings, a brother who is eight (8) and a sister who is five (5). Shauna has been very involved in and supportive of Henry's treatment. While Henry has not harmed his siblings to date, his increasing aggression has left her afraid both for her own safety and the safety of her other children.
As part of the planning for Henry's discharge from inpatient psychiatric care, Shauna requested residential treatment for Henry to stabilize his Behavioral Health condition and work on managing his aggressive behaviors before Henry is returned to her home. The team involved in Henry's discharge planning is encountering difficulties in identifying an appropriate and available placement option to meet Henry's IDD and behavioral health needs. The inpatient facility is pressing for the Member's discharge and has suggested intensifying outpatient services until a suitable placement is available. Shauna has stated that while she wishes things were different, she is unable to allow Henry to return home in his current condition — that the threats to the safety of the family have grown to an unacceptable level, and that if forced, she will request that he be placed in state custody.

Introduction

Aetna is devoted to supporting the whole person through the most difficult challenges. We support Members of all ages as we recognize the interconnectivity between the individual Member and the health of the entire family. Our **integrated approach** to care coordination addresses the **whole person through a trauma-informed perspective**. We provide comprehensive case management, discharge planning, and access to community resources that addresses Henry's overall health needs and supports his mother, Shauna, in maintaining a safe and stable home environment for all her children. This approach prioritizes family preservation while affirming that Henry gets the help he needs.

Henry's change in condition is distressing to both him and his family. With his increased aggression, Shauna has voiced her safety concerns and stated that she can no longer continue as Henry's primary caregiver. Henry may need to be placed in a Psychiatric Residential Treatment Facility (PRTF) for the foreseeable future for his and his family's safety. An unfamiliar setting and a change in caregiver from his mother to treatment facility staff will be stressful to Henry. The change will also be stressful for Shauna because she may have feelings of guilt and loss of control of Henry's care. Fortunately, Aetna has an established a relationship with Henry and his mother since he is an existing KanCare Member. Our team will help Henry and Shauna navigate the process and work toward the best outcome.

Our **One Team, One Member** collaborative approach involves multiple specialties. The **Care Advocate Team (CAT)** helps in coordinating the discharge planning. The **IDD Administrator for the CAT** is also involved in the discharge planning and helps with IDD services, including

facilitation of the Crisis Exception or Transition Request. They help guide the assigned care coordinator on how to complete this process. The Behavioral Health (BH) team supports the Care Coordination team to prioritize Henry's and Shauna's emotional and BH needs. The team conducts complex case rounds to discuss Henrys needs and holistically address his care.

Identification and Needs Assessment

Henry has been engaged throughout the process by his Aetna Care Coordinator, Madison. She has experience with at-risk youth like Henry. Madison has an established relationship with both Henry and Shauna. She has been the liaison among Henry, his support system, Providers, and his school as she coordinates Henry's care.

Madison makes a referral to our community partners such as the Community Developmental Disability Organization (CDDO) to request an assessment to determine eligibility for the **IDD waiver.** She is aware that a 10-year waiting list for an IDD waiver currently exists. If Henry is found to be eligible, the CDDO will discuss Henry's options for services, including a Targeted Care Manager (TCM), day service, residential services, group living, staffing needs, etc. The TCM can assist Shauna with applying for crisis funding for immediate access to the IDD waiver and services. If Henry secures placement in a PRTF for over 90 days, Madison can complete the Institutional Transition Process to bypass the waiting list.

Madison collaborates with the team to determine the best course of action for Henry. She meets weekly with the **Interdisciplinary Care Team (**ICT), which consists of the BH director, BH medical director, Transition of Care (TOC) specialist, IDD administrator, child care advocate administrator, and BH Utilization Management (UM) to coordinate the discharge. **The inpatient psychiatric hospital is prepared to discharge and recommend intensive outpatient care until appropriate placement is available. However, safe placement is the priority.** Because of Henry's documented increased aggression and Shauna's expressed concerns, a discharge to home would be inappropriate and potentially unsafe. The **goal of the team is to coordinate Henry's admission to a safe comprehensive treatment facility.**

Madison has made sure that Henry was under the intensive stratification so that a more intensive level of care was provided to the team. During these outreaches and engagements, Madison updates and provides information on coordination of services with the regional CCBHC for SED waiver services/access, the Value-Added Benefits (VABs) available for individuals on the IDD waiting list, and engagement with the TCM and CDDO for potential access to waiver services through crisis intervention. During discussions and outreaches, Madison provided information on crisis interventions, such as Beacon Mobile, Family Preservation, and support through local resources to meet his and the family's needs. In addition, Henry's physical health needs have been identified and discussed at length to develop a true wrap around support so that all areas of Henry's needs are met.

From the time of Henry's admission, the discharge planning process begins. The discharge planning process involves an ICT approach with Madison, Shauna, Henry's PCP, and the inpatient psychiatric hospital staff reviewing Henry's status. Madison acts as Henry's primary point of contact. The ICT explores a referral to the PRTF, per Shauna's request. The options are limited due to Henry's complex medical needs and IDD presentation, which the team takes into

consideration in their search for a PRTF that can meet his needs. Madison shifts her focus to supporting Henry and his family while they await placement.

Madison updates his comprehensive Health Risk Assessment (HRA) because of the change in condition and inpatient admission. The HRA evaluates Henry's level of care and the services and supports he now requires. As a 12-year-old child, he requires a wellness and physical exam to update his vaccines and to rule out underlying medical condition that may have exacerbated his BH issues. Madison recommends updating his neuro-psych evaluation and sensory evaluation and assists Shauna in locating a Provider for these services.

Shauna has a tremendous amount of stress and anxiety due to Henry's escalation in behaviors. Madison is committed to supporting Shauna through each step of the process, offering information regarding access to the SED waiver and the supports that can be provided through this waiver in Parent Support and Training, Independent Living/Skills Building, Short Term Respite Care, Wraparound Facilitation, Professional Resource Family Care, and Attendant Care. These services are provided through the regional Community Mental Health Center (CMHC) and individual services for the family. Madison also discusses added supports and services that can assist Shauna through the Department for Children and Families (DCF) for Family Preservation.

Person-Centered Service Planning

Engage

Madison uses a **trauma-informed approach,** recognizing that Henry may have experienced significant stressors. She usually spends time with Henry and has established a trusting relationship. Her methods of communicating with Henry are honest and nonbiased, and she listens to make sure his voice is heard. Given Henry's age, Madison tailors her approach to his developmental stage, recognizing the unique challenges and communication strategies required for adolescents. This approach fosters an **environment of safety and trust.** Throughout this process, Madison continues to work directly with Henry and his support team to monitor his progress and maintains open lines of communication between the ICT and Shauna to address concerns and facilitate a smooth transition to a PRTF and ultimately return home. In all her communications, she maintains an **integrative, collaborative approach** that respects Henry's voice and choice.

Engaging with Henry in the immediate situation is critical for his safety. Our approach to case management, discharge planning, and identification of community resources for Henry is focused on his safe and effective transition back to the community setting with his family while addressing Shauna's concerns.

Madison shares Henry's clinical history and data from his past assessments with the psychiatric hospital staff to provide a snapshot of **key data and clinical indicators** to assist while planning his discharge.

Educate

Madison strategizes both short-term and long-term plans when updating resources and therapeutic services available for Henry in the community, including **outpatient therapy and behavioral interventions,** to address his BH needs. In addition, Madison has offered

information regarding access to the SED waiver and the supports that can be provided through this waiver in Parent Support and Training, Independent Living/Skills Building, Short Term Respite Care, Wraparound Facilitation, Professional Resource Family Care, Attendant Care. This service is provided through the regional CMHC and individual services for the family as well. Madison also discusses supports and services that can assist Shauna through DCF for Family Preservation.

Madison works with Henry's mother and his school to update his **Individualized Education Plan (IEP),** which is done annually at a minimum. Madison will connect Shauna with community resources such as Families Together, who provide advocacy for families of children such as Henry. Family therapy would be beneficial for Henry and Shauna to address the changes within the family and nurture growth and development of the family structure. **Applied Behavioral Analysis (ABA) services** are a therapeutic behavioral intervention that are designed to help Henry if needed. Madison refers Henry to the local **CMHC** for evaluation of ABA services, **safety planning, crisis services, and mental health needs.**

To support Shauna when Henry returns home, Madison refers her to the **Careforth Caregiver program and caregiver support groups.** Madison refers Shauna to a caregiver support group so Shauna can discuss her experiences and gain useful tools on how to manage once Henry is able to return home. Madison facilitates a contingency plan with Shauna to anticipate and mitigate the risk of potential disruptions to the delivery of authorized services. The contingency plan is updated regularly.

The Careforth app services direct caregivers with coaching, resources, and emotional support to help them better care for their loved one by taking care of themselves.
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To address Shauna's concerns regarding Henry's return home, Madison develops an immediate safety and crisis plan for Henry with the help of the psychiatric hospital staff and the CMHC, in the event he returns home following discharge. The plan will address both PH and BH needs. She assesses Shauna's circumstances, considering her work schedule, household dynamics, and her ability to provide support and supervision for all her children. Madison refers Shauna to Family Preservation Services that could provide therapeutic interventions for the entire family including Henry's siblings.

Empower

Our Care Coordination team works to **empower our Members and their caregivers** through continuous engagement and communication. By including both in the care plan, **Henry's person-centered care** focuses on self-advocacy and empowers him and Shauna throughout the discharge and care planning processes to enable them to share their needs and questions. This process encourages Shauna to advocate for his physical health, behavioral health, and social needs.

As the primary caregiver for Henry, Shauna is encouraged to seek assistance through the Careforth. The Careforth app and caregiver centric platform that provides support through health coaches, serves as a resource on various issues and conditions, and connects caregivers to support one another. This HIPAA-secure, mobile, platform is easy to use and available 24/7. It focuses on increasing caregiver engagement on the Member's behalf and reducing caregiver

burnout. As the complexity of the Member and burden of caregiving responsibilities increase, caregivers rely more heavily on coaching supports and move to higher intensity program tiers.

Care Monitoring and Oversight

Susan develops a Person-Centered Service Plan with Henry and his support team. The plan considers the totality of his circumstances and the stability and health of his entire family. **Member choice and family choice** are at the heart of the care planning process. Henry and Shauna are active participants in creating his goals. The goals identified for Henry include **transition to PRTF and then home, safety of Henry and his whole family, medical needs, family support, and educational through school support.** Susan addresses the interventions, and monitors the success of each and updates the care plan as needed, and shares it with his Providers, school, and PCP per state requirements.

Safety is the primary goal of Henry's care plan**,** which we achieve through PRTF placement. The TOC team works tirelessly to secure a placement primarily in state and if options are limited, an out of state search will take place.

Due to Henry's complex medical and behavioral needs, Susan can plan for DME, and therapies as needed upon discharge to the community. She will assess for any barriers relative to the delivery of services for Henry and his entire family.

Caregiver support is the second most important goal. Family support is needed to help Shauna with his increase in aggression and the change in his level of care.

Lastly, **consistent support with education and school** is an important care need for Henry. Educational advocacy will help address and monitor Henry's IEP to help him succeed in school.

Henry's Goals	CM-Led Interventions
Safety	PRTF placement to address BH needs
Family/Caregiver Supports	To address family/caregiver stress
Educational and School Supports	Educational Advocacy to address educational needs

Follow-up and Ongoing Reassessments

Susan continues to plan with Shauna for Henry's discharge from the PRTF back to his home. She discusses the availability of intense outpatient (IOP) therapies from which Henry can benefit post-discharge. She coordinates his needs with Henry's PCP by sharing the integrated care plan and service plan with each update. Susan collaborates with the ICT to address any gaps in care.

Henry is provided access to the IDD waiver through the institutional transition process. As part of this process, Madison provides a seamless warm handoff to an LTSS care coordinator, Susan. Susan connects Shauna with the CDDO for options counseling so that services such as personal care services can be arranged in time for Henry's discharge. Shauna, with the help of Susan, chooses a TCM, Andrew, while continuing to support Henry and coordinate his care with Andrew. As the TCM, Andrew is managing Henry's care post discharge. Henry will require assistance with activities of daily living when he returns home due to his complex medical needs. NEMT is available to help with Henry's transportation needs. Henry would benefit from Applied

Behavioral Analysis services to help redirect him in school. An education advocate is necessary to help Henry reengage with his education and stabilize his behaviors.

