Financial Statements - Statutory Basis

Aetna Better Health, Inc.
(a Louisiana corporation)

Years Ended December 31, 2019 and 2018
with Report of Independent Auditors

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Report of Independent Auditors

Board of Directors
Aetna Better Health, Inc. (a Louisiana Corporation)

We have audited the accompanying statutory-basis financial statements of Aetna Better Health, Inc. (a Louisiana Corporation) (the Company), which comprise the balance sheet as of December 31, 2019, and the related statements of operations, changes in capital and surplus and cash flow for the year 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 Louisiana Department of Insurance. 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 audit. We conducted our audit in accordance with auditing standards generally accepted in the United States. 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 Louisiana Department of Insurance, 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, 2019, or the results of its operations or its cash flows for the year 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, 2019, and the results of its operations and its cash flows for the year then ended, on the basis of accounting described in Note 2.

Report of Other Auditors on December 31, 2018 Financial Statements

The statutory-basis financial statements of Aetna Better Health, Inc. (Louisiana) for the year ended December 31, 2018, were audited by other auditors who expressed 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 Louisiana Department of Insurance on those statements on May 30, 2019.

Ernst & Young LLP

April 28, 2020

Balance Sheets - Statutory Basis

(In Thousands)	December 31, 2019	2018
Admitted assets		
Cash and invested assets		
Bonds	$ 127,872	$ 119,309
Cash, cash equivalents and short-term investments	11,901	18,266
Other invested assets	9,953	—
Total cash and invested assets	149,726	137,575
Investment income due and accrued	920	862
Premiums and considerations receivable	75,861	61,536
Reinsurance recoverable	357	—
Amounts receivable relating to uninsured plans	1,673	—
Current federal income tax recoverable	776	—
Net deferred tax asset	1,712	3,218
Receivables from parent, subsidiaries and affiliates	—	12,648
Health care and other amounts receivable	3,606	3,062
State tax recoverable	199	593
Total admitted assets	$ 234,830	$ 219,494

See accompanying Notes to the Statutory Financial Statements

Balance Sheets - Statutory Basis (continued)

(In Thousands)	December 31, 2019	2018
Liabilities and capital and surplus		
Liabilities:		
Claims unpaid	$ 115,603	$ 84,534
Accrued medical incentive pool and bonus amounts	728	472
Unpaid claims adjustment expenses	1,631	1,937
Aggregate health policy reserves	41	19,911
General expenses due or accrued	12,943	10,432
Current federal income tax payable	—	652
Remittances and items not allocated	120	395
Amounts due to parent, subsidiaries and affiliates	23,150	36,200
Other liabilities	738	427
Total liabilities	154,954	154,960
Capital and surplus:		
Gross paid in and contributed surplus	78,300	78,300
Unassigned deficit	(12,840)	(13,766)
Special surplus funds	14,416	—
Total capital and surplus	79,876	64,534
Total liabilities and capital and surplus	$ 234,830	$ 219,494

See accompanying Notes to the Statutory Financial Statements

Statements of Operations - Statutory Basis

(In Thousands)	Year ended December 31, 2019	2018
Revenues		
Premium income	$ 715,366	$ 634,735
Total revenues	715,366	634,735
Benefits and expenses		
Claims	640,723	539,130
Net reinsurance recoveries	(571)	(20)
Claims adjustment expenses	19,239	15,072
General administrative expenses	66,925	73,098
Change in reserves for accident and health contracts	(19,911)	19,911
Total benefits and expenses	706,405	647,191
Net underwriting gain (loss)	8,961	(12,456)
Investment gains		
Net investment income earned	4,563	4,013
Net realized capital gains (losses) less capital gains tax (benefit)	810	(1,942)
Total investment gains	5,373	2,071
Other expense	(170)	(66)
Income (loss) before federal income taxes	14,164	(10,451)
Federal income (benefits) taxes	(3,370)	3,919
Net income (loss)	$ 17,534	$ (14,370)

See accompanying Notes to the Statutory Financial Statements

Statements of Changes in Capital and Surplus - Statutory Basis

(In Thousands)	Year ended December 31, 2019	2018
Capital and surplus,beginning of year	$ 64,534	$ 87,946
Net income (loss)	17,534	(14,370)
Change in net deferred income tax	(873)	577
Change in nonadmitted assets	(1,319)	(919)
Surplus adjustments:		
Paid in	—	(8,700)
Net change in capital and surplus	15,342	(23,412)
Capital and surplus, end of year	$ 79,876	$ 64,534

