MYERS AND STAUFFER LC

Aetna Better Health of Virginia
Virginia Medicaid
Managed Care Programs

Adjusted Medical Loss Ratio and Adjusted Underwriting Gain

With Independent Accountant's Report Theron

For the State Fiscal Year Ended June 30, 2023

Paid Through March 31, 2024

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Independent Accountant's Report

Commonwealth of Virginia
Department of Medical Assistance Services
Richmond, Virginia

We have examined the accompanying Adjusted Medical Loss Ratio and Adjusted Underwriting Gain of Aetna Better Health of Virginia (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 42 Code of Federal Regulations (CFR) § 438.8 and other applicable federal guidance (federal criteria). They are also responsible for presenting the Underwriting Gain in accordance with this federal criteria as well as the managed care contract (criteria). This criteria was used to prepare the Adjusted Medical Loss Ratio and Adjusted Underwriting Gain. Our responsibility is to express an opinion on the Adjusted Medical Loss Ratio and Adjusted Underwriting Gain 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 and Adjusted Underwriting Gain are in accordance with the criteria, in all material respects. An examination involves performing procedures to obtain evidence about the Adjusted Medical Loss Ratio and Adjusted Underwriting Gain. 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 and Adjusted Underwriting Gain, 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 and Adjusted Underwriting Gain were prepared from information contained in the Medical Loss Ratio and Underwriting Gain 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 and Adjusted Underwriting Gain are presented in accordance with the criteria, in all material respects, for the State Fiscal year ended June 30, 2023. Related to non-expansion, the Adjusted Medical Loss Ratio exceeds the state requirement of [85] percent and the Adjusted Underwriting Gain exceeds the state maximum requirement of [3] percent. Related to expansion, the Adjusted Medical Loss Ratio exceeds the state requirement of [85] percent and the Underwriting Gain is not applicable.

This report is intended solely for the information and use of the Department of Medical Assistance Services 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
Glen Allen, Virginia
August 14, 2025

Aetna Better Health of Virginia
Adjusted Medical Loss Ratio
Non-Expansion Population

Line #	Line Description	Reported Amounts	Adjustment Amounts	Adjusted Amounts
1	**Medical Loss Ratio Numerator**	-	-	-
1.1	Incurred Claims	$1,393,611,778	-$1,358,275	$1,392,253,503
1.2	Activities that Improve Health Care Quality	$44,867,690	-$3,885,170	$40,982,520
1.3	MLR Numerator	$1,438,479,468	-$5,243,445	$1,433,236,023
2	**Medical Loss Ratio Denominator**	-	-	-
2.1	Premium Revenue	$1,554,392,746	$10,126,861	$1,564,519,607
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	$16,181,593	$12,333,397	$28,514,990
2.3	MLR Denominator	$1,538,211,154	-$2,206,536	$1,536,004,618
3	**MLR Calculation**	-	-	-
3.1	Member Months	1,870,952	0	1,870,952
3.2	Unadjusted MLR	93.5%	-0.2%	93.3%
3.3	Credibility Adjustment	0.0%	0.0%	0.0%
3.4	Adjusted MLR	93.5%	-0.2%	93.3%
4	**Remittance**	-	-	-
4.2	State Minimum MLR Requirement	85.0%	-	85.0%
4.6.1	Remittance Calculation	$0	$0	$0

Aetna Better Health of Virginia
Adjusted Medical Loss Ratio
Expansion Population

Line #	Line Description	Reported Amounts	Adjustment Amounts	Adjusted Amounts
1	**Medical Loss Ratio Numerator**	-	-	-
1.1	Incurred Claims	$981,328,454	-$607,978	$980,720,476
1.2	Activities that Improve Health Care Quality	$7,574,086	$0	$7,574,086
1.3	MLR Numerator	$988,902,539	-$607,978	$988,294,561
2	**Medical Loss Ratio Denominator**	-	-	-
2.1	Premium Revenue	$1,230,566,045	-$132,135,922	$1,098,430,123
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	$45,533,011	-$36,880,562	$8,652,449
2.3	MLR Denominator	$1,185,033,034	-$95,255,360	$1,089,777,674
3	**MLR Calculation**	-	-	-
3.1	Member Months	1,382,033	0	1,382,033
3.2	Unadjusted MLR	83.4%	7.3%	90.7%
3.3	Credibility Adjustment	0.0%	0.0%	0.0%
3.4	Adjusted MLR	83.4%	7.3%	90.7%
4	**Remittance**	-	-	-
4.2	State Minimum MLR Requirement	85.0%	-	85.0%
4.6.1	Remittance Calculation	$0	$0	$0