Susan and Andrew continue to work together with Shauna post discharge from the PRTF. Susan completes the interRAI assessment, which addresses his PH, BH, SDOH, and therapeutic needs, and a needs tool, which is designed to determine support needs for daily living activities. Susan will follow up in person with Shauna **within 48 hours of the discharge** to confirm he is receiving all authorized and planned services. She and Andrew will meet with Henry for **a face-to-face visit within 30 days of his discharge.**

Outcomes

Susan and Andrew continue to provide ongoing support to Henry and his family in subsequent months. Henry eventually transitions to the PRTF after a month on the waitlist. The PRTF stabilizes his BH needs. Henry is discharged to his home in the community after three months at the PRTF. Henry is managed at an intensive level for a minimum of 60 days and then reassessed by Susan. Intensive level Members receives monthly visits, so Susan conducts face-to-face visits monthly with Henry and Shauna. If she determines that Henry has stabilized after 60 days, she will update his level of care to supportive. If Henry is found to be supportive level, Susan will continue to follow up every 90 days. Upon his return home, Susan makes sure Henry has continuity of care by scheduling appointments for IOP and wrap around services post discharge. Henry has new medications prescribed at discharge to help manage his condition. He starts to experience side effects, which he reports to Susan at his regular face-to-face visit with her. Henry states that the medication makes him lethargic, and Shauna reports that his grades have declined in school because he is always tired. Susan immediately notifies the prescriber who switches to another medication to ease the side effects. Susan also contacts the education advocate and discusses the medication change and ways to address Henry’s IEP to promote success in school.

Care coordination continues to address Henry’s needs and support Shauna with caregiver support. Our proactive approach cultivates **positive health outcomes.** Henry and Shauna have supports in place to meet his **whole person needs** and encourage **family preservation.** Susan will continue to provide services and supports to achieve successful outcomes.

As a result of Aetna's continued engagement through case management, Henry has maintained successful transition to the community and continues to show improvement in his education.

Topic Area 7: Case Scenarios - Alice

34. Alice is a three (3)-year-old, white, female KanCare Member who lives in Holcomb and was referred by her pediatrician to a developmental pediatrician for further assessment. Alice is an only child. She started using words at 16 months of age, but her use of language has regressed. She communicates primarily using hand and body gestures.
In order to provide an opportunity for social engagement, Alice's parents enrolled Alice in day care. Alice attends day care three (3) days out of the week for four (4) hours per day. Contrary to Alice's parents' intentions, daycare staff report Alice isolates from and is unable to effectively communicate with other children and staff. Staff also report Alice engaged in head banging and hand flapping when they tried to engage her in activities.
Alice was assessed by the developmental pediatrician as being at risk for autism. The developmental pediatrician recommends Applied Behavior Analysis (ABA) therapy for Alice, specifically, early intensive behavioral intervention. The developmental pediatrician's office has contacted the bidder's Provider services line to assist with locating a Provider because the coordinator was unable to find an ABA therapist within a reasonable distance from the Member and her family.
Describe the process the bidder will follow to respond to the Provider's call and assist the Member and her family to ensure adequate and timely access to ABA therapy services.

Introduction

Navigating a new diagnosis can be overwhelming and complicated. Our **Integrated Care Coordination (ICC) team** walks with our Members and their families to create **a caring and supportive environment**. We **engage** our Members, build trust, and educate them on the services and supports available for Members like Alice. The ICC team completes a comprehensive assessment to determine the Member's needs and connects the family to Providers and community resources that will holistically address their care needs. We encourage **and support** our Members through **Value-Added Benefits (VAB)** that provide additional support.

Most importantly, we **empower** Members to advocate for their health care and set care planning goals to **improve their health outcomes.** This is especially relevant to our Members with Autism Spectrum Disorder (ASD). In the last two years, Aetna Better Health of Kansas Inc. (Aetna) has seen a 15.5% increase in Members with ASD.

Our ICC team would connect Alice and her parents to one of your experienced care coordinators, Sara. Sara would help Alice access services such as Applied Behavior Analysis (ABA) therapy through EPSDT. EPSDT assures non-covered services are covered for members who are under the age of 21. Through early and periodic screenings and tests to catch and diagnose potential problems, we can intervene and help Members like Alice receive treatment quickly. In the last 2.5 years, we have achieved significant increases in members with ASD who have completed annual screenings and primary care visits:

- 31.0% increase in Members with ASD who completed their annual hearing screening (Jan. 2021 - July 2023)
- 26.1% increase in Members with ASD who completed their annual vision screening (Jan. 2021 - July 2023)
- 14.1% increase in Members with ASD who saw their dentist annually (Jan. 2021 - July 2023)

Aetna has identified **health disparities among Members in urban, semi-urban, rural, and frontier areas** within Kansas. Our care coordinators have extensive experience facilitating access to services via EPSDT and supporting Members like Alice and her family in this process. Holcomb is a rural area where access to Providers and services, particularly **Applied Behavioral Analysis (ABA) therapy,** is limited. In some cases, Members in rural areas travel twice as far to find a Provider. While we continue to work to expand our Provider network, telemedicine creates an opportunity for Alice access to services such as ABA and therapies as quickly as possible.

To serve Members in more rural areas in Kansas, the University of Kansas has trained more than **45 early intervention and education teams** throughout the state to collaborate with health care Providers and remotely evaluate children suspected of having autism, through **telemedicine.** Because they reside in Holcomb, Sara helps Alice's family explore this option. Aetna provides access through EPSDT to assure Alice gains timely access to critical services. Sara also assists Alice's family in exploring local services including **Head Start and early education services** through the **Kansas Children's Service League (KCSL).**

Identification and Needs Assessment

The developmental pediatrician that completed Alice's assessment contacted Aetna's Provider Services line for assistance in locating an ABA Provider for her. The provider services representative performs a search for ABA Providers near Holcomb where Alice and her family live; this search, which results in few options, is shared with the referring pediatrician. Because Alice is an existing KanCare Member who has an **established relationship with her Care Coordinator,** Sara, the provider services representative notifies Sara via email.

Sara responds by reaching out to Alice's parents to offer them support as she understands that this may be an emotional task for them to navigate alone. With the evaluation and **possible autism diagnosis,** Alice's parents need help to navigate available resources. Sara reassures them that she will help coordinate services and supports to aid in Alice's care. She completes an updated **comprehensive Health Risk Assessment (HRA)** with Alice's parents to assess her current needs. Sara also contacts Alice's developmental physician to gather additional input. She educates the pediatrician on options for Alice and explains that she will reconnect with him when additional providers are located and added to the network. Sara connects with Alice's family to gather the necessary information and then presents Alice's case to the complex case rounds where the Interdisciplinary Care Team (ICT) reviews her case and discusses her care needs and begins to problem solve. The Care Advocate Team (CAT) is involved in this process. Our provider services, care coordinators, and CAT specialists work closely together to support each other and effectively help our Members and Providers.

Sara stays deeply engaged with Alice and her family throughout. She uses her thorough understanding of the resources available to Alice to address barriers and arrange the most effective and appropriate care. Sara discusses potential waivers that Alice may be eligible for, including the **Autism waiver,** which may allow Alice to receive Home and Community-Based Services (HCBS). Sara refers Alice's parents to the **Community Mental Health Center (CMHC),** Compass Behavioral Health Center (Compass) in Garden City, Kansas, for an eligibility assessment. The parents are informed that if eligible for the Autism waiver, they will be placed on the **Proposed Recipients List.** At the request of Alice's parents, Sara attends the

eligibility assessment and results session with them. Regardless of the results, Sara still works with the family within the structure of the ICT team to make sure Alice continues to receive all evidence-based services through EPSDT.

Compass conducts a clinical assessment to determine if Alice may be experiencing any co-occurring behavioral health concerns. The clinical assessment interpretation assists in identifying the need for additional community-based services. If the assessment interpretation identifies such a need, Alice could access these services through Compass, including case management and attendant care services. Compass also offers a program called ABC Hope, which is for children aged 3–5 who are unable to maintain in a day care/preschool setting. They provide crisis services and can assist with transportation to appointments, if needed.

Person-Centered Service Planning

Engage

Using a person-centered planning process, Sara develops a Plan of Service that includes Covered Services, EPSDT, value-added benefits, and informal supports to address Alice's needs, including SDOH needs. Sara shares information with Alice's parents regarding the process of accessing waiver services in Kansas and highlights key points from the **Waiver Services Access Guide on the Kansas Department of Aging and Disabilities Services (KDADS) website.** She reviews services available to Alice's family through the Autism waiver. One of these services is **Family Adjust Counseling,** which offers guidance and assistance to Family Members of a child with ASD. A licensed mental health provider provides these services. It helps the family cope with the child's illness and daily needs by offering a safe and supportive environment to express emotions and ask questions. At the request of Alice's parents, Sara attends the eligibility assessments and results sessions with them.

In accordance with KDADS HCBS Quality Review Reporting from October to December 2022, Aetna demonstrated increasing positive trends quarter over quarter for Autism waiver Members, exceeding Statewide results and achieving 100% compliance:

- Measure 1: service plans address participants' goals achieved.
- Measure 2: service plans address their assessed needs and capabilities.
- Measure 3: service plans address health and safety risk factors.
- Measure 4: service plans were developed according to the processes in the approved waiver.
- Measure 5: present and involved in the development of their service plan.

The **Department of Child Health and Development at the University of Kansas (KU)** can conduct an **ASD evaluation** to assess various developmental areas such as communication, social and emotional development, behavior, adaptive skills, play skills, cognition, and development. Sara educates Alice's parents about this resource and connects them to the university for more information and assistance in completing the referral information.

To serve Members in more rural areas in Kansas, KU has trained more than **45 Early Intervention and Education teams** throughout the state to collaborate with health care Providers and remotely evaluate children suspected of having autism, through **telemedicine.** Because they are in Holcomb, Sara helps Alice's family explore this. Regardless of the results,

Sara still works with the family to make sure Alice continues to receive all evidence-based services through EPSDT.

Educate

Sara shares information about the process of accessing waiver services in Kansas with Alice's parents and highlights key points from the **Waiver Services Access Guide on the Kansas Department of Aging and Disabilities Services (KDADS) website.** She reviews services available to Alice's family through the Autism waiver, including:

- **Family Adjust Counseling** to offer guidance and assistance for family members of a child with ASD
- **Parent Support and Training** (peer-to-peer) to help family members acquire the knowledge and skills they need to understand and address the specific needs of and treatment for the child in relation to ASD and help the family to develop specific problem-solving skills, coping mechanisms, and strategies for the child's symptom and behavior management
- **Respite Care** offers temporary direct care to support the family caregivers.

Alice's parents request extra assistance from Sara to support their needs as caregivers. The KCSL offers a monthly **Virtual Special Needs Parenting Support group**. Alice's parents would benefit from the support group. Sara also shares information about therapies that would help Alice such as **Research Units in Behavioral Intervention (RUBI) therapy.** RUBI therapy is a parent-mediated virtual program that is grounded in ABA therapy available through Children's Mercy Health Care System. In RUBI therapy, therapists teach parents how to implement a range of behavioral strategies over 11 core and seven supplemental (focal problem) sessions (e.g., toileting, feeding, sleep issues) to build a behavioral management toolbox. Sara asks for feedback from Alice's parents and, if agreeable, will assist them in completing the parent referral information to receive this service.

Aetna actively pursues all options for our Members to access ABA therapy by recruiting all available providers to our network. Dodge City, an hour from Holcomb, has several ABA providers. Sara contacts the ABA providers to inquire about availability. If she finds an available provider, Sara will help Alice's family use the travel reimbursement for mileage and lodging. Sara proactively researches telehealth options for ABA therapy in case the ABA providers in Dodge City are unable to accommodate Alice. Kansas Behavioral Supports, Heartspring, and Integrated Behavioral Technologies all offer virtual ABA therapy and are options for Alice either in-network or through SCA. Aetna is also actively seeking other telemedicine alternatives for ABA therapy, including OneTelemed. We are committed to providing all Members with the most appropriate, evidence-based, quality treatment and care.

