MYERS AND STAUFFER LC

MARYLAND DEPARTMENT OF HEALTH

Consolidated Significant Matters HealthChoice Financial Monitoring Report

For the Calendar Year Ended December 31, 2024

Experience through June 30, 2025

Consolidated Report

May 1, 2026

Maryland Department of Health
Office of Finance, Medical Care Programs
201 West Preston Street
Baltimore, MD 21201

The purpose of this letter is to provide you with a summary of significant matters related to our agreed-upon procedures (AUP) engagement. Our AUP engagement included analyzing certain financial information of the managed care organizations (MCOs) participating in the Maryland HealthChoice Program (Program) for the year ended December 31, 2024.

We have prepared separate AUP reports for the following nine MCOs participating in the Program for the year ended December 31, 2024:

- Aetna Better Health of Maryland.
- CareFirst BlueCross BlueShield Community Health Plan Maryland.
- Jai Medical Systems Managed Care Organization, Inc.
- Kaiser Foundation Health Plan of the Mid-Atlantic, Inc.
- Maryland Physicians Care.
- MedStar Family Choice, Inc.
- Priority Partners Managed Care Organization, Inc.
- UnitedHealthcare of the Mid-Atlantic, Inc.
- Wellpoint Maryland, Inc.

This engagement to apply AUPs was performed in accordance with standards established by the American Institute of Certified Public Accountants. The sufficiency of the procedures was solely the responsibility of the Maryland Department of Health (MDH). Consequently, we made no representations regarding the sufficiency of the procedures described in each report for the purpose for which the reports were requested or for any other purpose.

Scope of Work

The MCOs manage the medical care of Program enrollees for a capitated per member per month premium. The MCOs enter into service contracts with various health care providers to provide the

required health care services to the Program enrollees. In return, the MCO pays the participating providers through fee-for-service or managed care arrangements. Monthly capitation payments to health care providers are expensed as incurred. Medical services expense includes amounts for known services rendered and an estimate for incurred but not reported (IBNR) services rendered by hospitals, physicians, and other health care providers during the year. The estimated IBNR medical services liability is actuarially determined based on relevant industry data and historical trends.

Activity for the Program is reported on the HealthChoice Financial Monitoring Report (HFMR). This report is a supplemental schedule to the quarterly and annual filings made to the Maryland Insurance Administration. The report is comprised of five sections: 1) Background; 2) Expense and Utilization Structure (Incurred Basis); 3) Major Sub-Capitated Provider Schedule, Specific Federally Qualified Health Center (FQHC), Medical Management administrative costs, and Pharmacy Requests; 4a) Services Provided by MCOs that Exceed Services Covered in the Medicaid State Plan; 4b) Components of Payments and Risk Corridors; and 5) MCO Financial Reporting Questionnaire on FQHC total expenses, payments from the trauma fund, COVID-19 vaccine ingredient costs, COVID-19 vaccine administration payments, high-cost, low-volume (HCLV) drugs, and payments related to the Maryland Quality Innovation Program (M-QIP) and their impact on HFMR reporting. For the year ended December 31, 2024, the HFMR included run-out of claims paid through June 30, 2025.

The primary emphasis of our test procedures consisted of verifying and reconciling financial data reported on the HFMR for the year ended December 31, 2024, to the MCOs’ audited financial statements, the Annual Statement submitted to the Insurance Administration of the state of Maryland (Annual Statement), trial balances, claims databases, and supporting documentation. For MCOs with programs other than the Program, we obtained detailed financial information broken down by operating unit to perform our test procedures.

Other procedures included:

- Reconciling medical expenses paid and incurred per the Annual Statement to the IBNR lag reports, as well as the medical claims payable for known and unknown services to the financial reports.
- Selecting a sample of 100 claims to ensure transactions were recorded in the proper period, region, risk adjustment category (RAC), and at the proper amount. Claims errors identified were reviewed to determine whether the error was systemic and the total impact on the claims population.
- Documenting the procedures performed for receipt, processing, and reconciliation of claims for outside providers, including reports on internal controls.
- Documenting our understanding of the administration expenses reported on the Annual Statement, including allocation of expenses from other lines of business or related entities and

reconciling and verifying financial data reported on the Annual Statement for administrative expenses.