See accompanying Notes to the Statutory Financial Statements

Statements of Cash Flow - Statutory Basis

(In Thousands)	Year ended December 31, 2019	2018
Cash from operations		
Premiums collected	$ 701,082	$ 622,752
Investment income received	3,651	3,808
Claims paid	(610,030)	(551,171)
General administrative expenses and other benefits and expenses paid	(85,408)	(91,948)
Federal income taxes recovered	1,892	3,637
Net cash provided by (used in) operating activities	11,187	(12,922)
Cash from investments		
Proceeds from investments sold, matured or repaid	54,898	68,048
Cost of investments acquired	(71,701)	(32,662)
Net cash (used in) provided by investment activities	(16,803)	35,386
Cash from financing and miscellaneous sources		
Capital returned to parent	—	(8,700)
Other cash used in financing and miscellaneous activities	(749)	(2,000)
Net cash used in financing and miscellaneous activities	(749)	(10,700)
Change in cash, cash equivalents and short-term investments	(6,365)	11,764
Cash, cash equivalents and short-term investments, beginning of year	18,266	6,502
Cash, cash equivalents and short-term investments, end of year	$ 11,901	$ 18,266

1. Organization and operation

Aetna Better Health, Inc. (a Louisiana corporation) (the "Company") is a wholly-owned subsidiary of Aetna Health Holdings, LLC, whose ultimate parent is CVS Health Corporation ("CVS Health"). On November 28, 2018, CVS Health acquired Aetna Inc. ("Aetna") and at that date became the Company's ultimate parent (the "Aetna Acquisition").

The Company was incorporated in the State of Louisiana on July 27, 2010.

During 2018 and 2019 the Company administered a health plan for individuals who qualify for Medicaid and Children's Health Insurance Pool ("CHIP") coverage in the State of Louisiana. This contract ended on December 31, 2019. In early August 2019, it was announced by the State of Louisiana that the Company had not been awarded a new contract for 2020 to 2023. The Company is currently protesting that decision. It is anticipated the protest process will take considerable time. Therefore, the Company and the Louisiana Department of Health entered into an Emergency Contract effective January 1, 2020. This Emergency Contract will stay in effect until the protest process is complete or is terminated for some other reason as permitted by the contract.

Beginning January 1, 2019, the Company was awarded a Centers for Medicare and Medicaid Services ("CMS") contract to sell dual eligible Medicaid and Medicare plans in the State of Louisiana. This contract is expanding to the State of Alabama beginning January 1, 2020.

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 Louisiana Department of Insurance ("Louisiana Department") ("Louisiana Accounting Practices"). The Louisiana Department recognizes statutory accounting practices prescribed or permitted by the State of Louisiana 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 Louisiana were the same as of and for the years ended December 31, 2019 and 2018.

Louisiana 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;

- 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;
- The Company's Statements of Operations reflect income and expenses related to claims, losses, premiums, and other amounts paid on behalf of uninsured administrative service contracts, as defined by the NAIC SAP, as a net reduction of administrative expense. Under GAAP, these amounts would have been classified as revenue;
- 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 represents 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 Louisiana for the years ended December 31, 2019 and 2018.

Use of estimates in the preparation of the financial statements

The preparation of these financial statements in conformity with Louisiana 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, 2019 and 2018. 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.

Other invested assets

Other invested assets consist primarily of partnerships and equity subsidiaries. Partnerships and equity subsidiaries are reported using the equity method. Unaudited other invested assets are nonadmitted as they do not meet the admissibility requirements of SSAP No. 48, *Joint Ventures, Partnerships and Limited Liability Companies*, and SSAP No. 97, *Investments in Subsidiary, Controlled and Affiliated Entities*, which requires prescribed types of audited financial statements of the investments. The Company periodically reviews other invested assets for

impairment. An impairment shall be considered to have occurred if it is probable that the Company will be unable to recover the carrying amount of the investment or there is evidence indicating the inability of the investee to sustain earnings which would justify the carrying amount of the investment.

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, 2019 and 2018, 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 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.

Pharmaceutical rebate receivables

The Company estimates pharmaceutical rebate receivables based upon historical payment trends, actual utilization and other variables. Pharmaceutical rebates for a quarter are billed to the vendor within one month of the completion of the quarter with any adjustment to previously recorded amounts reflected at the time of billing. The Company reports pharmaceutical rebate receivables as health care receivables. Pharmacy rebate receivables not in accordance with SSAP No. 84 – *Health Care and Government Insured Plan Receivables* or are over 90 days past due are nonadmitted. All rebates are processed and settled monthly with an affiliated entity, including adjustments to previously billed periods. The pharmaceutical rebate receivables are more fully discussed in Note 6.

