WELLPOINT IOWA, INC.
Iowa Health Link
Iowa Medicaid
Managed Care Programs

Adjusted Medical Loss Ratio

With Independent Accountant's Report Thereon

For the State Fiscal Year Ended June 30, 2023

Paid through December 31, 2023

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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State of Iowa
Department of Health and Human Services, Iowa Medicaid
Des Moines, Iowa

Independent Accountant's Report

We have examined the accompanying Adjusted Medical Loss Ratio of Wellpoint Iowa, Inc. (health plan) for the state fiscal year ended June 30, 2023. The health plan's management is responsible for presenting the Medical Loss Ratio in accordance with the criteria set forth in the Code of Federal Regulations (CFR) 42 § 438.8 and other applicable federal guidance (criteria). This criteria was used to prepare the Adjusted Medical Loss Ratio. Our responsibility is to express an opinion on the Adjusted Medical Loss Ratio based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether the Adjusted Medical Loss Ratio is in accordance with the criteria, in all material respects. An examination involves performing procedures to obtain evidence about the Adjusted Medical Loss Ratio. The nature, timing, and extent of the procedures selected depend on our judgment, including an assessment of the risk of material misstatement of the Adjusted Medical Loss Ratio, whether due to fraud or error. We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion.

We are required to be independent and to meet our other ethical responsibilities in accordance with relevant ethical requirements related to our engagement.

The accompanying Adjusted Medical Loss Ratio was prepared from information contained in the Medical Loss Ratio for the purpose of complying with the criteria, and is not intended to be a complete presentation in conformity with accounting principles generally accepted in the United States of America.

In our opinion, the Adjusted Medical Loss Ratio is presented in accordance with the criteria, in all material respects, and the Adjusted Medical Loss Ratio meets or exceeds the state requirement of 88 percent for the state fiscal year ended June 30, 2023.

This report is intended solely for the information and use of the Iowa Medicaid, CBIZ Optumas, and the health plan and is not intended to be and should not be used by anyone other than these specified parties.

Myers and Stauffer LC

Myers and Stauffer LC
Kansas City, Missouri
January 6, 2025

Adjusted Medical Loss Ratio for the State Fiscal Year Ended June 30, 2023 Paid Through December 31, 2023

Adjusted Medical Loss Ratio for the State Fiscal Year Ended June 30, 2023 Paid Through December 31, 2023				
Line #	**Line Description**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
1.	**Medical Loss Ratio Numerator**			
1.1	Incurred Claims	$ 3,385,366,353	$ 102,063,908	$ 3,487,430,261
1.2	Activities that Improve Health Care Quality	$ 65,477,433	$ (28,077,929)	$ 37,399,504
1.3	MLR Numerator	$ 3,450,843,787	$ 73,985,979	$ 3,524,829,766
1.4	Non-Claims Costs (Not Included in Numerator)	$ 145,120,160	$ -	$ 145,120,160
2.	**Medical Loss Ratio Denominator**			
2.1	Premium Revenue	$ 3,801,143,172	$ 72,697,693	$ 3,873,840,865
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	$ 55,391,484	$ (31,330,021)	$ 24,061,463
2.3	MLR Denominator	$ 3,745,751,688	$ 104,027,714	$ 3,849,779,402
3.	**MLR Calculation**			
3.1	Member Months	5,435,338	(160)	5,435,178
3.2	Unadjusted MLR	92.1%	-0.5%	91.6%
3.3	Credibility Adjustment	0.0%	0.0%	0.0%
3.4	Adjusted MLR	92.1%	-0.5%	91.6%
4.	**Remittance**			
4.1	Contract Includes Remittance Requirement	No		No
4.2	State Minimum MLR Requirement	88.0%		88.0%

**The Non-Claims Costs line has not been subjected to the procedures applied in the examination, including testing for allowability of expenses or appropriate allocation to the Medicaid line of business. Adjustments identified during the course of the examination were not tested to determine any impact on Non-Claims Costs. Accordingly, we express no opinion on the Non-Claims Costs line.*

Schedule of Adjustments

During the course of the engagement, the following adjustment(s) were identified.

Adjustment #1 – To adjust state directed payment revenue and associated expense per state data

The health plan reported state directed payments in the numerator and the denominator for the medical loss ratio (MLR) reporting period. It was determined that both directed expenses and revenues were understated in total based on comparison to state data for the University of Iowa Hospitals and Clinics Average Commercial Rate (UIHC ACR - Hospital), UIHC ACR Physician (UIHC ACR - Physician), and Ground Emergency Medical Transportation (GEMT). An adjustment was proposed to increase the state directed payments and associated expense per state data. See below for additional tables to break out the specific payments. The state directed payment reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR §§ 438.8(e)(2), 438.8(f)(2), and 438.6(c). The health plan completed the MLR based on the template instructions.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
2.1	Premium Revenue	$108,026,457
1.1	Incurred Claims	$108,027,664

UIHC ACR - Hospital	
Description	**Amount**
Total Directed Payment Revenue	$98,626,082
Total Directed Payment Expense	$98,626,082

UIHC ACR - Physician	
Description	**Amount**
Total Directed Payment Revenue	$9,401,582
Total Directed Payment Expense	$9,401,582

GEMT	
Description	**Amount**
Total Directed Payment Revenue	($1,207)
Total Directed Payment Expense	$0

