



**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, 2024  
Paid through December 31, 2024



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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, 2024. The health plan's management is responsible for presenting the Medical Loss Ratio in accordance with the criteria set forth in 42 Code of Federal Regulations (CFR) § 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, 2024.

This report is intended solely for the information and use of 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  
Kansas City, Missouri  
December 15, 2025



**WELLPOINT IOWA, INC.  
ADJUSTED MEDICAL LOSS RATIO  
IOWA HEALTH LINK**

**Adjusted Medical Loss Ratio for the State Fiscal Year Ended June 30, 2024 Paid  
Through December 31, 2024**

Adjusted Medical Loss Ratio for the State Fiscal Year Ended June 30, 2024 Paid Through December 31, 2024				
Line #	Line Description	Reported Amounts	Adjustment Amounts	Adjusted Amounts
<b>1. Medical Loss Ratio Numerator</b>				
1.1 Incurred Claims		\$ 3,274,539,902	\$ (55,153,997)	\$ 3,219,385,905
1.2 Activities that Improve Health Care Quality		\$ 61,020,352	\$ (17,062,935)	\$ 43,957,417
1.3 MLR Numerator		\$ 3,335,560,254	\$ (72,216,932)	\$ 3,263,343,322
1.4 Non-Claims Costs (Not Included in Numerator)		\$ 116,931,426	\$ -	\$ 116,931,426
<b>2. Medical Loss Ratio Denominator</b>				
2.1 Premium Revenue		\$ 3,479,602,590	\$ (58,631,696)	\$ 3,420,970,894
2.2 Federal, State, and Local Taxes and Licensing and Regulatory Fees		\$ (22,508,074)	\$ 54,106,996	\$ 31,598,922
2.3 MLR Denominator		\$ 3,502,110,663	\$ (112,738,692)	\$ 3,389,371,971
<b>3. MLR Calculation</b>				
3.1 Member Months		3,151,782	(1,833)	3,149,949
3.2 Unadjusted MLR		95.2%	1.1%	96.3%
3.3 Credibility Adjustment		0.0%	0.0%	0.0%
3.4 Adjusted MLR		95.2%	1.1%	96.3%
<b>4. Remittance</b>				
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.*

*Note: The amounts reflected within the MLR calculation on line 2.3 contain a variance due to rounding.*



# Schedule of Adjustments

During the course of the engagement, we identified the following adjustments.

## **Adjustment #1 – To adjust VAS expenses per health plan supporting documentation**

The health plan reported state approved value-added services (VAS) expenses for the medical loss ratio (MLR) reporting period. It was determined the health plan overstated VAS expenses. An adjustment was proposed to reduce VAS expenses 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).

<b>Proposed Adjustment</b>		
<b>Line #</b>	<b>Line Description</b>	<b>Amount</b>
1.1	Incurred Claims	(\$115,856)

## **Adjustment #2 – 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 MLR reporting period. It was determined that both revenues and expenses were overstated in total based on a comparison to state data for the following state directed payments: University of Iowa Hospitals and Clinics (UIHC) Hospital Average Commercial Rate (ACR), UIHC Physician ACR, Hospital Inpatient and Hospital Outpatient Services ACR, and Ground Emergency Medical Transportation Payment Program. An adjustment was proposed to reduce the state directed payments and associated expense per state data. 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.

<b>Proposed Adjustment</b>		
<b>Line #</b>	<b>Line Description</b>	<b>Amount</b>
1.1	Incurred Claims	(\$63,893,545)
2.1	Premium Revenue	(\$60,753,346)

## **Adjustment #3 – To adjust subcapitated incurred claims per related party provider supporting documentation**

The health plan reported incurred claims for a related party subcapitated provider, Carelon Health (formerly CareMore). It was determined the health plan understated the amount reported for incurred claims based on the actual cost of the services performed by the related party provider. An adjustment



## SCHEDULE OF ADJUSTMENTS

was proposed to increase incurred claims per provider supporting documentation. The incurred claims and related party reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and CMS Publication 15-1, Chapter 10.

Proposed Adjustment		
Line #	Line Description	Amount
1.1	Incurred Claims	\$401,383

### **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 third party pharmacy benefit manager (PBM), Caremark PCS Health LLC. 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 was shown as a negative adjustment. The prescription drug rebates received and accrued 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	(\$405,110)

### **Adjustment #5 – To adjust 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 understated, attributed primarily to underestimating final payments. An adjustment was proposed to increase provider incentives payments per health plan supporting documentation. The provider incentive payments 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	\$9,248,735



## SCHEDULE OF ADJUSTMENTS

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### **Adjustment #6 – To remove non-qualifying HCQI/HIT expenses per health plan supporting documentation and include provider care coordination expenses per provider supporting documentation**

The health plan reported health care quality improvement (HCQI) and health information technology (HIT) expenses based on salaries and benefits, vendor costs (Elevance and Carelon), overhead costs, third party provider care coordination per-member per-month expense, and related party provider (Carelon Health) 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, and overhead per health plan supporting documentation and include provider care coordination expenses per provider supporting documentation. The HCQI/HIT reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3).

Proposed Adjustment		
Line #	Line Description	Amount
1.2	Activities that Improve Health Care Quality	(\$17,062,935)

### **Adjustment #7 – To adjust incurred claims reimbursed outside of the claims system and provider 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. It was determined amounts reported were overstated. 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	(\$389,604)

### **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 and maternity 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.



## SCHEDULE OF ADJUSTMENTS

Proposed Adjustment		
Line #	Line Description	Amount
2.1	Premium Revenue	(\$2,831,817)

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

The health plan reported an estimated amount for the anticipated earned withhold related to achieved pay for performance metrics. An adjustment was proposed to report earned withhold payments per state data. 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	\$4,953,467

### Adjustment #10 – 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	(1,833)

### Adjustment #11 – To adjust premium taxes per adjusted state data

The health plan reported premium taxes for the MLR reporting period. Since the premium tax became effective on January 1, 2024, it applied only to revenues related to the first six months of 2024. An adjustment was proposed to recalculate premium taxes per adjusted state data. 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	\$3,210,498



## SCHEDULE OF ADJUSTMENTS

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### **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 state tax refunds not associated with the MLR reporting period. An adjustment was proposed to increase 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	\$50,896,498