Hospital and medical costs and claims adjustment expenses and related reserves

Hospital and medical costs 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, contract requirement changes in membership and product mix, seasonality and other relevant factors. The Company reflects changes in estimates in hospital and medical 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. Where allowed, anticipated investment income is considered in the calculation of any 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 balance at December 31, 2019. A PDR of $19,911 thousand was recorded at December 31, 2018.

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 health insurer 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 22, 2018, Public Law No: 115-120 was signed into law and it imposes a moratorium on the health insurer fee for calendar year 2019. As interpreted in INT 18-02: ACA Section 9010 Assessment Moratoriums, because there was not an ACA Section 9010 fee due in September 2019, there was not an accrual of a liability on January 1, 2019 based on 2018 data year net written premiums. Accrual of a liability on January 1, 2020 for the ACA Section 9010 assessment based on 2019 data year net written premiums and the reclassification from unassigned surplus to special surplus funds equal to the estimated 2020 fee year assessment accrued in data year 2019 will both continue as prescribed under SSAP No. 106. See Note 15 for disclosure of all amounts related to the health insurer fee for the Company.

Federal and state income taxes

For the period January 1, 2018 through November 27, 2018 the Company is included in the consolidated federal income tax return of its parent company, Aetna and Aetna's other wholly-owned subsidiaries, pursuant to the terms of a tax sharing agreement. Effective November 28, 2018, 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 agreements, 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 agreements, 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.

Certain 2018 amounts in the Company's financial statements have been reclassified to conform to the 2019 financial statement presentation.

3. Bonds and other financial instruments

The following is a summary of bonds and other financial instruments receiving bond treatment, which include cash equivalents, and short-term investments, at December 31, 2019 and 2018:

December 31, 2019

(In Thousands)	Amortized cost	Statutory carrying value	Gross unrealized gains	Gross unrealized losses	Fair value
U.S. government	$ 27,653	$ 27,653	$ 744	$ (1)	$ 28,396
U.S. states, territories and possessions (direct and guaranteed)	7,787	7,787	731	—	8,518
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	2,592	2,592	202	—	2,794
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	29,877	29,877	956	(9)	30,824
Industrial and miscellaneous (unaffiliated)	76,083	76,083	1,022	(26)	77,079
Total	$ 143,992	$ 143,992	$ 3,655	$ (36)	$ 147,611

December 31, 2018

(In Thousands)	Amortized cost	Statutory carrying value	Gross unrealized gains	Gross unrealized losses	Fair value
U.S. government	$ 43,376	$ 43,376	$ 617	$ —	$ 43,993
U.S. states, territories and possessions (direct and guaranteed)	12,019	12,019	255	—	12,274
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	6,948	6,948	127	—	7,075
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	19,405	19,405	334	(44)	19,695
Industrial and miscellaneous (unaffiliated)	53,364	53,364	26	(618)	52,772
Total	$ 135,112	$ 135,112	$ 1,359	$ (662)	$ 135,809

Summarized below are the Company's bonds and other financial instruments receiving bond treatment with unrealized losses at December 31, 2019 and 2018, along with the related fair values, aggregated by the length of time the investments have been in an unrealized loss position:

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	$ 2,974	$ 1	—	$ —	$ —
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	3	4,190	9	—	—	—
Industrial and miscellaneous (unaffiliated)	7	7,820	22	1	496	4
Total	11	$ 14,984	$ 32	1	$ 496	$ 4

	Total		
($ in Thousands)	**Number of securities**	**Fair value**	**Unrealized losses**
U.S. government	1	$ 2,974	$ 1
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	3	4,190	9
Industrial and miscellaneous (unaffiliated)	8	8,316	26
Total	12	$ 15,480	$ 36

December 31, 2018

	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	$ 4,255	$ 12	1	$ 5,839	$ 33
Industrial and miscellaneous (unaffiliated)	10	12,949	118	11	18,594	499
Total	11	$ 17,204	$ 130	12	$ 24,433	$ 532

	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	2	$ 10,094	$ 45
Industrial and miscellaneous (unaffiliated)	21	31,543	617
Total	23	$ 41,637	$ 662

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, 2019 and 2018 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. 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, 2019 and 2018 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, 2019 were as follows:

(In Thousands)	**Carrying value**	**Fair value**
Due one year or less	$ 20,390	$ 20,140
Due after one year through five years	74,096	75,764
Due after five years through ten years	38,801	40,452
Due after ten years	10,705	11,255
Total	$ 143,992	$ 147,611

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 as of December 31, 2019 and 2018 were as follows:

(In Thousands)	**2019**	**2018**
Proceeds from sales of bonds	$ 50,054	$ 66,530
Proceeds from maturities of bonds	4,844	1,434
Gross realized gains on sales of bonds	904	127
Gross realized losses on sales of bonds	(44)	(266)
Included in net realized capital losses (OTTI charges on bonds that were in an unrealized loss position	—	2,006

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. The Company had no individually material realized capital losses on bonds or other financial instruments receiving bond treatment that impacted its results of operations in 2019 or 2018.