Aetna Better Health of Virginia
Adjusted Underwriting Gain
Non-Expansion Population

Line #	Line Description	Reported Amounts	Adjustment Amounts	Adjusted Amounts
1	**Medical Loss Ratio Denominator**	-	-	-
1.1	Premium Revenue	$1,554,392,746	$10,126,861	$1,564,519,607
1.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	$16,181,593	$12,333,397	$28,514,990
1.3	Underwriting Gain Denominator	$1,538,211,153	-$2,206,536	$1,536,004,617
2	**Medical Loss Ratio Numerator**	-	-	-
2.1	Incurred Claims	$1,393,611,778	-$1,358,275	$1,392,253,503
2.2	Activities that Improve Health Care Quality	$44,867,690	-$3,885,170	$40,982,520
2.3	Total Adjusted Underwriting Gain Claims Expenses	$1,438,479,468	-$5,243,445	$1,433,236,023
3	**Non Claims Cost**	-	-	-
3.1	Administrative Expenses	$61,324,131	$5,159,284	$66,483,415
3.2	Less: Unallowable Expenses	-$665,086	$0	-$665,086
3.3	Allowable Administrative Expenses	$60,659,045	$5,159,284	$65,818,329
4	**Underwriting Gain**	-	-	-
4.1	Underwriting Gain $	$39,072,641	-$2,122,376	$36,950,265
4.2	Less: Remittance Amount Due to State for Coverage Year	$0	$0	$0
4.3	Adjusted Underwriting Gain $	$39,072,641	-$2,122,376	$36,950,265
4.4	Underwriting Gain %	2.5%	-0.1%	2.4%
5	**Underwriting Gain Remittance Calculation**	-	-	-
5.1	Member Month Requirement Met?	Y	-	Y
5.2	At least 12 months contract experience at the beginning of the Contract Year?	Y	-	Y
5.3	Percent to Remit	0.0%	0.0%	0.0%
5.4	Amount to Remit	$0	$0	$0

Schedule of Adjustments

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

Non-Expansion Adjustment #1 – To adjust state directed payment revenue and associated expense per state data.

The health plan properly included the revenue and expense associated with state directed payments in the Medical Loss Ratio and Underwriting Gain. The associated revenues and expenses were adjusted to agree with state data. The state directed payment and associated expense 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).

Table 1. Proposed Adjustment

Calculation	Line #	Line Description	Amount
Adjusted Medical Loss Ratio	1.1	Incurred Claims	$9,329,654
Adjusted Medical Loss Ratio	2.1	Premium Revenue	$9,329,654
Adjusted Underwriting Gain	1.1	Premium Revenue	$9,329,654
Adjusted Underwriting Gain	2.1	Incurred Claims	$9,329,654

Non-Expansion Adjustment #2 – To adjust to reclassify claims payments made to Logisticare, the non-emergent transportation vendor, in excess of claims expense to administrative expense.

The health plan reported claims expense for non-emergent transportation services arranged by Logisticare. During the examination, it was determined that the reported expense was greater than the actual claims incurred and paid by Logisticare. An adjustment was proposed to agree the reported transportation expense to incurred claims expense reported by Logisticare. The incurred claims 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.

Table 2. Proposed Adjustment

Calculation	Line #	Line Description	Amount
Adjusted Medical Loss Ratio	1.1	Incurred Claims	-$1,815,963
Adjusted Underwriting Gain	2.1	Incurred Claims	-$1,815,963
Adjusted Underwriting Gain	3.1	Administrative Expenses	$1,815,963

Non-Expansion Adjustment #3 – To adjust to reclassify incurred claims expense related to Public Partnership, LLC, the consumer directed vendor, to payroll related expenses.