Telemedicine helps to expand the number of Providers available for ABA therapy and other services. Living in a rural area may limit their **internet availability.** Sara checks to confirm the family's internet connection to access online resources. If they do not have adequate internet access, Sara connects with the CAT to explore local connectivity options, such as local health departments, libraries, or local PCP offices, including four in Holcomb that offer internet services. Once online access is confirmed, Sara shares additional resources with Alice's parents, including **Autism Speaks,** an online platform for support and resources related to autism that they could also access for support.

Empower

Sara continues to provide Alice's family with information about additional resources, such as the annual **Connect 2 Care Behavioral Health and Wellness Event** in Garden City, which brings together a variety of organizations to educate the community on the resources available for mental and behavioral wellness and how those resources can help. Sara recommends and connects Alice's parents to **online training through OASIS with the Kansas Center for Autism Research and Training.** The training introduces autism and behavioral treatment, measuring and recording data, principles of behavior, stimulus control, determining the function of behavior and decreasing behaviors using antecedent strategies and consequences. For support with other parents and families navigating similar health care concerns, Sara recommends and connects Alice's parents to the Autism Society—The Heartland (ASH). ASH provides support, educational workshops, social and support groups, and information and referral services.

Alice's parents, now empowered and much better informed of the resources available to them, have a strengthened knowledge and a deeper understanding of her potential autism diagnosis and associated health care needs. They also feel much more confident in their ability to care for Alice. ASH, perhaps most importantly, connects Alice and her family to other families in similar situations, and with children with similar needs. They find a community with empathetic ears and a collective voice that empowers them to navigate their new environment and more confidently advocate for Alice's needs and care.

Care Monitoring and Oversight

An evaluation and assessment to confirm the autism diagnosis is the initial goal for Alice. If the diagnosis is confirmed, then Alice's treatment goal **is to secure an ABA Provider.** Sara successfully connects Alice to an ABA provider in Dodge City. Aetna's Provider Services team continuously works to evaluate and expand the network of ABA Providers. We also collaborate with other health plans and lobbyists at the state level to strategize how to secure additional ABA Providers, especially in our rural and frontier areas. Sara reaches out to the ABA Providers to ask about telemedicine options for Alice. She also shares the list of providers with Alice's pediatrician and other developmental pediatricians in the area as they are enrolled.

Sara creates a plan to monitor the Behavioral Analysis Plan that the ABA provider will complete for Alice. The plan will provide **positive behavior supports**, which provide a process for:

- Identifying challenging behaviors,
- Developing an understanding of their purpose or function,
- Creating a behavior plan to reduce the challenging behaviors
- Developing and implementing new skills for Alice and the family

Additional goals are to **confirm the diagnosis and secure access to services and family support** to help her parents navigate the services and understand her new diagnosis. The Autism waiver would introduce Alice and her parents to a wealth of resources. The team at KU will **assess her** and share their recommendations and resources with her parents and Sara. Since there is a Proposed Participants List, Alice would not have immediate access to the Autism waiver.

The following therapies are treatment options available to accompany ABA therapy:

- Play therapy
- ABA therapy
- Speech therapy
- Occupational therapy
- Physical therapy
- BH supports
- Personal Care Services (PCS)

Sara facilitates coordination and collaboration between KU and Compass. She also shares community resources with Alice's parents.

Follow-Up and Ongoing Reassessments

Sara conducts regular face-to-face visits with Alice and her parents to reassess her needs and monitor and update the care plan and service plan. Sara stratifies Alice as Intensive and completes regular visits every 30 days to confirm that Alice has the support in place. Sara follows up with Alice and her parents to confirm services that can be provided to Alice through EPSDT including play, speech, occupational, and physical therapy are also considered. Sara works to obtain ABA services for Alice through EPSDT and assists in locating service Providers. She also follows up on referrals for community resources that can support Alice. She communicates with Alice's developmental pediatrician regularly to share information and updates on services and support that have been secured and any gaps in care to address. They collaborate on Alice's progress and coordinate to meet her care plan goals.

Outcomes

Alice and her family travel to KU where, after thorough testing and assessment, the diagnosis of ASD is confirmed. Alice's parents complete and submit the initial application for the Autism Waiver, which includes details of the Autism diagnosis: when it was given, who gave the diagnosis and what assessment was used. Alice receives a letter a short time later from the Autism program manager informing her parents that she has been placed on the Proposed Recipient List and their numerical position on the list.

Alice begins ABA therapy with the ABA provider in Dodge City and progresses well with the addition of services. While Alice awaits placement on the Autism waiver, she receives services and support through EPSDT and makes sure that her Kan B Healthy is up-to-date. While Aetna works to secure additional ABA Providers, Alice has access to online providers to participate in virtual therapies. Sara will coordinate getting Alice on the IDD waiver waiting list and explore services available to Alice once she becomes school-aged. Sara continues to track Alice's placement on the waiting list as part of her care coordination. Sara is aware that the Autism Waiver only goes through age five. To prevent a gap in care, she will proactively review options such as the Intellectual Developmental Disabilities (IDD) waiver that Alice could access at age 6 for continued services and support.

Topic Area 7: Case Scenarios - Ernest

35. Ernest is a senior executive with a hospital in a Rural area of the State.
He reaches out to the bidder's Provider services call center seeking to find someone to speak to at an appropriate level in the MCO who will "take this situation seriously" and "has the authority to do something to try to fix this."
Ernest explains that, as a Rural hospital, the ED provides a particularly important service for the community and surrounding area. The ED has, however, been struggling with the challenge of KanCare Members who present at the ED with significant psychiatric issues and who end up staying in the hospital's ED for extended periods because of a lack of available and suitable discharge options for them.
Ernest reminds your Provider services representative that the ED is small and that as a Rural area, the community heavily depends on being able to access ED services. He shares that providing "psychiatric boarding" in the ED for these Members is problematic for many reasons, including: the loss of available treatment space; the challenges presented to his staff, who are not trained to provide psychiatric care; Members' agitation and other disruptive behaviors that escalate as the ED stay lengthens; and the effect of the Members' behaviors on other ED patients.
Ernest states that he is concerned about the ED's ability to continue to ensure access to other patients in need of ED services and that his staff, already under significant strain, may begin to leave hospital employment. Additionally, Ernest shares his concern that KanCare Members with psychiatric conditions do not have appropriate discharge options. Ernest says that while he recognizes this problem is not just limited to the bidder's MCO, your MCO is a contributor to the issue. Ernest wants to speak to the "right person" to understand what the bidder will do to address his concerns.
Describe how the bidder will route and handle the call from Ernest, and the bidder's approach to addressing the Provider's concerns.

Introduction

Ernest, a senior executive at a rural Kansas hospital, contacted our Aetna provider services line regarding a challenge in his hospital's emergency department (ED)—managing KanCare Members with significant psychiatric issues. Our response to this scenario is not just a plan; it is a commitment to addressing the critical challenges faced by Ernest's hospital and, by extension, the rural health care system in the State. We recognize the pivotal role that emergency departments like Ernest's play in serving their communities, especially in rural areas where health care options are limited.

Upon receiving Ernest's call, our provider services line representative immediately initiated our initial contact and triage process, as outlined in our administrative desktop procedures. We maintain a 'no wrong door' approach for Providers to contact us and obtain assistance, with various venues Ernest could use including via 1) his assigned provider experience representative; 2) our dedicated intake email box for inquiry/complaint escalations; 3) the Contact Us function on our Kansas Provider website; 4) by calling our Kansas-based provider services call center; or 5) direct feedback from the State. Our representative, John, quickly assessed the urgency of the situation, identifying Ernest's concerns as a high priority due to their complexity and community impact. In accordance with the rapid escalation step within our desktop procedure, John promptly transferred Ernest's call to our Director of Behavioral Health Supports, Becky Austin-

Morris. Becky, who brings a wealth of experience in psychiatric care, program development and patient coordination, immediately recognized the challenges posed by psychiatric boarding, a common yet complex issue in rural health care settings. Drawing from past successful interventions, such as reducing the average length of stay and improving the discharge process for psychiatric patients in EDs, she empathized with Ernest's situation, referencing similar instances along with our intervention strategies in managing them. Becky listened to Ernest's concerns and conveyed our understanding of the situation. Furthermore, she assured Ernest of our willingness and readiness to work quickly and collaboratively to address his concerns, demonstrating our commitment to a responsive and effective partnership in handling these critical health care challenges.

Understanding the seriousness of Ernest's concerns, Becky informed Ernest she would relay the details of his call to both our chief medical officer (CMO) and our behavioral health medical director. She also assured Ernest our CMO would call him with 24 hours to discuss the situation further. Following the call, this group briefly discussed the challenges Ernest is facing and acknowledged his hospital's issues are both a state and national concern. Additionally, they identified and committed to next steps, which included assessing Ernest's hospital emergency department comprehensively, developing an action plan tailored to the psychiatric patient management processes at the ED, and engaging other MCOs, state agencies, and community stakeholders in this discussion.

As promised, our CMO set up an in-person follow-up meeting to build a better relationship with Ernest's team, where we could jointly discuss strategy and next steps, making certain that our commitment to timely and responsive communication was met. Our CMO also committed to be Ernest's primary point of contact as they work through his hospital's challenges.

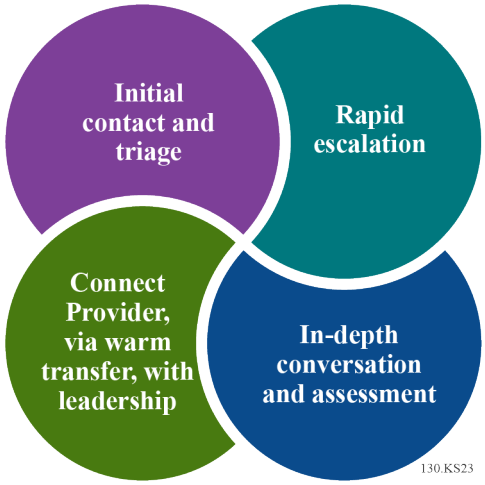

Figure 35-1: Provider Services Call Response and Escalation Process. *Our provider services processes support prompt and thoughtful engagement, regardless of the caller's purpose in calling us.*

Our CMO, along with our clinical services leadership team and our CEO and COO, then met to start developing an action plan for Ernest and his hospital. Our clinical services leadership team is composed of key personnel specializing in various aspects of health care management, including our behavioral health medical director, director of behavioral health supports, director of care coordination, provider relations director, and other representatives from our provider experience team. This group, which also has a deep understanding of rural health care challenges, will provide practical and empathetic solutions, reflecting our commitment to supporting Ernest's hospital.

Strategic Discovery and Care Enhancements

The following approach outlines and guarantees that Ernest's concerns are not only acknowledged but are met with immediate and well-coordinated action. We will adopt a phased approach that incorporates thorough problem identification, designing targeted supports, resource

allocation for implementation, and continuous monitoring for long-term improvement. This structured methodology, which can be applied to other hospitals across the State, verifies our understanding of the hospital's unique challenges, facilitates the development of tailored solutions, and references a set of key highlights at the end of each phase, which are intended to enhance the quality and efficiency of psychiatric care in an ED.

Problem Identification and Engagement

Within a week of Ernest's initial call, our CMO, accompanied by our multidisciplinary team of behavioral health, operations, quality, and community engagement experts will meet with Ernest and his leadership team at the hospital. This direct and hands-on approach is centered on identifying and understanding his hospital's challenges related to psychiatric care in the ED, including staffing issues, patient management and resource constraints. Our CMO, as the primary contact, will facilitate these discussions, confirming that Ernest's concerns are addressed in a comprehensive and effective manner.