The Company’s unrealized loss position on loan-backed and structured securities held by the Company at December 31, 2019 and 2018 is as follows:

(In Thousands)	**2019**	**2018**
Aggregate amount of unrealized losses		
Less than 12 months	$ 18	$ 11
12 months or longer	4	76
Aggregate related fair value of securities with unrealized losses		
Less than 12 months	$ 3,275	$ 3,717
12 months or longer	496	4,973

The Company has reviewed the loan-backed and structured securities in accordance with SSAP No. 43R - *Loan-Backed and Structured Securities* ("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, 2019 and 2018 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, 2019 and 2018.

Certain of the Company's financial instruments are measured at fair value in the financial statements. 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. 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.

The valuation methods and assumptions used by the Company in estimating the fair value of bonds are discussed in Note 2.

There were no material realized and unrealized capital gains, purchases, sales, settlements, or transfers into or out of the Company's Level 3 financial assets during December 31, 2019 and 2018.

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, 2019 and 2018 were as follows:

December 31, 2019

(In Thousands)	Aggregate fair value	Admitted assets	(Level 1)	(Level 2)	(Level 3)
Assets					
Bonds, short term, and cash equivalent	$ 147,611	$ 143,992	$ 28,394	$ 119,217	$ —
Total	$ 147,611	$ 143,992	$ 28,394	$ 119,217	$ —

December 31, 2018

(In Thousands)	Aggregate fair value	Admitted assets	(Level 1)	(Level 2)	(Level 3)
Assets					
Bonds, short term, and cash equivalent	$ 135,809	$ 135,112	$ 43,992	$ 91,817	$ —
Total	$ 135,809	$ 135,112	$ 43,992	$ 91,817	$ —

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, 2019 and 2018, 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 provides 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 $46,967 thousand and $41,366 thousand in 2019 and 2018, 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 it's 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 made an investment in Aetna Partners Diversified Fund, LLC (“APDF LLC”) in 2019 and the value of the Company’s investment in APDF LLC was $9,953 thousand at December 31, 2019.

At December 31, 2019 and 2018, the Company had the following amounts due to/from affiliates, which exclude amounts related to pharmacy rebate transactions as discussed more fully in Note 6 and the Company's reinsurance agreements if applicable:

	December 31,	
(In Thousands)	**2019**	**2018**
Amounts due to affiliates		
Aetna Medicaid Administrators, LLC	$ 23,150	$ —
Aetna, Inc.	—	36,197
Aetna Life Insurance Company	—	3
Total due to affiliates	$ 23,150	$ 36,200
Amounts due from affiliates		
Aetna Medicaid Administrators, LLC	—	12,648
Total due from affiliates	$ —	$ 12,648

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

6. Health care receivables

Pharmaceutical rebates

The Company receives pharmaceutical rebates through an agreement with AHM. AHM has contractual agreements with pharmaceutical companies for rebates, which cover the Company's membership as well as the membership of other Aetna programs and/or affiliates. The Company receives those rebates from AHM (either directly or through intercompany arrangements with other Aetna affiliates) that relate to the Company's membership. The Company estimates pharmaceutical rebate receivables based upon the historical payment trends, actual utilization and other variables. Actual rebates collected are applied to the collection periods below, using a first in first out methodology. At December 31, 2019 and 2018, the Company had pharmaceutical rebate receivables of $99 thousand and $894 thousand, respectively (refer to the Company's accounting practices related to pharmaceutical rebate receivables in Note 2).

The following table discloses the quarterly revenue and subsequent cash collections relating to the pharmaceutical rebates discussed in Note 2:

(In Thousands)

Date	Estimated pharmacy rebates as reported on financial statements	Pharmacy rebates as billed or otherwise confirmed	Actual rebates received within 90 days of billing	Actual rebates received within 91 to 180 days of billing	Actual rebates received more than 180 days after billing
12/31/2019	$ 561	$ 236	$ 463 [1]	$ —	$ —
09/30/2019	745	478	479	—	—
06/30/2019	1,129	671	273	397	—
03/30/2019	963	1,048	332	581	134
12/31/2018	894	865	252	581	31
09/30/2018	926	891	237	607	47
06/30/2018	862	924	204	644	76
03/31/2018	741	859	295	531	34
12/31/2017	732	736	337	396	3
09/30/2017	731	730	343	383	4
06/30/2017	438	630	189	433	8
03/31/2017	424	441	123	312	5

[1] Represents a portion of the estimated rebates for the quarter ending December 31, 2019, which were paid by AHM to the Company prior to December 31, 2019 and invoicing in 2020.