The health plan reported claims expense for consumer directed services arranged by Public Partnership LLC via payroll. During the examination, it was determined that the reported expense was greater than the actual payroll and employer tax expense incurred and paid by Public Partnership LLC. An adjustment was proposed to agree the reported expense to payroll and employer tax expense reported by Public Partnership LLC. The incurred claims 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.

Table 3. Proposed Adjustment

Calculation	Line #	Line Description	Amount
Adjusted Medical Loss Ratio	1.1	Incurred Claims	-$2,476,017
Adjusted Underwriting Gain	2.1	Incurred Claims	-$2,476,017
Adjusted Underwriting Gain	3.1	Administrative Expenses	$2,476,017

Non-Expansion Adjustment #4 – To adjust to agree incurred claims expense related to CVS Caremark, the Pharmacy Benefit Manager (PBM), to actual costs incurred.

The health plan reported claims expense net of rebates and rate guarantees for pharmacy services arranged by CVS Caremark, a related party to the health plan. During the examination, it was determined that claims were overstated in comparison to the amount reported by CVS Caremark. It was also determined that rebates and rate guarantees were understated in comparison to the amount reported by CVS Caremark. Finally, it was determined that amounts received by CVS Caremark from pharmacies related to transmission fees were not reported. An adjustment was proposed to agree the reported expense to incurred claims less rebates, rate guarantees, and transmission fees reported by CVS Caremark. The incurred claims 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.

Table 4. Proposed Adjustment

Calculation	Line #	Line Description	Amount
Adjusted Medical Loss Ratio	1.1	Incurred Claims	-$6,395,949
Adjusted Underwriting Gain	2.1	Incurred Claims	-$6,395,949

Non-Expansion Adjustment #5 – To reclassify non-allowable Health Care Quality Improvement (HCQI) and Health Information Technology (HIT) expenses.

The health plan reported HCQI expenses based on an analysis of cost centers determined to relate in whole or in part to HCQI. These costs centers were allocated to HCQI based on employee full time equivalent reports and job duties. The total cost allocated for HCQI included two types of costs, direct costs and intercompany costs. Several of the job titles and duties included in HCQI allocation of costs did not meet the definitions of HCQI for MLR reporting purposes. Amounts were found at the cost center level, account level, and within the salaries review of job descriptions. These expenses have been reclassified from HCQI to administrative expenses through this adjustment. 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.

Table 5. Proposed Adjustment

Calculation	Line #	Line Description	Amount
Adjusted Medical Loss Ratio	1.2	Activities that Improve Health Care Quality	-$3,885,170
Adjusted Underwriting Gain	2.2	Activities that Improve Health Care Quality	-$3,885,170
Adjusted Underwriting Gain	3.1	Administrative Expenses	$3,885,170

Non-Expansion Adjustment #6 – To adjust revenues to agree with state data.

The health plan reported revenue amounts that did not reflect all payments received for its members applicable to the covered dates of service for the reporting period. Revenue was adjusted per the state's data to reflect all payments, including capitation payments, maternity kick payments, pharmacy reinsurance recoupments, performance withhold program payments, clinical efficacy payments, and discrete incentive payments. The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2).

Table 6. Proposed Adjustment

Calculation	Line #	Line Description	Amount
Adjusted Medical Loss Ratio	2.1	Premium Revenue	$797,207
Adjusted Underwriting Gain	1.1	Premium Revenue	$797,207

Non-Expansion Adjustment #7 – To adjust income tax expense per recalculation to the audited financial statements.

The health plan reported federal income taxes calculated based on net income of the Virginia Medicaid population reflected on the MLR reporting statement rather than according to the audited financial statements. The calculation did not appear to appropriately reflect the tax allocation and actual tax expense for the reporting period. A recalculation was performed utilizing the audited financial

statements and the NAIC annual statement to determine the amount of taxes applicable to the MLR reporting period and appropriate population allocation. The recalculation removed taxes for investment income and factored in the change in deferred tax assets noted in the audited financial statements. An adjustment was proposed to the recalculated tax amount. The qualifying taxes reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(3) and Centers for Medicare and Medicaid Services Medical Loss Ratio Annual Reporting Form Filing Instructions.