Through direct interactions, such as conducting interviews with front-line staff, we want to develop a deep understanding of the daily operational challenges and the hospital's specific needs in providing care. Our team will conduct a thorough analysis of the hospital's situation by evaluating patient flow, staff capabilities, existing care protocols, and the effectiveness of current discharge options. This analysis will be crucial, particularly in light of our recent data, which shows that **around 20% of Members in our KanCare plan consistently live with SMI** - 20.2% in July 2021 and 21.0% on December 1, 2023. This **rate is nearly double the national prevalence rate of 11.4% among young adults aged 18-25 years and triple compared to adults aged 26-49 years, who have an SMI prevalence rate of 7.1%** according to the National Institute of Mental Health. This persistent high prevalence with KanCare members validates Ernest's concerns and underscores the ongoing and significant challenges faced by hospitals like Ernest's across the state of Kansas.

Additionally, we will focus on the compounded challenge and significant disparity in active care coordination engagement for Members who are living with SMI. Again, for Members in our KanCare plan from July 2021 to December 1, 2023, we saw a **112% increase in the gap between Members with SMI, who need and are not receiving care coordination and all other Members who are eligible for care coordination services.**

Our CMO, serving as the primary contact, will verify that Ernest's concerns are addressed in a comprehensive and effective manner. We believe these collective efforts will demonstrate our commitment to making sure Ernest feels heard and his concerns are acknowledged and understood.

Problem Identification, Assessment and Analysis Highlights	
Strategy	**Summary**
Dedicated psychiatric assessment area (Immediate solution)	Explore establishing a specialized area within the emergency department (ED) to streamline psychiatric evaluations.

Problem Identification, Assessment and Analysis Highlights	
Embedding behavioral health specialist (Immediate solution)	Support ED staff by providing on-site expertise for managing psychiatric cases and enhancing the ED's capacity to address mental health issues.
Collaborative personnel engagement (Immediate solution)	Engage our housing and transition of care administrators for collaborative work with Ernest's team.
Collaborative forums (Longer-term solution)	Actively participate in forums uniting key stakeholders, such as State agencies, other MCOs, and CCBHCs/CMHCs to share best practices in psychiatric care and patient flow management.
Community partnerships (Longer-term solution)	Develop partnerships with local organizations for downstream supports like housing or residential care and intensive outpatient services.

Designing Targeted Support and Interventions

Following our thorough assessment, members of our provider experience and clinical services teams in collaboration with our leadership, including our CEO and COO, will coordinate with the hospital's team to develop specific interventions and support mechanisms tailored to the hospital's unique needs.

Initially, we will concentrate on enhancing the hospital staff's capabilities in psychiatric care. These efforts will include specialized training programs designed to equip the hospital's staff with the latest best practices in managing psychiatric patients in the ED. Our training will address the growing and still disparate care coordination service needs, as indicated by the **128.7% increase in care coordination enrollment for Members in our KanCare plan who are living with SMI from July 2021 to December 1, 2023.** Such training will not only improve patient care but also support the staff in managing these complex situations more effectively.

In parallel, we will review and potentially recommend changes to the hospital's existing protocols. This could include introducing new procedures or refining current ones to improve the clinical management of psychiatric patients. A key focus here will be on optimizing patient flow within the ED, verifying these processes are efficient and patient centered. We will also explore innovative solutions such as the integration of telehealth services. Aetna is establishing multiple partnerships with wraparound service and telehealth Providers to work with network Providers who need to expand their service capacity and capabilities, as well as subcontracts with national and Member's preferred Providers. [redacted] which can provide additional support and flexibility in patient care and follow-up. We will also investigate enhancing discharge planning and patient placement options. This review will involve a comprehensive evaluation of the current discharge process and exploring ways to streamline it, by integrating community resources or establishing new partnerships for patient placement and follow-up care.

Our objective with these efforts is not only to address the immediate challenges but also partner with the hospital's leadership to build a stronger, more resilient system for managing psychiatric patients in the ED. By doing so, we aim to create a model of care that can be adaptable and sustainable, especially as the needs of the hospital and its community evolve.

Once we have a complete understanding of the hospital's immediate needs, we will then extend our collaboration to include other Kansas-based MCOs, community stakeholders and State agency representatives. This broader engagement will focus on enhancing long-term capacity for psychiatric care within the community and will involve regular meetings and workshops with these stakeholders, to confirm alignment and support for a set of shared objectives.

Designing Targeted Supports and Intervention Highlights	
Strategy	**Summary**
Streamlined triage process (Immediate solution)	Explore implementation of a more efficient triage process for patients with psychiatric symptoms and to reduce "psychiatric boarding" time.
Behavioral health in primary care (Immediate solution)	Propose specialized training for PCPs in mental health management to improve mental health screening capacity, coordinating management of patients exhibiting psychiatric symptoms and building a more resilient ED team.
Structured training program (Immediate solution)	Enhance interdisciplinary team performance with training in emergency psychiatric care, patient flow management, discharge planning efficiency, and transition strategies.
Cultural competency training (Longer-term solution)	Offer training including scenario-based learning tailored to the rural context for effective patient engagement and culturally sensitive care delivery.
Care continuum expansion (Longer-term solution)	Explore opportunities for to expand care, such as intensive outpatient programs and short-term residential care,

Resource Allocation and Implementation

During this phase, we will collaborate closely with Ernest’s team to identify and allocate the necessary resources to effectively implement the strategies developed during our identification and design phases. Our goal here is to confirm that these plans are not simply theoretical will be translated into practical, actionable steps that make a tangible difference in the hospital's operations.

Our approach is hands-on and specifically tailored to the unique needs identified in our assessment. **Considering the 14.2% higher prevalence of SMI in rural areas compared to urban areas as of November 2023,** we will propose allocating additional resources to rural settings like Ernest's ED. This prioritization will enhance our support to manage the increased SMI-related challenges in these areas, with a focused commitment of more behavioral health resources. For example, we will suggest embedding behavioral health specialists and community health workers (CHWs) at the hospital. **Our data shows that Community Health Workers have engaged with approximately 450 Members and saved our organization $1.5 Million dollars overall, with the largest portion of the savings coming from reduced in-patient costs.**

Furthermore, we recognize the growing importance and effectiveness of telepsychiatry services, especially in rural settings like Ernest's hospital. Therefore, coordinating access to these services will be a priority. This not only expands the hospital's capacity to manage psychiatric patients but also brings in specialized expertise that may not be available locally. Telepsychiatry can be a key

resource in terms of providing timely, effective mental health care, especially during periods of high demand or staffing shortages.

In addition, we will facilitate connections with community mental health resources. By integrating these resources into the hospital's network, we aim to create a more cohesive and comprehensive care pathway for psychiatric patients. This will not only improve the discharge process but also verify the continuity of care post-discharge.

Throughout this resource allocation and implementation phase, our focus remains on practicality and timeliness. We are committed to working within a defined timeline to confirm that these interventions are not just planned but are also effectively implemented, leading to measurable improvements in the hospital's ED and psychiatric care capacity. In addition, we will recommend the formation of a Behavioral Health Advisory Board to further support these efforts by providing expert input on behavioral health service planning and evaluation at Ernest's hospital and across the state.

Resource Allocation and Implementation Highlights	
Strategy	**Summary**
Virtual care coordination and engagement (Immediate solution)	Propose embedding a care coordinator and/or community health worker for enhanced care coordination and seamless care transitions. This innovative approach can supplement the hospital's existing staff, providing additional bandwidth and specialized skills that are crucial in managing complex psychiatric cases.
Network provider modifications (Immediate solution)	[redacted]
CCBHC/CMHC coordination and mobile crisis teams (Longer-term solution)	Enhance collaboration with CCBHC/CMHCs, by exploring on-site assessment capabilities, extended service hours to improve rural health care access, and joint training with hospital ED staff.
Community outreach (Longer-term solution)	Our Care Advocate Team will explore a regional housing health care collaborative for robust housing solutions integrated with health care services.
Behavioral Health Advisory Board (Longer-term solution)	Establish a Behavioral Health Advisory Board to offer guidance on policy development, service planning, and evaluation. The board will consist of diverse representatives, including BH Health Home and peer recovery specialists, meeting quarterly to support the effective delivery of behavioral health services.

Continuous Monitoring and Evaluation

As we move into the implementation phase of our interventions, our commitment to a collaborative approach with Ernest and his team will be consistently reinforced. While a

challenge in both rural and urban areas, we will particularly focus our monitoring and evaluation efforts on the **somewhat lower prevalence of active care coordination engagement among Members living with SMI and living in rural areas (11.6%) compared to similar Members living in urban areas (13.0%), as of December 1, 2023**. In addition, we will maintain ongoing communication with Ernest's team to regularly assess the effectiveness of our actions. For instance, if a new or revised discharge process is introduced by Ernest and the hospital, we will closely monitor its integration and effectiveness within the hospital's operations. These activities will include assessing how well the discharge process aligns with the hospital's existing practices and identifying areas where additional support or modifications may be needed.

Beyond process integration, we will also focus on evaluating the broader impact of our interventions. These efforts will encompass assessing the capacity of community mental health providers and understanding their role in the enhanced care pathway. Monitoring the hospital staff's workload and morale will be another crucial aspect, as these factors directly impact the quality of patient care and the overall efficiency of the ED.

Furthermore, collecting feedback from staff and other stakeholders will be an integral part of our evaluation process. This feedback will provide invaluable insights into the day-to-day effectiveness of our interventions and highlight areas for further refinement. In addition to these efforts, we will offer joint rounds with our care coordination staff and hospital care management staff to facilitate improved discharge and transitional planning. Through these collaborative efforts and continuously gathering and analyzing this data, we can verify that our collective strategies are not only effective in the short term but are also sustainable and adaptable to the hospital's evolving needs and the broader community's requirements.

Continuous Monitoring and Evaluation Highlights

Strategy	Summary
Quality enhancements (Immediate solution)	Participate in monthly joint operating committee meetings to support continuous improvement and quality enhancement opportunities.
Technology integration efforts (Immediate solution)	Commit to telehealth technology integration for comprehensive psychiatric and substance use disorder care.
Enhanced data analytics (Immediate solution)	Use our data and analytical capabilities to identify patterns in psychiatric boarding and propose preventive solutions.
Clinical support programs (Longer-term solution)	Implement support programs to improve clinician resilience and job satisfaction, fostering a supportive team dynamic.
Workforce and performance strengthening (Longer-term solution)	Collaborate with the Kansas Office of Primary Care and Rural Health on recruitment drives to enhance and retain a quality workforce.

Shared Goals and Achievements

Our multidisciplinary team, including our CMO, CEO and COO and our provider experience and clinical services team members will work with Ernest and his team to jointly assess the impact of these efforts on improving care as well as morale in Ernest's hospital along with improvements in the broader rural community. We will collaborate with Ernest to develop a range of metrics that

will help us to measure the short-term impact of our interventions as well as to set the stage for ongoing improvements.

Short-term Evaluation Metrics and Measures

In the near term, the following table summarizes how we will jointly track metrics such as the reduction in ED wait times, the number of psychiatric patients successfully discharged to appropriate care settings, and the feedback from staff regarding changes in workload and stress levels.

Goal	Metric	Measure
Reduce "Psychiatric Boarding" times: Aim to decrease the average length of stay for psychiatric patients by 25% within six months.	Average length of stay (LOS) for psychiatric patients in the ED.	Comparison of LOS data pre/post-intervention.
Enhance discharge efficiency: Improve the discharge process efficiency by 30% in the next quarter.	Time from decision-to-discharge to actual discharge.	Analysis of discharge process time logs.
Augment staff training and support: Provide training to 100% of the ED staff on psychiatric patient management within three months.	Number of staff trained.	Training completion rates and pre/post-training competency assessments.
Improve care coordination engagement: Increase number of care coordination interactions by 25% for at-risk or Members living with SMI, with the goal of reducing the number of ED visits.	Number of ED visits per unique Member.	Tracking number of ED visits.
	Percentage increase in care coordination utilization.	Compare number of care coordination interactions (e.g., visits, calls, virtual consultations) per quarter for Members with SMI against baseline.