Adjustment #2 – To adjust incurred claims expense to final net payments to pharmacies

The health plan reported pharmacy incurred claims expense for the third party pharmacy benefit manager (PBM), CVS Health, based on paid claims detail only reflecting ingredient cost and dispensing fees. It was determined the reported pharmacy incurred claims expense was overstated due to excluding the transmission fees assessed to the pharmacies by the PBM. An adjustment was proposed to reduce incurred claims by the amount related to the transmission fees in order to reflect the final amount paid to the pharmacies. The incurred claims and third party reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and Center for Medicaid & CHIP Services Informational Bulletin: MLR Requirements Related to Third Party Vendors dated May 15, 2019.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($1,123,810)

Adjustment #3 – To adjust PBM vendor rate guarantee calculation per PBM supporting documentation

The health plan reported pharmacy incurred claims for the third party PBM, CVS Health. It was determined that contracted rate guarantee calculations were calculated annually for participating pharmacies based on contracts with the PBM. The calculation outlined, at the Medicaid line of business level, the effective rates paid to pharmacies compared to the contracted rate and dispensing fees. The overall impact for the Medicaid line of business was a reduction in reimbursement to pharmacies. An adjustment was proposed to remove the Medicaid calculated amount for the MLR reporting period from incurred claims. The incurred claims and third party reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and Center for Medicaid & CHIP Services Informational Bulletin: MLR Requirements Related to Third Party Vendors dated May 15, 2019.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($130,419)

Adjustment #4 – To adjust pharmacy rebates per PBM supporting documentation

The health plan reported prescription drug rebates received and accrued. It was determined the amount reported was understated based on supporting documentation submitted from the PBM, CVS Health. An adjustment was proposed to increase the prescription drug rebates based on PBM supporting documentation. Pharmacy rebates are a reduction to incurred claims, therefore the increase in rebates

is shown as a negative adjustment. The prescription drug rebates received and accrued reporting requirement are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and Center for Medicaid & CHIP Services Informational Bulletin: MLR Requirements Related to Third Party Vendors dated May 15, 2019.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($378,417)

Adjustment #5 – To remove overstated provider incentives payments per health plan supporting documentation

The health plan reported provider incentive payments for the MLR reporting period. It was determined the health plan amounts reported were overstated, attributed primarily to over capturing estimated payments that were ultimately not earned and paid to providers for the MLR reporting period. An adjustment was proposed to reduce provider incentives payments per health plan supporting documentation. The provider incentive reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($4,291,165)

Adjustment #6 – To remove non-qualifying HCQI/HIT expenses

The health plan reported health care quality improvement (HCQI) and health information technology (HIT) expenses based on salaries and benefits, vendor costs, overhead costs, provider care coordination PMPM expense, and related party provider (CareMore) salaries and benefits. It was determined the health plan included non-qualifying expenses based on federal guidance. An adjustment was proposed to remove non-qualifying health plan and provider salaries and benefits, vendor costs (Elevance and Carelon), and overhead. The HCQI/HIT reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3) and 45 CFR § 158.150.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.2	Activities that Improve health Care Quality	($28,077,929)

Adjustment #7 – To adjust claims paid outside the claims system and cost settlements per health plan supporting documentation

The health plan reported additional incurred claims expense related to claims reimbursed outside the claims system and provider cost settlements for the MLR reporting period. Amounts reported were overstated based on health plan supporting documentation. An adjustment was proposed to reduce incurred claims per health plan supporting documentation. The incurred claims reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($39,945)

Adjustment #8 – To adjust revenues per state data

The health plan reported revenue amounts that overstated payments received for its members applicable to the covered dates of service for the MLR reporting period. An adjustment was proposed to reduce revenues per state data for capitation, maternity, and graduate medical education (GME) payments. The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2). The health plan completed the MLR based on the template instructions.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
2.1	Premium Revenue	($378,571)

Adjustment #9 – To adjust earned withhold payments per state data

The health plan reported an estimated amount for the anticipated earned withholds related to achieved pay for performance metrics. An adjustment was proposed to report earned withhold payments per state data. The withhold payments reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2). The health plan completed the MLR based on the template instructions.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
2.1	Premium Revenue	$2,374,610

Adjustment #10 – To adjust ARPA revenues per state data

The health plan reported revenues related to the American Rescue Plan Act (ARPA) program in error, as the ARPA program was not was not a state directed payment for the MLR reporting period. An adjustment was proposed to remove the ARPA payments per state data. The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR §§ 438.8(f)(2).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
2.1	Premium Revenue	($37,324,803)

Adjustment #11 – To adjust member months per state data

The health plan reported member months that did not reflect accurate amounts for the MLR reporting period. An adjustment was proposed to reflect member months per state data. The member month reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(k).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
3.1	Member Months	(160)

Adjustment #12 – To adjust income taxes per health plan supporting documentation

The health plan reported income taxes that did not reconcile to supporting documentation. It was determined the health plan appropriately removed taxes for investment income and factored in the change in deferred tax assets noted in the audited financial statements. However, the health plan inappropriately included tax expenses for the entire 2022 and 2023 calendar years. An adjustment was proposed to reduce taxes to the appropriate amounts per health plan supporting documentation. The tax reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(3).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	($31,330,021)