Other receivables

The Company reported $3,476 thousand and $2,168 thousand of claim overpayment receivables at December 31, 2019 and 2018.

7. Income taxes

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

	December 31, 2019		
(In Thousands)	**Ordinary**	**Capital**	**Total**
Gross DTAs	$ 2,380	$ 393	$ 2,773
Statutory valuation allowance adjustment	—	—	—
Adjusted gross DTAs	2,380	393	2,773
DTAs nonadmitted	(530)	(104)	(634)
Subtotal net admitted DTAs	1,850	289	2,139
DTLs	(138)	(289)	(427)
Net admitted DTAs/(DTLs)	$ 1,712	$ —	$ 1,712

	December 31, 2018		
(In Thousands)	**Ordinary**	**Capital**	**Total**
Gross DTAs	$ 6,758	$ 524	$ 7,282
Statutory valuation allowance adjustment	(3,203)	(524)	(3,727)
Adjusted gross DTAs	3,555	—	3,555
DTAs nonadmitted	—	—	—
Subtotal net admitted DTAs	3,555	—	3,555
DTLs	(337)	—	(337)
Net admitted DTAs/(DTLs)	$ 3,218	$ —	$ 3,218

	Change		
(In Thousands)	**Ordinary**	**Capital**	**Total**
Gross DTAs	$ (4,378)	$ (131)	$ (4,509)
Statutory valuation allowance adjustment	3,203	524	3,727
Adjusted gross DTAs	(1,175)	393	(782)
DTAs nonadmitted	(530)	(104)	(634)
Subtotal net admitted DTAs	(1,705)	289	(1,416)
DTLs	199	(289)	(90)
Net admitted DTAs/(DTLs)	$ (1,506)	$ —	$ (1,506)

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

	December 31, 2019		
(In Thousands)	**Ordinary**	**Capital**	**Total**
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$ 278	$ —	$ 278
(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))	1,434	—	1,434
Adjusted gross DTAs expected to be realized following the balance sheet date	1,434	—	1,434
2. Adjusted gross DTAs allowed per limitation threshold	XX	XX	11,725
(c) Adjusted gross DTAs (excluding the amount of DTAs from (a) and (b) above) offset by gross DTLs	138	289	427
(d) DTAs admitted as the result of application of SSAP No. 101	$ 1,850	$ 289	$ 2,139

	December 31, 2018		
(In Thousands)	**Ordinary**	**Capital**	**Total**
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$ 3,218	$ —	$ 3,218
(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))	—	—	—
Adjusted gross DTAs expected to be realized following the balance sheet date	—	—	—
2. Adjusted gross DTAs allowed per limitation threshold	XX	XX	9,197
(c) Adjusted gross DTAs (excluding the amount of DTAs from (a) and (b) above) offset by gross DTLs	337	—	337
(d) DTAs admitted as the result of application of SSAP No. 101	$ 3,555	$ —	$ 3,555

	Change		
(In Thousands)	**Ordinary**	**Capital**	**Total**
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$ (2,940)	$ —	$ (2,940)
(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))	1,434	—	1,434
Adjusted gross DTAs expected to be realized following the balance sheet date	1,434	—	1,434
2. Adjusted gross DTAs allowed per limitation threshold	XX	XX	2,527
(c) Adjusted gross DTAs (excluding the amount of DTAs from (a) and (b) above) offset by gross DTLs	(199)	289	90
(d) DTAs admitted as the result of application of SSAP No. 101	$ (1,705)	$ 289	$ (1,416)

($ in Thousands)	**2019**	**2018**
(a) Ratio percentage used to determine recovery period and threshold limitation amount	343 %	342 %
(b) Amount of adjusted capital and surplus used to determine recovery period threshold limitation in (b)2 above	$ 78,164	$ 61,316

The impact of tax planning strategies is as follows:

	December 31, 2019		
($ in Thousands)	**Ordinary**	**Capital**	**Total**
(a) Determination of adjusted gross DTAs and net admitted DTAs, by tax character as a percentage:			
1. Adjusted gross DTAs	$ 2,380	$ 393	$ 2,773
2. Percentage of adjusted DTAs by tax character attributable to the impact of tax planning strategies	5 %	— %	5 %
3. Net admitted adjusted gross DTAs	1,850	289	2,139
4. Percentage of net admitted adjusted DTAs by tax character admitted because of the impact of tax planning strategies	6 %	— %	6 %