Long-term Evaluation Metrics and Measures

For sustained improvements, the table below summarizes the metrics and measures we propose to collectively use to track key performance indicators such as the frequency of rehospitalizations for psychiatric patients, retention rates of ED staff, and the overall health outcomes of patients. These indicators will guide our joint continuous quality improvement initiatives and guide our shared responsibility to make sure the hospital provides a high-level of care to all patients.

Goal	Metric	Measure
Strengthening telehealth services: We aim to extend telehealth services to a significant portion of the rural population served by the hospital, with a target to increase utilization by 50% over the next two years.	Increase in telehealth consultations and follow-up appointments.	Patient access rates and satisfaction with telehealth services.
Increase patient diversion to appropriate care settings: Divert 20% of psychiatric cases to	Number of patients diverted to reduce	Tracking referrals and follow-ups to

Goal	Metric	Measure
alternative care settings within the next six months.	prevalence of SMI in rural areas compared to urban areas.	alternative care settings.
Enhancing provider networks: We will work to enhance the network of available mental health providers and services within the existing infrastructure, fostering partnerships and resource sharing.	The number of active partnerships and shared services agreements.	Provider network adequacy assessments and patient service accessibility feedback.
Developing workforce stability: Our goal is to support the hospital in improving staff retention, aiming for a turnover rate reduction in line with regional benchmarks over the next three years.	Year-over-year staff retention and turnover rates.	Staff job satisfaction metrics and exit interview data.

By focusing on these strategic areas, we commit to a partnership with Ernest's hospital that not only addresses current challenges but also supports a robust and reliable health care system for this rural community over the long-term.

Outcomes

Our approach aims to meet this hospital's challenges head-on. By jointly implementing a multi-faceted approach with Ernest's hospital, which includes enhancing psychiatric care, streamlining discharge processes, providing specialized staff training, and leveraging technology like telehealth, we are dedicated to making sure that Ernest's hospital ED is not only relieved of its current burden but is also strengthened for future demands. Moreover, our strategy involves a continuous partnership with the hospital and community stakeholders. We understand that the success of these efforts hinges on our ability to work closely with Ernest and his team, adapting our approach based on real-world feedback and evolving needs. Our strategy also involves a continuous partnership through our provider engagement model, which includes our Kansas-based provider relations team that is dedicated to assisting with the strategy and confirming a strong, localized support system for Ernest's hospital. This collaboration will extend beyond immediate fixes, aiming to establish a sustainable, resilient health care environment for KanCare Members and the broader community.

By implementing these strategies, our goal is to not only provide immediate support but also to empower Ernest’s hospital with enhanced capabilities and resources for sustainable health care delivery in their rural community.

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Topic Area 7: Case Scenarios - Lola

36. Lola is a black female KanCare Member who just turned sixty-five (65) years of age and enrolled in the bidder's dual eligible special needs plan (D-SNP). She lives by herself in Abilene. Lola has high blood pressure and kidney disease. She receives dialysis twice a week and requires Transportation to access care because she does not have a vehicle. Lola has a difficult time hearing, making it difficult for her to communicate on the phone, schedule appointments and Transportation, and understand treatment recommendations from her Providers. While Lola's Primary Care and dialysis Providers are in the bidder's D-SNP network, her Nephrologist is not.
Describe the bidder's approach to meeting Lola's needs.

Introduction

Aetna's approach to successfully transition and integrate Lola into the Medicare plan started with understanding Lola, her goals, and creating personalized connections among care for access, engagement, education, and incentives. Lola is currently in Aetna's Medicaid plan and transitioning to the Highly Integrated Dual-Eligible Special Needs Plan (HIDE SNP). Each month the D-SNP Care team receives a Crosswalk Membership report that indicates which D-SNP Members are also enrolled in Aetna Medicaid. The Medicare Care team proactively reaches out to the Medicaid team to share information and collaborate. The D-SNP care manager reaches out to the Medicaid care coordinator on a regular basis to exchange information and coordinate the delivery of services. The Medicaid care coordinator is also invited to the D-SNP bimonthly Interdisciplinary Care Team (ICT) meetings and weekly utilization management rounds. We have alerts in our Care Management System so that when engaging with D-SNP Members by phone, our D-SNP Care team instantly sees that the Lola is fully aligned with both our D-SNP and Aetna Medicaid program.

Aetna's D-SNP annual **growth rate has averaged over 54% and we will expand our service area to several new counties in 2024. More than 2,000 KanCare Members, like Lola,** are dually eligible and receive their Medicaid and Medicare benefits from Aetna since it allows for a highly integrated approach to her care. Through this integrated teamwork, Lola's needs are discussed, and a plan is formulated to prioritize outreach to her. When Lola ages into Medicare, she is connected with a broker to help her understand her options, including Medicare Advantage Plans. Lola likes Aetna's D-SNP because of its rich benefits, survey results, national standings, and how it complements her Medicaid benefits. The contract that includes Kansas D-SNPs achieved a 4 Star overall rating and the Kansas D-SNPs achieved superior CAHPS results, which measure member satisfaction. These CAHPS results are below.

CAHPS Measure Category	Star Rating for Kansas D-SNP
Care coordination	5 (out of 5)
Getting needed care	4
Getting needed prescription drugs	5
Overall rating of health plan	5

Her broker does inform her that the plan she is interested in only covers in-network Providers. Her broker looks up her Providers in Aetna's Medicare provider directory and finds that her nephrologist is out-of-network. The broker lets her know that she can work with her Aetna Care

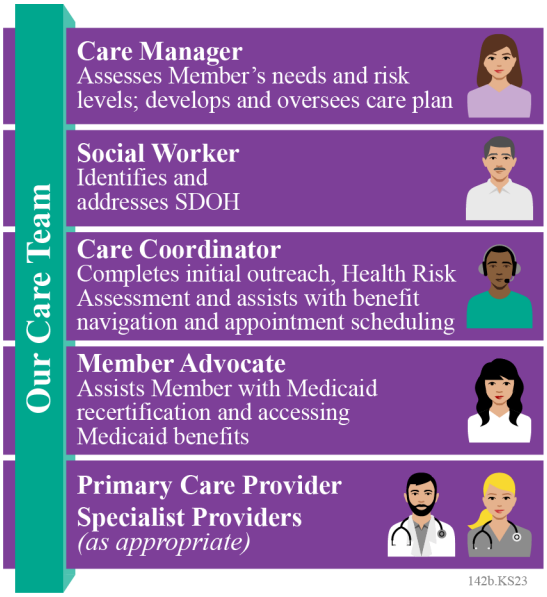
team to grant her an out-of-network exception to continue to see her nephrologist until she chooses an in-network Provider. The broker helps Lola call member services to request a Transition of Care form to initiate the process. Lola, with the help of the broker, fills out some of the information to get the form started and then the broker submits it to her nephrologist to complete.

Aetna Medicare approves Lola's request to continue to see her nephrologist for a period of 90 days, or longer, if needed or if specific-state criteria apply. Lola receives news of the approval by phone conversation with a member of the Care team and by mail. In efforts to help Lola make an informed decision, the Network team lists the **four available in-network Nephrologists within 25 miles** and partners on a request for her current nephrologist to join Aetna's network. This will afford Lola an opportunity for continued care by her nephrologist should the nephrologist wish to join the network.

Lola's broker also explained that while Lola receives her Medicaid and Medicare benefits from Aetna, Medicare will be the primary payor and the Medicare Care team will take the lead with providing care coordination activities and services to confirm a smooth transition. Aetna Medicare successfully employs a model of care that brings together a dedicated ICT which is responsible for coordinating care across all Medicare and Medicaid covered benefits.

The members of Lola's Medicare ICT will include, at a minimum:

- A nurse case manager
- A social worker
- A Medicaid care coordinator
- A member advocate
- A PCP
- Specialist Providers, as appropriate



The care manager pulls in other clinical experts, as needed, to support Lola. These include:

- A behavioral health specialist
- A clinical pharmacist
- A medical director

Members like Lola have complex needs which may be primarily physical, behavioral, or psychosocial in nature, we align the team based on each Member's needs and primary challenges.

Next, to achieve a holistic view of Lola's health and wellness, the assigned Medicare care manager, who is a Registered Nurse (RN), proactively outreaches to the Medicaid care coordinator (who may be an RN or may be a non-clinical care manager) to get information about Lola's medical history, pressing needs, priorities, availability of caregiver support, and anything else that is key to her engagement. Aetna's shared objectives with Lola are to:

- Orient Lola to Aetna's fully aligned HIDE SNP
- Confirm a continuity of critical health care services, in particular that her dialysis treatments are not interrupted

- Address Lola's hearing loss, which has posed a barrier to her accessing services and taking care of her health
- Assess and address her medical, behavioral, transportation, and psychosocial needs and preferences
- Confirm that disparities in care do not impact her service delivery

Like many Medicare Members, Lola lives alone in her home in Abilene, Kansas—a sparse, town where **Memorial Health System is contracted** with Aetna to deliver most, if not all, services. Lola's care manager knows that she can develop a robust plan to meet all of Lola's physical and behavioral health needs, as well as her social support needs, so that she can remain in the community.

Lola can complete a Health Risk Assessment (HRA) with her broker when her enrollment application is submitted. If she does that, it will allow our D-SNP Care team to contact her within her first 30 days of enrollment for next steps in her care journey. If Lola declines completing the HRA with her broker, once she is enrolled in D-SNP, our dedicated team of health survey specialists will reach out to her to explain the importance of the HRA and offer to complete it with her so her Care team can develop an Individualized Care Plan (ICP) to address her needs. Aetna has 90 days from the date of Lola's effective date to complete the HRA.

Lola also has the option to complete the HRA via paper or electronic format/online, which may be a better option due to her hearing challenges. **As an incentive to complete her HRA, Aetna gives Lola a $50 incentive card that can use at selected retail stores.**

Identification and Needs Assessment

Aetna's D-SNP care manager begins Lola's person-centered care delivery by being sensitive to her needs. Aetna's Learning and Development team conducts monthly scheduled sessions to work with members of the care team allowing them to expand their knowledge and increase their skills, awareness, and sensitivity to promote diversity and inclusion. In addition, there are several courses offered internally to widen awareness of empathy, health equity, diversity in the workplace, and active listening, which all assist members of the care team in better relating to Members.

Aetna uses geo mapping to initiate care manager assignments. Should Lola request someone who may have similar cultural and lived-in experiences, we make every effort to honor her request. Aetna believes in managing Members' cultural and linguistic needs. In our matchmaking of our Members to care managers, Aetna further looks at preferences as well as needs, such as language, skill set (ex: intensive/high risk- RN need or BH need), race, and gender. In Lola's case, once enrolled, she asked her Care team if she could be paired with a Black care manager. She wanted to be paired with someone who she believed would better understand her from a cultural perspective. Aetna identified a Black care manager on the team and was able to assign Lola to Beverly, a care manager that would better suit Lola's request. Available through our geo mapping, Beverly will further understand Kansas surroundings, neighborhoods, community resources, strengths, and challenges to care.

After Beverly is assigned, and due to Lola's hearing difficulties, Lola opted to have her HRA

conducted in-person at her home. As a part of Lola's Care team, Debbie, a social worker, was assigned to complete an in-person assessment.

Based upon her HRA responses, Aetna's predictive modeling tool has stratified Lola as **high-risk** due to her multiple comorbidities, frequent physicians' visits, multiple specialist involvement managing Lola's care, and transportation concerns. Lola is at high-risk for poor health care outcomes and related costs. Because she is high-risk, she will have scheduled interaction/**visits a minimum of every three months, but more often as needed.** Our face-to-face encounters with Lola may include visits by individuals of her ICT. Aetna can offer multiple types of visits with a social worker, care manager, or nurse practitioner. Lola's assessment tool indicates that she does not need LTSS at this time, but will continue to be monitored to identify any changes in her condition or her activities of daily living that would warrant LTSS services.

Individualized Care Planning

Engage

Lola's choices are prioritized, and her input drives the meetings and decisions to create a positive experience while meeting her needs and complying with all state and federal requirements.