- Comparing investment income by operating unit to comparable factors and obtaining explanations for any unusual relationships.
- Determining whether the administrative component of sub-capitated payments were included with reported medical expenses.
- Verifying and assessing the business purpose and valuation of related-party transactions.
- Verifying pharmacy rebate revenue and proper offset against pharmacy expense.
- Verifying the amount of rebate revenue applicable to hepatitis C drugs.
- Verifying non-State Plan service amounts.
- Verifying FQHC payments and expenses, trauma fund reimbursement, payments made for COVID vaccine ingredients, COVID vaccine administration, HCLV drugs, and payments related to M-QIP to ensure revenue and expense is removed.
- Reconciling third-party liability (TPL) reports and proper recording of recoveries.
- Reporting Premium Taxes and Affordable Care Act (ACA) Stabilization Fees separately from administration taxes while ensuring ACA fees were not included on the HFMR.
- Determining total submitted hepatitis C expense, including total number of scripts included on the HFMR, excluding verified hepatitis C rebates.
- Verifying that reported Primary Care Expenses meets the primary care physician (PCP) criteria included in the HFMR instructions, revised as of July 3, 2025.
- Determining the amount paid for Independent Review Organization (IRO) reviews and remove from expense.
- Determining the amount paid for dues to the Maryland MCO Association (MMCOA) and remove from expense.
- Verifying that the HFMR was prepared in accordance with the RAC definitions effective September 23, 2019.
- Verifying pharmacy benefit manager (PBM) expense reported on Section III of the HFMR.
- Verifying that behavioral health, rare and expensive case management (REM), and incarcerated individuals' expense is excluded from the HFMR.
- Quantification of denied encounter and $0 paid encounters identified by MDH/the Hilltop Institute included in the claims data reported in HFMR.

Summary of MCO Results

The following adjustments were made to the HealthChoice financial data.

Gross Premium Revenue

Adjusted to Include	Adjusted to Exclude
Mid-Year Supplemental Payments	Reinsurance Premiums
Out-of-State (OOS) Capitation Revenue	FQHC Payments Above the Market Rate
Calendar Year (CY) 2024 Population Health Incentive Payments	M-QIP Revenue
CY 2024 Medical Loss Ratio (MLR) Remittance Accruals	Trauma Fund Reimbursement
Hepatitis C Reconciliation Payments	-
Health Equity Incentive	-
Finalized Risk Corridor – Diabetes Prevention Program	-
Finalized Risk Corridor – Maternal and Child	-
Finalized Risk Corridor – Collaborative Care	-
PHE Acuity Incentive Payments	-

Medical Expenses Paid

Adjusted to Include	Adjusted to Exclude
Verified Pharmacy Rebates	TPL Recoveries
HCLV Drug Expense	HCLV Drug Expense
Claim Error Impacts	Bad Debt Expense
OOS/NULL Claims with Matching Capitation	Claims Expense Related to CY 2023
Orphan Claims with Matching Revenue	Subrogation Recovery Attorney Fees
-	Claim Error Impacts
-	Charges in Excess of Claims Paid to Related Entities
-	Submitted Medical Management Expense
-	Trauma Fund Reimbursement
-	COVID Vaccine Administration Expense
-	COVID Vaccine Ingredients Expense
-	FQHC Expenses above the Market Rate
-	OOS/NULL Claims without Matching Revenue
-	Non-Covered Services
-	Reinsurance Recoveries
-	Medical Expenses Unpaid
-	TPL Vendor Recovery Fees Reclassified to Administrative Expense
-	Non-State Plan Expenses Reclassified to Administrative and Medical Management Expense
-	Care Coordination Expenses Reclassified to Medical Management Expense
-	Administrative Component of Sub-Capitated Vendors Reclassified to Administrative Expense

Medical Management Expense

Medical Management expense was included with Medical Expenses Paid and/or Administrative Expenses on the Health Plan Submitted Total column of the Underwriting Exhibit. Verified Medical Management expense was reclassified to its respective line on the Myers and Stauffer Adjusted Total column of the Underwriting Exhibit. Medical Management expense was reported separately on the Health Plan Submitted Total of the Underwriting Exhibit for presentation purposes only.

Adjusted to Include	Adjusted to Exclude	Reclassified to Administrative Expense
Provider Incentives not Included on the HFMR	Unpaid Provider Incentives	Non-Qualifying Salaries and Benefits
Reporting Variances between MLR and HFMR	AbsoluteCare Accrual	Non-Qualifying Vendor Expenses
Non-State Plan Expenses Qualifying as Medical Management	Duplicate Non-Billable Voids	Non-Qualifying Overhead Expenses
Care Coordination Capitated Payments	Premium Tax Exemption Reported Separately	Intersegment Expenses
Health Information Technology (IT) and External Quality Review (EQR) Expenses	-	Unsupported Care Coordination Capitated Payments
Qualifying Vendor Expenses	-	Utilization Management
MOM Case Management Expenses Reclassified from Administrative Expense	-	Self-Disallowed Expenses
Interoperability Fees Reclassified from Administrative Expense	-	-