	December 31, 2018		
($ in Thousands)	**Ordinary**	**Capital**	**Total**
(a) Determination of adjusted gross DTAs and net admitted DTAs, by tax character as a percentage:			
1. Adjusted gross DTAs	$ 3,555	$ —	$ 3,555
2. Percentage of adjusted DTAs by tax character attributable to the impact of tax planning strategies	— %	— %	— %
3. Net admitted adjusted gross DTAs	3,555	—	3,555
4. Percentage of net admitted adjusted DTAs by tax character admitted because of the impact of tax planning strategies	— %	— %	— %

	Change		
($ in Thousands)	**Ordinary**	**Capital**	**Total**
(a) Determination of adjusted gross DTAs and net admitted DTAs, by tax character as a percentage:			
1. Adjusted gross DTAs	$ (1,175)	$ 393	$ (782)
2. Percentage of adjusted DTAs by tax character attributable to the impact of tax planning strategies	5 %	— %	5 %
3. Net admitted adjusted gross DTAs	(1,705)	289	(1,416)
4. Percentage of net admitted adjusted DTAs by tax character admitted because of the impact of tax planning strategies	6 %	— %	6 %

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

There are no DTLs that were not recognized at December 31, 2019 or 2018.

The provision (benefit) for income taxes for the years ended December 31, 2019 and 2018 was as follows:

	December 31,		
(In Thousands)	**2019**	**2018**	**Change**
Federal income tax (benefit) expense on operations	$ (3,370)	$ 3,919	$ (7,289)
Federal income tax expense (benefit) on net capital gains (losses)	49	(203)	252
Federal income tax incurred	$ (3,321)	$ 3,716	$ (7,037)

The tax effects of temporary differences that gave rise to deferred tax assets and liabilities at December 31, 2019 and 2018 were as follows:

	December 31,		
(In Thousands)	**2019**	**2018**	**Change**
DTAs:			
Ordinary			
Claims unpaid	$ 1,259	$ 1,600	$ (341)
Policyholder reserves	—	4,181	(4,181)
Nonadmitted Assets	1,121	977	144
Total ordinary DTAs	2,380	6,758	(4,378)
Statutory valuation allowance adjustment	—	(3,203)	3,203
Nonadmitted ordinary DTAs	(530)	—	(530)
Admitted ordinary DTAs	1,850	3,555	(1,705)
Capital			
Bonds and other investments	393	524	(131)
Total capital DTAs	393	524	(131)
Statutory valuation allowance adjustment	—	(524)	524
Nonadmitted capital DTAs	(104)	—	(104)
Admitted capital DTAs	289	—	289
Admitted DTAs	2,139	3,555	(1,416)
DTLs:			
Ordinary			
Investments	36	214	(178)
Discounted unpaid losses - TCJA transitional tax adjustment	102	123	(21)
Ordinary DTLs	138	337	(199)
Capital			
Investments	289	—	289
Capital DTLs	289	—	289
Total DTLs	427	337	90
Net admitted DTAs/(DTLs)	$ 1,712	$ 3,218	$ (1,506)

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

	December 31,		
(In Thousands)	**2019**	**2018**	**Change**
Total DTAs	$ 2,773	$ 3,555	$ (782)
Total DTLs	(427)	(337)	(90)
Net DTAs/(DTLs)	2,346	3,218	(872)
Tax effect of unrealized gains (losses)			(1)
Change in net deferred income tax			$ (873)

There was no valuation allowance adjustment to gross DTAs at December 31, 2019. The valuation adjustment to gross DTAs was $3,727 thousand at December 31, 2018.

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, 2019	Effective Tax Rate	December 31, 2018	Effective Tax Rate
Provision computed at statutory rate	$ 2,985	21.0 %	$ (2,237)	21.0 %
Health insurer fee	—	— %	2,493	(23.4)%
Transfer pricing adjustment	(1,345)	(9.5)%	(1,055)	9.9 %
Tax-exempt interest	(114)	(0.8)%	(181)	1.7 %
Change in nonadmitted assets	(144)	(1.0)%	(202)	1.9 %
Prior year true-up	(138)	(1.0)%	580	(5.4)%
Change in valuation allowance adjustment	(3,728)	(26.2)%	3,728	(35.0)%
Total	$ (2,448)	(17.2)%	$ 3,139	(29.4)%
Federal and foreign income tax (benefit) expense incurred	$ (3,321)	(23.4)%	$ 3,716	(34.9)%
Change in net deferred income taxes	873	6.2 %	(577)	5.5 %
Total statutory income taxes	$ (2,448)	(17.2)%	$ 3,139	(29.4)%

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, 2019 and 2018, 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
2019	$ —	$ 49	$ 49
2018 Stub 2	278	—	278
2018 Stub 1	N/A	—	—
Total	$ 278	$ 49	$ 327

The Company did not report any deposits as admitted assets under Internal Revenue Code Section 6603 at December 31, 2019 and 2018.