Beverly, the D-SNP care manager meets with Lola to discuss her medical, behavioral, and social support needs in a holistic integrated manner. Lola agrees and is comfortable with the content of her ICP, which includes interventions covered by her Medicaid benefits such as her ongoing need for transportation to dialysis and other Provider appointments. The ICP is aligned with Lola's preferences, priorities, and goals. Input from the various members of the ICT is considered when developing Lola's ICP, inclusive of consideration toward Lola's Medicaid benefits and services.

Access2Care, which is Aetna's D-SNP and Medicaid transportation vendor is essential to Lola's ICP. Aetna partners with the Access2Care team to provide support directly to care facilities and care management staff. The Access2Care team supports scheduling of trips, notating member profiles with important information, and problem-solving. Access2Care helps in a variety of ways, including new member eligibility verification, recurring and future trip management, evaluating and assigning a Preferred Provider transport company to a Member, cancellations and rescheduling rides relating to changes in health care delivery needs (for example changes in dialysis "chair time"), real-time problem-solving and resolution, special needs management tailored to a Member's individual requirements, as well as personalized service with familiar and highly focused personnel. Access2Care can schedule care transport 30 days in advance and verifies attendance and standing order schedules directly with the care center quarterly, or as needed, when a change in the schedule is requested.

Educate

In alignment with KanCare's focus on care integration for beneficiaries with both Medicaid and Medicare, we explain D-SNP benefits to Lola and how the D-SNP program is designed to deliver person-centered, holistic care. We tailor our interactions with Lola to confirm that education is provided and offered in a manner that is geared to meet her learning ability and hearing challenges. An assessment of her current knowledge base regarding her physical, dietary, and behavioral needs is conducted. Integration of benefits and how they are geared to support her health care journey is discussed to expand her knowledge on these benefits and how she can

access them to support her needs. Each interaction with Lola offers another opportunity to further educate or support prior education.

Lola's ICT has extensive training in Motivational Interviewing, where a collaborative conversation occurs with the intention of strengthening Lola's commitment to change that will ultimately result in positive outcomes for Lola and her health care journey.

In addition, with agreement from Lola, she will receive a Healthy Home Visit by a Nurse Practitioner (NP). The visits are scheduled in a variety of ways; 1) by the Care team 2) Lola can reach out to member services 3) Lola can schedule using the online portal 4) the NP reaches out to Lola proactively to offer a visit.

As of September 2023 YTD, **41% of Aetna's D-SNP Members** have either completed or scheduled a Healthy Home Visit. 149.KS23

The visit includes a comprehensive assessment consisting of an in-home physical with a medical, functional, SDOH, and mental health evaluation. The assessment will also review home safety and incorporate a medication reconciliation. Beverly tells Lola about the visit and Lola looks forward to it. The NP who completes the visit will, with Lola's permission, send a visit summary to her PCP. The complete assessment will be visible to Lola's D-SNP Care team in the Care Management System. The NP also can request immediate outreach from Lola's Care team, if needed.

The ICT identifies and confirms its understanding of needs, preferences, and personal goals with Lola and documents in her respective care plan.

Individualized Care Plan (ICP)

Lola's Goal	Aetna's Intervention	Outcome
Address and improve her hearing challenges	Assist her in finding a specialist to assess her hearing impairment and follow the recommendations	Assist Lola in obtaining hearing aids using her Aetna D-SNP Medicare benefit first ($2,500/ear/year) with an in-network Provider who has offices near her. Aetna's vendor has a location in Abilene. If she exhausts her Medicare benefit, her Medicaid benefit should cover additional hearing expenses.
Manage high blood pressure	Evaluate history of high blood pressure. Review and record medications.	Arrange home monitoring of high blood pressure. Educate on adherence to her medication. Coordinate, if applicable, 90-day prescription drug deliveries at home on an ongoing basis.
Continue to manage her kidney disease	Assess for other chronic illnesses in addition to end-stage renal disease	Monitor care to confirm that Lola is stable.
Maintain dialysis schedule	Confirm transportation to dialysis	Confirm ongoing prescriptions and transportation to dialysis without a break in appointments.
Access to a Nephrologist	Offer a period of continuity of care of 90 days	Reach out to Lola's current Nephrologist to ask him/her to join the network.

Benefits

The Medicare supplemental benefits, Medicaid value-added benefits, and financial assistance programs are designed to reduce the barriers to accessing food, transportation, housing, and health care, while increasing the social and quality of Lola's well-being.

Medicare Supplemental benefits available to all D-SNP Members. For example, **Lola can have a basic membership to SilverSneakers® fitness locations**. If she prefers to exercise at home, she can attend online classes or get an at-home fitness kit. She will also receive an Extra Benefits Card with a $250 monthly allowance to pay for items such as transportation costs (public transportation, gas, Ubers), healthy foods, utilities, rent or mortgage, personal care items, and select over-the-counter pharmacy product. Also, the following table illustrates **benefits available under Aetna's D-SNP and Medicaid plans.**

Benefit	Description of the Medicare and Medicaid Value Available
Access2Care	Unlimited trips for medically necessary treatments/care (i.e., dialysis, hearing appointments and Silver Sneakers).
Hearing	Medicaid, annual hearing exam, a hearing aid evaluation/fitting, and $2,500 per ear per year to pay for hearing aids.
Dental	$3,000 per year for Medicare and $500 under Medicaid and All ADA codes covered except for cosmetic procedures.
LifeStation Medical Alert System	Medicare, A medical alert system that provides members with 24/7 access to help in the event of a fall or other emergency. It includes an optional fall detection feature. Available Communication Systems.
Vision	Medicaid, annual eye exam and $400 per year for prescription eyewear.
Verizon cellphone	Medicaid, expanding on the Federal Lifeline benefits to expand access to care, assisting with telehealth, ability to use mobile app.
Pyx Health	Medicaid, Pyx Health Members can download an application that helps them fight loneliness. Members can connect with compassionate humans for a friendly chat or help with resources.

Empower

Lola is given the opportunity to receive up to $150 in incentive cards if she completes the Health Risk Assessment, Healthy Home Visit and certain screenings/tests to help manage her care.

We will empower Lola to take an active role in her ICP, closely aligning with the members of Lola's ICT to increase access to available supports and services to meet Lola's community and health needs in living independently. The Lola's ICT include Care team members who have specialized knowledge of Medicare and Medicaid benefits as well as community services that are available to address Lola's needs. On an ongoing basis, we will further educate her about her conditions and help her to mitigate any issues she may have regarding her hearing loss and transportation issues. In addition, through Motivational Interviewing, we will empower Lola to make positive behavior changes, inclusive of dietary, medical, pharmaceutical, and social aspects of her life, which will enable her to be successful in her health care journey.

Prioritizing goals is also an important step in Lola's service plan, defining success on her terms, based on her needs with action steps motivating her to have a say in a) **what is addressed** and b)

the order in which items are addressed. Our Teletypewriters (TTY) and Assistive Technology for Kansans (ATK) programs provide Lola with the ability to communicate effectively with her care team, providers, and social network, thereby increasing her confidence and ability to communicate effectively. With every interaction, in-person care, and coordination, she is provided with the opportunity to identify the assistive technology necessary to learn, work, play, and participate in the community safely and independently.

Care Monitoring and Oversight

Reaching Lola's goals requires consistent monitoring and support, assessing progress and making modifications where needed. The ICT connects with Lola based on her personal preferences via **on-site or video conference every three months to confirm her ICP objectives and progress or address any barriers to her care.** In addition, Lola will be given the opportunity to receive a Healthy Home Visit from a NP each year. The visit, a component of Lola's ICP will entail a comprehensive assessment that consists of an in-home physical with a medical, function, medical, SDOH, and mental health evaluation. The assessment will further review home safety and incorporate a medication reconciliation. Finally, this visit seeks to close gaps in care on-site in Lola's home. **As of** September **2023, 41% of D-SNP Members have completed or scheduled a Healthy Home Visit.**

We recognize that unexpected life events may occur that impact Lola's current high-risk status or LTSS eligibility. We are fully equipped to recognize and address any barriers. Members receive coordinated, high-quality care that holistically addresses their health needs and offers opportunity to live in the community of their choice. We do this by confirming appropriate infrastructure, staffing, technology, programs, and resources, and by building partnerships with local, trusted community-based organizations to address members' social needs.

Outcomes

Aetna, a market share leader, embraces KanCare's vision to support Lola in improving her experience, satisfaction, and outcomes. Lola's goals are achieved because of the passionate and relentless efforts demonstrated by Lola's ICT delivering a holistic, member-centric approach through seamless coordination and delivery. Lola's care is addressed through prioritization and goal setting. She is an integral part of her own care, and the Care team engages with Lola to address her health and needs. As a result of enrolling with Aetna in the D-SNP plan, Lola can receive continued care related to her nephrological needs as her nephrologist became an in-network Provider. Lola's hearing is addressed through access to hearing specialists, testing, and customized hearing aids that have allowed Lola to enjoy interacting with her friends and family, using a telephone, watching TV, and socializing with others. Her blood pressure is under control. She can use transportation for needed medical services as well as use supplemental benefits to transport her to her weekly religious services and attend weekly social gatherings with others in her community. Lola's dietary choices have improved through education and training she has received because of her Care team providing education and support that is geared toward Lola's physical and medical needs.

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Topic Area 7: Case Scenarios - Jason

37. Jason is a twenty-eight (28)-year-old, male, American Indian who is currently living with his family on the Potawatomi Indian Reservation, but intermittently moves off and on the Reservation. The bidder has just been notified of Jason's Enrollment in the bidder's MCO. Not only is Jason a new KanCare Member, he is also new to managed care.
Jason moved home after he was evicted from his apartment in Topeka for non-payment of rent. He has been unable to maintain ongoing employment due to inconsistent attendance.
Prior to Enrollment with the bidder, Jason was recently seen at a nearby non-participating Indian health care Provider (IHCP) where he was diagnosed with type 2 diabetes. Jason has a Hemoglobin A1C of 8.76 and has a history of binge drinking since age sixteen (16). He said he drinks when he is depressed and that his drinking and depression have created problems for his maintaining work and in his relationship with his family and friends. The nurse practitioner at the IHCP prescribed Metformin, recommended Jason consider participating in a special diabetes program offered through the Tribe, and provided Jason with a referral to a non-participating Provider for a Behavioral Health assessment and treatment. Jason has not followed up on either the recommendation or the referral.
Describe how the bidder will identify the needs of this KanCare Member, the bidder's approach to meeting the needs of the Member, and how the bidder will coordinate the Member's care.

Introduction

Upon his enrollment with Aetna, Jason will begin a managed care journey that **honors his choices**. Jason will have **access to convenient, high-quality care** and **new benefits** that will help him achieve health, wellbeing, and independence. We will walk in wellness with Jason's Indian Health Care Providers (IHCPs) to **engage**, **educate, incentivize, and empower Jason to self-direct his care** so he is equipped to achieve his personally defined health goals.

Our holistic approach to care coordination will help Jason improve his **physical, behavioral, and social well-being.** His Person-Centered Service Plan (PCSP) will tailor solutions to address his depression, Alcohol Use Disorder (AUD), and diabetes; improve his interpersonal relationships; and stabilize his housing and employment. Jason will select his **Interdisciplinary Care Team (ICT)**, including his **Tribal and Aetna care coordinators,** his Tribal and non-Tribal Providers, family members and friends, and Community-Based Organizations (CBOs) that will support him every step of the way.

Commitment to Health Equity

We share the State's goal to **reduce health care disparities** across all socioeconomic and demographic populations, including Members like Jason who are American Indian/Alaska Native (AI/AN) and live in rural areas. Since October 2019, we have supported **more than 4,000 AI/AN KanCare Members**.