Table 7. Proposed Adjustment

Calculation	Line #	Line Description	Amount
Adjusted Medical Loss Ratio	2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	$12,333,397
Adjusted Underwriting Gain	1.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	$12,333,397

Non-Expansion Adjustment #8 – To adjust administrative expense to apply adjustments identified during the 2022 and 2023 administrative cost procedures.

Adjustments are applied to administrative costs through a separate engagement. The health plan included lobbying expenses, contribution and donation expenses, related party expenses in excess of cost, accruals for future losses, interest claims expense, fines/penalties/late fees expenses, and marketing and advertising expenses in administrative expenses. The split of administrative expenses between Non-Expansion and Expansion also appeared to be inaccurate. An adjustment was proposed to apply these adjustments. Administrative cost principles are addressed in 45 CFR §§ 75.420 through 75.477 and CMS Publication 15-1, Chapters 10 and 21.

Table 8. Proposed Adjustment

Calculation	Line #	Line Description	Amount
Adjusted Underwriting Gain	3.1	Administrative Expenses	-$3,017,866

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

The health plan properly included the revenue and expense associated with state directed payments in the Medical Loss Ratio. The associated revenues and expenses were adjusted to agree with state data. The state directed payment and associated expense 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).

Table 9. Proposed Adjustment

Calculation	Line #	Line Description	Amount
Adjusted Medical Loss Ratio	1.1	Incurred Claims	$5,702,953
Adjusted Medical Loss Ratio	2.1	Premium Revenue	$5,702,953

Expansion Adjustment #2 – To adjust to agree incurred claims expense related to CVS Caremark, the PBM, to actual costs incurred.

The health plan reported claims expense net of rebates and rate guarantees for pharmacy services arranged by CVS Caremark, a related party to the health plan. During the examination, it was determined that claims and rebates were overstated in comparison to the amount reported by CVS Caremark. It was also determined that rate guarantees were understated in comparison to the amount reported by CVS Caremark. Finally, it was determined that amounts received by CVS Caremark from pharmacies related to transmission fees were not reported. An adjustment was proposed to agree the reported expense to incurred claims less rebates, rate guarantees, and transmission fees reported by CVS Caremark. The incurred claims 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.

Table 10. Proposed Adjustment

Calculation	Line #	Line Description	Amount
Adjusted Medical Loss Ratio	1.1	Incurred Claims	-$6,310,931

Expansion Adjustment #3 – To adjust revenues to agree with state data.

The health plan reported revenue amounts that did not reflect all payments received for its members applicable to the covered dates of service for the reporting period. Revenue was adjusted per the state's data to reflect all payments, including capitation payments, maternity kick payments, pharmacy reinsurance recoupments, performance withhold program payments, clinical efficacy payments, and risk corridor recoupments. The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2).

Table 11. Proposed Adjustment

Calculation	Line #	Line Description	Amount
Adjusted Medical Loss Ratio	2.1	Premium Revenue	-$137,838,875

Expansion Adjustment #4 – To adjust income tax expense per recalculation to the audited financial statements.

The health plan reported federal income taxes calculated based on net income of the Virginia Medicaid population reflected on the MLR reporting statement rather than according to the audited financial statements. The calculation did not appear to appropriately reflect the tax allocation and actual tax expense for the reporting period. A recalculation was performed utilizing the audited financial statements and the NAIC annual statement to determine the amount of taxes applicable to the MLR reporting period and appropriate population allocation. The recalculation removed taxes for investment income and factored in the change in deferred tax assets noted in the audited financial statements. An adjustment was proposed to the recalculated tax amount. The qualifying taxes reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(3) and Centers for Medicare and Medicaid Services Medical Loss Ratio Annual Reporting Form Filing Instructions.

Table 12. Proposed Adjustment

Calculation	Line #	Line Description	Amount
Adjusted Medical Loss Ratio	2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	-$36,880,562