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, 2019.

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 $39,519 thousand and $34,451 thousand for the years ended December 31, 2019 and 2018, respectively. The Company's premium tax payable of $12,380 thousand and $10,426 thousand at December 31, 2019 and 2018, respectively, are included in general expenses due and accrued in the Balance Sheets.

8. Change in claims unpaid, unpaid claims adjustment expense, and aggregate health claim reserves

The following table shows the components of the change in claims unpaid, accrued medical incentive pool and bonus amounts, unpaid claims adjustment expense and aggregate health claim reserves for the years ended December 31, 2019 and 2018:

(In Thousands)	2019	2018
Balance, January 1	$ 86,943	$ 95,567
Health care receivable	(7,713)	(5,023)
Balance, January 1, net of health care receivable	79,230	90,544
Incurred related to:		
Current year	683,406	588,043
Prior years	(24,015)	(33,861)
Total incurred	659,391	554,182
Paid related to:		
Current year	569,734	506,622
Prior years	59,484	58,874
Total paid	629,218	565,496
Balance, December 31, net of health care receivable	109,403	79,230
Health care receivable	8,559	7,713
Balance, December 31	$ 117,962	$ 86,943

Reserves as of December 31, 2018 were $86,943 thousand. As of December 31, 2019, $59,484 thousand has been paid for incurred claims and claim adjustment expenses attributable to insured events of prior years. Reserves remaining for prior years are now $3,444 thousand as a result of re-estimation of unpaid claims and claim adjustment expenses. Therefore, there has been $24,015 thousand favorable prior-year development since December 31, 2018 to December 31, 2019. The decrease is generally the result of ongoing analysis of recent loss development trends. In December 31, 2018, reserves for incurred claims and claim adjustment expenses attributable to insured events of prior years decreased by $33,861 thousand from $95,567 thousand in 2017 to $61,706 thousand in 2018. The lower than anticipated health care cost trend rates observed in December 31, 2018 for claims incurred in 2017 were due to moderating outpatient and physician trends and faster than expected claim payment speed. Original estimates are increased or decreased, as additional information becomes known regarding individual claims.

9. Capital and surplus, shareholder's dividend restrictions and quasi-reorganizations

The Company had 10,000 shares of common stock with no par value authorized authorized, with 1,000 shares issued and outstanding at December 31, 2019 and 2018.

Dividend restrictions

No domestic stock insurer shall declare and pay any dividends to its stockholders unless its capital is fully paid in cash and is unimpaired and it has a surplus beyond its capital stock and the initial minimum surplus required and all other liabilities equal to fifteen percent of its capital stock, provided that this restriction shall not apply to an insurer when its paid-in capital and surplus exceed the minimum required by the Louisiana Department Code by one hundred percent or more.

At December 31, 2019 and 2018, there was no portion of the Company’s profits that may be paid as ordinary dividends to its shareholder without prior approval from the Louisiana Department.

The Company did not pay any dividends in 2019 or 2018.

The Company did not receive any capital contributions in 2019 or 2018.

The Company paid $8,700 thousand as a return of capital to its parent on December 10, 2018.

There were no restrictions placed on the Company's surplus, including for whom the surplus was being held at December 31, 2019 and 2018, except as noted in Note 13.

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 funds or surplus to aggregate write-ins for special surplus funds as discussed more fully in Note 2 and Note 15.

10. Commitments and contingencies

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 is a party to numerous legal proceedings, investigations, audits and claims arising, for the most part, in the ordinary course of its businesses, including the matters described below. 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. It is reasonably possible that the outcome of such legal matters 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 health care 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 these services and/or otherwise allege that the CVS Health Group failed to timely or appropriately pay or administer 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

The Centers for Medicare & Medicaid Services ("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 health care 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 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 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 health care 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 Health and Human Services (the "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, the U.S. Department of Health and Human Services ("HHS") or otherwise, including audits of the CVS Health Group's minimum 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.

Medicare CIDs

The CVS Health Group has received Civil Investigative Demands ("CIDs") from the Civil Division of the U.S. Department of Justice (the "DOJ") in connection with a current investigation of Aetna Inc. and its subsidiaries patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. The CVS Health Group has been cooperating with the government and providing documents and information in response to these CIDs.