Our longstanding commitment to health equity

Health disparities among American Indian/Alaska Natives (AI/AN)

Worse outcomes for alcohol use disorder

- Higher rates of heavy alcohol use (binge drinking on 5+ days/month)
- Young adults (15-24) are **12x more likely** to die from alcohol than non-Hispanic Whites
- AI/AN in the Midwest are **4x more likely** to die from alcohol than in other regions of the country
- Highest rates of death attributed to alcohol poisoning compared to other racial/ethnic groups

Worse outcomes for diabetes

- **3x more likely** to be diagnosed with diabetes
- **2x more likely** to be diagnosed with end-stage renal disease
- **2x more** likely to die from diabetes-related causes than non-Hispanic Whites

Source: CDC, 2021

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reflects who we are as a company; it is embedded in our purpose of **bringing our heart to every moment of your health.**

Our commitment will be strengthened even further under our new **Kansas-based health equity director.** This person will advance health equity for our Members, Providers, and communities through internal health plan operations and external partnerships.

Aetna has invested **$42 million across eight states to create, preserve, or renovate 565 affordable rental units** for AI/NA populations, most with on-site supportive services.
Some of these investments have been in partnership with Travois, a Kansas City, Missouri-based Certified B Corporation® focused exclusively on promoting housing and economic development for American Indian, Alaska Native and Native Hawaiian communities. 131.KS23

We are proud to be an NCQA inaugural health equity-accredited plan and will coordinate care for Jason and all Aetna KanCare Members so that they have a **fair and just opportunity to achieve optimal health.** From January 2022 to June 2023, we achieved:

AI/AN KanCare Members	Rural KanCare Members engaged in care coordination*
• 28.8% reduced BH-related hospitalizations • 7.5% higher diabetic medication adherence • 6.9% higher antidepressant adherence • 3.8% higher annual A1c and/or LDL testing • 5.5% higher diabetic nephropathy testing	• 26% higher rate for nephropathy screenings • 17% higher rate for at least one A1c test • 8% higher rate for having at least one prescription for diabetes medication

**compared to rural Members not engaged in care coordination*

Identification and Needs Assessment

Upon receiving Jason's KanCare 834 enrollment file, we will initiate new Member outreach. Within 10 days of enrollment, we will attempt to contact him by phone at least three times during various times of the day to complete a health screen. We will send him a welcome packet that includes a Member handbook, his ID card, and a paper copy of the Health Screening Tool (HST). If we cannot reach him, we will call, text, and send letters every 90 days to complete the HST.

As a new KanCare and new Aetna Member, Jason will receive information about the KanCare programs and benefits available to him, including Aetna's value-added benefits (VAB), such as free dental exams and cleanings, transportation, monthly allowances to purchase over-the-counter supplies, and more. We will help Jason select a PCP within 10 business days of enrollment so that he has a consistent and convenient usual source of care. Jason can choose an IHCP—such as the nurse practitioner (NP) who recently treated him—or an Aetna-contracted Provider. If we are unable to reach Jason or he does not select a PCP, we will assign one within the required geographic access standards, though he can change PCPs at any time.

If Jason chooses the NP or a PCP at the Prairie Band Potawatomi Nation (PBPN) reservation clinic, we will treat them as in-network and reimburse them according to the Kansas Medicaid fee schedule. To date, 186 Aetna KanCare Members have received care at the PBPN clinic. Because we share the State's goal to **encourage Provider participation in Medicaid,** our network team will periodically reach out for potential contracting. Regardless of their network

status, Jason will be able to see his IHCPs. Any non-participating Providers to whom they refer Jason will also be treated as in-network and reimbursed at the Kansas Medicaid fee schedule.

Based on what we know about Jason, our risk stratification tool will identify him as high-risk and a candidate for Level III care coordination. Our Engagement Hub will contact him to complete the HST and ask about his interest in enrolling in our program. We are confident Jason will agree to participate in care coordination as we have an excellent track record in engaging the AI/AN population. From January 2022 to June 2023, **we increased the number of AI/AN Aetna KanCare Members enrolled in care coordination by more than 90%.**

With his consent, we will pair Jason with Monica, a Topeka-based **Aetna clinical care coordinator** with cultural competency and awareness of Tribal customs and beliefs. She has extensive experience working with AI/AN Members, Tribal social workers (TSWs), and IHCPs.

Person-Centered Service Planning

Our care coordination process comprises a set of person-centered, goal-oriented, culturally relevant, and logical steps to make sure Jason receives needed services in a supportive, effective, efficient, and cost-effective manner. The HRA and SDOH assessments will help Jason identify and understand the full range of his physical, behavioral, and social needs. They will also help document Jason's care preferences so that his service plan can be tailored to honor his beliefs and customs. Throughout the process, Jason will have the opportunity to answer and ask questions.

Engage

Monica will engage Jason by putting his needs, goals, and preferences at the center of his care. To make sure Jason has a **single point of contact**, she will ask him if he prefers to have a TSW as his lead **community care coordinator**. She will also ask if there are any family or friends' contact information we should add in case we are unable to reach him.

With Jason's consent, Monica will contact the PBPN Social Services Administration to connect with Jason's assigned TSW, whom we are calling Michael. To avoid duplication, Monica will ask Michael whether Jason has an existing service plan, has recently completed any assessments, or has ongoing relationships with any other providers besides the NP he recently saw. She will document these in our care coordination system. She will also ask Michael if they can set up regular check-ins, either in-person or by phone, so that they can establish a relationship, clarify roles and responsibilities, promote communication, and exchange information.

If Jason does not have assessments on file, Monica will work with Michael and Jason to schedule a face-to-face visit. During this visit, Jason will complete a Health Risk Assessment and SDOH Needs Assessment. As they go through the questionnaires, Jason, Michael, and Monica will begin developing Jason's PCSP and assembling his ICT.

Because he is new to managed care and has Tribal and non-Tribal benefits, we do not want to overwhelm or confuse Jason with appointments, providers, and programs. Rather, **Jason will set the pace and intensity of services he receives**. The following table provides examples of information Monica and Michael will use to help Jason develop his PCSP.

Jason's Care Preferences and Readiness	
• Health and technology literacy • Health beliefs and behaviors (including readiness for change) • Linguistic, cultural, and spiritual needs and preferences • Visual and hearing status and needs • Preferences for receiving care (in-person at a Provider office, at home, and virtually) • Best days/times to reach him	• Current and preferred living situation • Preferred timeline for moving • His physical environment and safety • Whether he has a usual source of transportation or would like assistance in arranging rides • Preferences for filling prescriptions (IHCP or another pharmacy, home delivery, 90-day refills • Participation or interest in community, recreational, and faith-based activities • How much involvement in his care Jason desires to have from family and friends

Together with Michael, Monica will ask Jason about where he wants to live. While he is not currently unsheltered, we understand that he is living with family and that AI/AN individuals face disproportionate—and often undercounted—rates of homelessness (National Alliance to End Homelessness, 2023). They will ask Jason if he prefers to stay with family for now or wants to find other housing right away. Monica will also ask whether Jason prefers to work with the PBPN housing agency, our local Aetna Care Advocate housing specialists, or both.

Monica will employ Motivational Interviewing and the Charting the LifeCourse framework to help Jason identify his goals for his health and his life overall. Identifying long-term objectives and knowing that resources and support will be available when the time comes will encourage Jason to focus on his near-term needs and assist him in setting **specific**, **measurable, achievable, realistic and timely (SMART) goals.** Jason tells Michael and Monica that his goals are to:

1. Learn about diabetes and how to self-manage his condition.
2. Take steps to understand and treat his depression and improve his relationships.
3. Participate in programs and support groups that will help him manage his binge drinking.
4. Find a job in Topeka that matches his skills and interests.
5. Maintain consistent attendance at work.
6. Move to Topeka on a timeline and with the supports in place to ensure the move is permanent.

Educate

We share the State's goal to **improve the public's capacity to make informed and appropriate health care decisions.** Thus, Jason will educate Michael and Monica on his needs, goals, and preferences, and they will educate him about the benefits and services available through the PBPN, other Tribes, and Aetna. Monica and Michael will also be learning from each other, which will further strengthen their **collaborative** relationship.

Michael will ask Jason about his interest in participating in the **Special Diabetes Program for Indians (SDPI).** Nationally, this program has demonstrated immense success. According to their 2020 report to Congress, the SDPI has reduced blood sugar levels, risk factors for cardiovascular disease, diabetes-related mortality (by 37%), hospitalizations for uncontrolled diabetes (by 87%), and the overall prevalence of diabetes among the AI/AN population—the only racial/ethnic group in the U.S. to have done so. The program has also helped **cut the rates of diabetic eye disease and end-stage renal disease in half** from 1999-2013.

To manage Jason's depression and AUD, Michael will provide information about the **PBPN Behavioral Health program.** They are a certified treatment Provider that employs a wide range of approaches. They combine biological, social, psychological, and spiritual models of addictive disease, including the Developmental Process of Recovery, self-help programs, MI, strength-based methods, the Red Road approach, and therapy.

Monica will share information about Aetna's VAB, transportation services, telehealth programs, housing and employment supports, and our closed-loop referral platform for SDOH services. For example, Monica will offer to connect Jason to Aetna's **No Place Like Home Program**, which can partner with the Tribe's housing specialists to support him with move-in costs and reduce financial barriers to permanent housing. Monica will ask Jason about any transportation issues and explain that **living in a rural or frontier area should never be a barrier to care.** Jason will have access to free rides not just to and from medical appointments, but also for things like job training, interviews, pharmacy pick-ups, and more.

Since he has been newly diagnosed with diabetes, Michael and Monica will emphasize the increased importance of routine physicals, dental check-ups and cleanings, and the availability of free podiatry and retinal eye exams through Aetna. Monica will offer to assist with scheduling free dental exams not only to support Jason's health but also to advance the State's goal to **expand access to and increase utilization of preventive oral health services.**

Incentivize

To incent Members like Jason to take an active role in their physical, mental, and social well-being, we offer several financial assistance and incentive-based programs. Monica will provide information on the ones most relevant to Jason, as listed in the table below.

Program or Benefit	Description
Healthy Rewards	$25 or $35 incentive card for completing: HbA1c test; diabetic retinal, kidney function, and podiatry exams; flu and COVID-19 vaccines.
[redacted]	[redacted]
Over-the-Counter (OTC) benefit	$25 monthly allowance to order OTC drugs and supplies delivered directly to Jason’s home.
Healthy Food Benefit	$30 monthly incentive card for three months to purchase healthy foods, after which Monica will assist him in signing up for SNAP benefits.
No Place Like Home	Up to $5,000 to support Jason with one-time costs like tenant application fees, security deposits, and first/last month’s rent.
Affordable Connectivity program	**Enhanced Tribal Benefit:** $75—rather than $30—per-month discount on internet service and up to $100 for a laptop, tablet, or computer.
Aetna Better Connections	Android smartphone and talk/text/data plan (can also be used as hot spot) for Members who have exhausted federal Lifeline benefit.

VAB and financial assistance programs are not just about incentive cards. They also advance:

1. **The State’s goal for MCOs to provide a bridge to independence and private health coverage:** helping Jason achieve small “wins” like completing an online learning module will

motivate him to tackle the bigger issues like AUD. Managing AUD will give Jason confidence and motivation to find and maintain a job and transition to private or employer coverage.

2. **Jason's goal of moving back to Topeka**: helping Jason enroll in financial assistance programs like Aetna Better Connections will relieve some of the worry and financial strain that comes with having to find a place to live and being able to pay the bills.
3. **Health Equity:** by helping Members like Jason enroll in the Enhanced Tribal Benefit, we make sure AI/AN and rural Members have the same level of access to broadband, telehealth, and online SDOH supports as urban and White/Non-Hispanic Members.

While 99% of urban households in the U.S. have access to broadband, only 65% of households on American Indian/Alaska Native rural lands do. *(Federal Communications Commission, 2019)*

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Ultimately, **Jason will decide which programs, providers, and services are right for him.** Michael will add them to his PCSP, and Monica will document them in our care coordination system. Monica will confirm Jason's PCSP addresses his **physical, behavioral, and SDOH needs in alignment with his self-defined goals.**

In developing his PCSP, Jason—with Michael and Monica's support—will identify his ICT. **Figure 37-1** shows an example of the people Jason will choose to be part of his ICT. Once Jason has agreed to his service plan, Monica will disseminate it to all members of his ICT through our care coordination communication portal. She will connect Jason to the non-Tribal programs and resources he has identified and will offer to assist Michael in obtaining referrals to non-Tribal services.