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, arising, for the most part, in the ordinary course of its businesses. 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. While the Company anticipates continued efforts in 2020 and beyond to invalidate, modify, repeal or replace the ACA, the Company expects aspects of the ACA to continue to significantly impact the Company's business operations and financial 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. The time frame for conclusion and final outcome and ultimate impact of this litigation are uncertain. 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.

11. Business concentrations

As further discussed in Note 14, the Company provides health benefits to CHIP and Medicaid members through its contract with the State of Louisiana. Such premium revenue, as a percentage of total premium revenue, was 98.9% and 100% December 31, 2019 and 2018, respectively. CHIP and Medicaid premium receivable, as a percentage of total premiums receivable, was 99.5% and 100% at December 31, 2019 and 2018, respectively.

As further discussed in Note 14, the Company started providing health benefits to Medicare members through its contract with the CMS in 2019. Such premium revenue, as a percentage of total premium revenue, was 1.1% at December 31, 2019. Medicare premium receivable, as a percentage of total premiums receivable, was 0.5% at December 31, 2019.

12. 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.

13. 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 both December 31, 2019 and 2018, 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 the 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, 2019 and 2018, the Company had capital and surplus that exceeded the highest threshold specified by the RBC rules.

14. Medicare and 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 which 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 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.

Effective January 1, 2019, the Company began administering a health plan for individuals who qualify for both Medicare and Medicaid coverage. This is known as "dual recipients." The Company's Medicare-Medicaid Plan ("MMP") under the Duals Demonstration Program administered by CMS in partnership with the State of Louisiana. The regulations and contractual requirements applicable to the Company and other participants in the Dual Demonstration program are complex, expensive to comply with and subject to change. The Company has invested significant resources to comply with Demonstration standards, and the Company's MMP compliance efforts will continue to require significant resources. CMS and/or the State of Louisiana may seek premium refunds, prohibit the Company from continuing to market and/or enroll members in one or more of the Company's Medicare Advantage or Standalone plans, exclude the Company from participating in one or more Medicare programs and/or institute other sanctions against the Company if the Company fails to comply with CMS regulations or the Company's Medicare-Medicaid Demonstration contractual requirements.

15. Subsequent events

Type I - Recognized subsequent events

Subsequent events have been considered through April 28, 2020. The Company had no known reportable recognized subsequent events.

Type II - Nonrecognized subsequent events

Subsequent events have been considered through April 28, 2020.

On January 1, 2020, the Company is subject to an annual fee under Section 9010 of the Federal Affordable Care Act ("ACA"). This annual fee will be 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 is 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 has written health insurance subject to the ACA assessment, expects to conduct health insurance business in 2020, and estimates its portion of the annual health insurance industry fee to be payable on September 30, 2020 to be $14,416 thousand. This amount is reflected in special surplus and was estimated based on premiums written subject to the ACA assessment of $715,707 thousand. The Company's total adjusted capital before and after the special surplus adjustment was $79,876 thousand and $65,460 thousand, respectively. The Company's total authorized control level both before and after the special surplus adjustment was estimated to be $22,797 thousand. As a result, this assessment is expected to impact risk based capital ("RBC") by 18%. Reporting the ACA assessment as of December 31, 2019 would not have triggered an RBC action level.

As discussed in Note 2, on January 22, 2018, Public Law No: 115-120 was signed into law and it imposes a moratorium on the health insurer fee for calendar year 2019. As a result, there was no annual health insurance industry fee payable on September 30, 2019 and there were no amounts reflected in the Company's special surplus related to this payable at December 31, 2018. There was also no resulting impact to the Company's RBC to assess as of December 31, 2018 as a result of this suspension. In December 2019, the annual fee was repealed beginning in 2021.

The agreement with AMA was amended effective January 1, 2020 and approved by the Louisiana Department on August 21, 2019. The amendment allows other affiliates to provide services in accordance to a schedule of services and fees.

The Coronavirus Disease 2019 ("COVID-19") pandemic is developing rapidly. The Company believes COVID-19's adverse impact on the Company's businesses, operating results, cash flows and/or financial condition primarily will be driven by the severity and duration of the pandemic, the pandemic's impact on the U.S. and global economies and the timing, scope and effectiveness of federal, state and local governmental responses to the pandemic. Those primary drivers are beyond the Company's knowledge and control, and as a result, at this time the Company cannot reasonably estimate the adverse impact COVID-19 will have on its businesses, operating results, cash flows and/or financial condition, but the adverse impact could be material.