Monica will also offer to assist with scheduling any follow-up appointments or arranging transportation. For example, if Jason shows interest in Alcoholics Anonymous (AA), Monica knows there are AA meetings on Wednesday evenings at the Rock Building at the Potawatomi reservation. However, individuals in recovery often need daily support, so Monica will help Jason find AA meetings offered on additional days of the week.

Figure 37-1: Jason's Interdisciplinary Care Team.

Coordination with Jason's Tribal Care Coordinator

Because our goal is **One Member, One Team**, Monica will strive to support Jason and Michael by sharing information, coordinating referrals and authorizations, and bridging any gaps so that Jason has access to the full range of benefits available to him. Her goal is to prevent confusion, avoid duplication of services, and complement—rather than take over or replace—Michael's efforts. As established during their initial contact, Monica and Michael will check in on a regular basis to foster a positive working relationship grounded in trust and collaboration.
Jason's ICT will meet with him monthly to review his progress on achieving his care goals, update or adjust any of his treatment plans, connect him to additional supports, and resolve any

gaps in care. As the lead care coordinator, Michael will schedule and run these calls. Monica will offer to assist with scheduling and leading them, honoring both Jason and Michael's preferences.

Before every ICT meeting, Monica will review Jason's claims history, any approved or pending prior authorizations, prescriptions, and Provider utilization data. These reviews help **resolve gaps in care and avoid duplication of services.** After each ICT meeting, Monica will document any updates to Jason's service plan, work with Michael to obtain signatures, and distribute new copies to all ICT members. She will also track and follow up on referrals to SDOH services. With Jason and Michael's approval, Monica will meet with Jason outside of the monthly ICT calls through bimonthly face-to-face visits and monthly phone calls. She will ask about his interests, remind him of incentive and VAB, help with referrals to SDOH supports, and provide information on diabetes management, nutrition, depression, and other topics to improve his health literacy. She will also answer his questions and follow-up on his requests.

Empower

We share the State's goals to **reduce poverty, spread prosperity to every corner of the State, and resolve systemic barriers to optimal health and independence.** By taking charge of his health and engaging in Tribal and Aetna-provided programs, Jason will be able to uncover and **address the root causes of his poor health.** This could include potential traumas that could have contributed to his binge drinking starting at age 16, historical and systemic injustices against AI/AN populations, and situational, environmental, or other triggers that exacerbate his depression and AUD, which in turn negatively affect his relationships with family and friends.

Through managed care, Jason will build new skills and tap into new support systems in addition to his Tribal benefits. Monica will coordinate with Michael to avoid duplicating Tribal services or overwhelming Jason with additional apps, appointments, and Providers. Together, they will **empower** Jason with the **people, programs, and technology** to achieve his life and health goals.

People. To assist Jason in finding suitable employment and affordable housing, Monica will work with Aetna's locally based **Care Advocate Specialists,** comprised of subject matter experts in Kansas-specific housing, employment, crisis/recovery, resiliency, and other areas. Our housing supports administrator, Simon Messmer, has a master's degree in social work and 20 years' leadership experience in Kansas-based BH and housing initiatives. He chairs the Greater Kansas City Coalition to End Homelessness, sits on the Steering Committee of the Kansas Statewide Homeless Coalition, and is the former Chair of the Governor's Behavioral Health Services Subcommittee on Housing and Homelessness. With Jason's consent, Simon and his team will assist Jason in securing an up-to-$5,000-grant to pay for one-time housing costs through Aetna's **No Place Like Home Program.** Since 2019, we have provided nearly $82,000 to 36 Members.

Jason can also choose to work with both the Tribal vocational support programs and Aetna's Kansas-based employment supports specialist, Shanti Ramcharan. Shanti has a master's degree in vocational rehabilitation counseling and is a Licensed Professional Counselor and Master Addiction Counselor. She has helped AI/AN individuals on college campuses and through the U.S. Department of Veterans Affairs. She also serves on the Kansas State Rehabilitation Council. With Shanti and her team's support, **Jason will identify his strengths, set career goals, overcome challenges, and apply for jobs**. Shanti can also connect Jason with job-related peer supports, training, and coaching.

Programs. We understand that health, education, and work are intertwined and have created **CVS Workforce Innovation and Talent Centers (WITCs)** to help Members become self-sufficient. WITCs offer health assessments, job training, and interview support such as clothing, resume writing, and mock interviews. If he is interested, Monica will connect Jason to our WITC in Topeka.

CVS WITCs train and find work for 13,000 individuals each year. Since 2013, we have helped 120,000 individuals transition from public assistance into careers with local employers and have supported 21,500 registered apprentices.
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Technology. In addition to making sure Jason has broadband, a laptop, a cellphone, and a data plan, Jason will have access to telehealth and online tools to support his physical, behavioral, and social well-being. He will identify the ones that are most convenient and appealing to him, and Monica will assist with enrolling in and navigating these tools.

Technology	Summary	Benefits for Jason
One Telemed	Telepsychiatry Provider increases access to psychiatrists, addictionologists, psychiatric NPs, nurses, licensed counselors, and medical assistants. Providers have diverse backgrounds and cultural competency.	• Jason will be able to see a BH Provider in less than 72 hours (One Telemed's average wait time).
Vheda Health	Remote Patient Monitoring program transmits real-time data from connected wearable devices via iPhone. Jason will receive an iPhone, unlimited monthly talk/text/data plan, a scale, a blood pressure cuff, a glucometer, and home delivery of diabetes test strips. Triage nurses will respond to alerts and make calls to Jason if his values are out of the normal range.	• Jason will interact with Providers via video, access diabetes education materials, and accomplish weekly tasks related to nutrition, healthy lifestyle, and diabetes management. • Vheda has **lowered HbA1cs for Members with diabetes by 2.4% and reduced costs 20% across multiple chronic conditions**.
Workit Health	24/7 access to SUD/AUD services, weekly counseling, and self-paced cognitive and dialectical BH courses. Platform monitors for depression and anxiety, triages medical concerns, resolves medication issues, and provides psycho-social support.	• Jason will have 24/7 access to treatment and services that empower him to manage his conditions. Workit has demonstrated high rates of patient retention in SUD treatment.
Pyx Health	Chatbot will build trusted/loyal relationship with Jason. Compassionate Call Center will make companionship calls when Jason scores low on loneliness assessments. Pyx Health will contact Jason within one business day to follow-up on any urgent SDOH needs. Pyx Health can connect Jason to SDOH resources, Providers, Aetna's 24/7 nurse hotline, or a suicide hotline.	• Jason will have tools to help manage his depression and improve his interpersonal relationships. In the five Aetna markets using Pyx, we have seen reductions in: Depression (52%), Anxiety (56%), and Loneliness (41%). Pyx Health has helped 78% of Members feel more connected to their plan.
MDLive	Video appointments for medical care, psychiatry, and talk therapy.	• Jason will have convenient access to Providers when PBPN clinic is closed.

Care Monitoring and Oversight

As the entity ultimately responsible for managing Jason's care, we will monitor, reassess, and coordinate Jason's benefits and services based on his evolving physical, behavioral, and social health needs. In collaboration with Michael, Monica will do this through; Claims and utilization review, Bimonthly Member face-to-face visits and monthly phone calls, Monthly ICT meetings, Monthly interval assessments and service plan updates, including new, accomplished, revised and outstanding care goals, SDOH Z Codes, referrals, and utilization and gaps in care reports.

If Jason is not making progress on his service plan, we may discuss him during our twice monthly complex case rounds. During these rounds, utilization management staff, pharmacy staff, clinical leaders, and medical directors discuss complex Members and collaborate on ways to better assist them. Care advocate specialists use their personal experiences and subject matter expertise to incorporate social, recovery, and cultural considerations into Members' care.

Monica, like all Aetna care coordinators, will be audited on a regular basis to make sure Jason is receiving the highest quality service. This includes health record audits, ride-alongs to in-home visits, and monitoring of live or recorded phone conversations. Care coordination directors and managers also review the **Daily Operational Dashboard** for care coordinator performance on metrics like timeliness of assessments and PCSPs, Member engagement, and caseloads.

Follow-up

Our Care Coordination program supports person-centered, whole-person, longitudinal care, from preventive to acute, complex, and chronic care needs, including social needs. As such, Jason will move fluidly between care coordination levels as his needs evolve over time.

Monica will meet with Jason by phone at least once a month and in-person at least once every other month, according to Jason's preferences. She will work closely with Michael to document any updates to his physical, behavioral, and social health status and any changes to his PCSP. Monica will employ discovery tools such as "What's Working/Not Working" and "4 plus 1 Questions" to help Jason overcome challenges, develop, and maintain positive habits, and ultimately succeed in achieving his long-term goals.

Monica will also coordinate with Michael to **actively facilitate connections** to BH providers, alcohol treatment programs, diabetes management and nutrition counseling, job coaching, and CBOs/SDOH services. [redacted]

Aetna care coordinator collaborates with Tribal social services to expedite waiver request for Kickapoo Member

An Aetna foster care Member with BH conditions and intellectual and developmental disabilities (IDD) was admitted to the ER. Hospital staff had concerns about discharging the Member to her home, recommending a facility transfer instead.

The Member's guardian expressed being overwhelmed and asked the Aetna care coordinator to work with Kickapoo social services on the best solution for discharge. They immediately scheduled an integrated care team (ICT) call to pursue a crisis exception request to access IDD waiver services, and the request was granted within seven days.

Through close collaboration with the Kickapoo care coordinator, we were able to honor our Member's desire to reside safely in the community by facilitating access to home- and community-based services.

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Ongoing Reassessments

Any time there is a change in Jason's circumstances or health conditions and whenever there is a triggering event, such as an ED visit, inpatient stay, change in living situation, or new diagnosis, Michael or Monica will complete a Health Screen and update Jason's PCSP.

If Jason is admitted to a facility for any reason, Monica will receive an ADT alert. She will notify Michael, participate in Jason's discharge planning, and assist with securing post-discharge services, such as DME. Any time there is a change, Monica will reassess Jason (or confirm that Michael has) and update his PCSP within three calendar days. She will also reassess him at least annually.

Outcomes

When Jason is doing well and achieving his near-term milestones, Monica will collaborate with him and Michael to set new care goals that range from greater self-management of his chronic conditions (such as lowering his A1c), to securing employment and maintaining consistent attendance at work, to taking steps to move to Topeka.

When Jason is struggling and needs additional support and resources to get back on track, Monica will make sure he obtains referrals and authorizations to Providers, closed-loop connections to SDOH services, and transportation.

We are confident Jason will engage in AUD treatment and self-manage his diabetes because his Tribe has demonstrated immense success and because **Aetna has the highest rates of AUD treatment initiation** and **highest scores for comprehensive diabetes care** of any Kansas MCO.

Aetna is the No. 1 ranked MCO in Kansas for comprehensive diabetes care, scoring above the 90th percentile for HbA1c control and above the 75th percentile for diabetic eye exams in 2022. 066.KS23

When Jason is ready to move to Topeka, Monica and Michael will update his preferences about where he wants to continue his care. Jason will choose whether to have Michael continue to serve as his lead care coordinator and single point of contact (SPOC) or transition to Monica.

If he chooses to keep his PBPN providers, Michael and Monica will confirm and document **continuity of care with Jason's IHCPs**. If he chooses to transition to in-network Providers, Monica will coordinate with Michael to help Jason select appropriate Providers located conveniently near his home or place of work. They will update his chosen ICT, including any new (or continued) family and friends who will be involved in his care in Topeka.

Monica will confirm that Jason's prescriptions are transferred to a pharmacy in Topeka and will assist Jason in finding local AA meetings or other community-based recovery and peer support services. She will also help with Topeka-based food supports and any other SDOH services he needs. Even if Jason decides to transition some or all of his care to Topeka-based providers, he will always have access to his Tribal Providers, benefits, and services.