Administrative Expense

Adjusted to Include	Adjusted to Exclude	Reclassified to Medical Management Expense
Non-Qualifying Medical Management Salaries and Benefits	Non-Allowable Marketing Expenses	Reporting Variances between MLR and HFMR
Non-Qualifying Medical Management Utilization Management Expense	Non-Allowable Grant Expenses	Health IT Expenses
Non-Qualifying Medical Management Intersegment Expenses	Non-Allowable Pharmacy Spread Pricing	EQR Expenses
Non-Qualifying Medical Management Vendor Expenses	Related Party Profit	Qualifying Vendor Expenses
Administrative Component of Sub-Capitated Vendors	Unsupported Management and Exclusivity Fees	MOM Case Management Expense
PBM Administrative Fees Excluded from the HFMR	Lobbying Expense	Interoperability Fees

Adjusted to Include	Adjusted to Exclude	Reclassified to Medical Management Expense
Generally Accepted Accounting Principles to Statutory Claim Adjustments not Included on the HFMR	MMCOA Dues	-
Non-Qualifying Medical Management Care Coordination Expenses	IRO Fees Paid	-
TPL Vendor Recovery Fees	Business Development Expenses	-
Reporting Variances between MLR Template and HFMR	Grievances and Appeals	-
Non-State Plan Patient Education and Nurse Advice Line Expenses	Fines and Penalties	-
MQIP Revenue Passthrough - Reversal	Submitted Medical Management Expense Reported Separately	-
Legal Fee and Consulting Accruals Removed in CY 2023	Premium Taxes and/or Exemptions and ACA Individual Market Stabilization Fees Reported Separately	-

Taxes

- Premium Taxes and/or exemptions were adjusted to agree to the HFMR reported amount.
- ACA Individual Market Stabilization Fees were reported separately from Premium Taxes.

Myers and Stauffer LC
Owings Mills, Maryland
May 1, 2025

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Exhibit I: Schedule of AUPs for Participating MCOs

Materiality

For procedures to test claims data by rate cell and categories of service, materiality will be set at 5% and $10,000 for the balance subject to the procedure. For procedures related to the testing of specific claims, materiality will be set at +/- 2% per transaction tested specific to proper amount paid. Claim error impact will be set at $10,000 per specific issue identified during the testing of claims. For all other procedures, materiality will be set at $10,000 for the balance subject to the procedure.

Trial Balance

Obtain the adjusted trial balance as of December 31, 2024, and agree a sample of descriptions, account numbers, and ending balances per the adjusted trial balance to the general ledger for the year ended December 31, 2024. Agree total expenses per the adjusted trial balance as of December 31, 2024, to the HFMR for the year ended December 31, 2024. Agree total expenses per the adjusted trial balance as of December 31, 2024, to the Annual Statement submitted to the Insurance Administration of the State of Maryland for the year ended December 31, 2024. Agree total expenses per the adjusted trial balance as of December 31, 2024, to the audited financial statements for the year ended December 31, 2024.

HealthChoice Financial Monitoring Report

Verify that the HFMR was prepared in accordance with the new RAC definitions included in the HFMR instructions revised as of September 23, 2019.

For each of the categories on the HFMR for the year ended December 31, 2024, perform the following:

Member Months

Agree the line labeled “Total” on each regional HFMR schedule for the column labeled “Member Months” to the query reports. Recalculate the line labeled “Grand Total” on the Statewide HFMR for the column labeled “Member Months” based on the amounts reported on the regional HFMRs. Haphazardly select five categories for “Member Months” from each regional HFMR schedule and agree the balances to the query reports. If errors are noted, MDH will determine if scope should be expanded.

Earned Premiums

Agree the line labeled “Total” on each regional HFMR schedule for the column labeled “Earned Premiums” to the query reports. Recalculate the line labeled “Grand Total” on the Statewide HFMR for the column labeled “Earned Premiums” based on the amounts reported on the regional HFMRs. Haphazardly select five categories for “Earned Premiums” from each regional HFMR schedule and agree the balances to the query reports. If errors are noted, MDH will determine if scope should be expanded.

Payments

Agree the payments balance per Section II – Statewide and Section IVb of the HFMR to supporting documentation.

Reinsurance Premiums

Agree the reinsurance premiums balance per Section II – Statewide of the HFMR to supporting documentation.

Reinsurance Recoveries

Agree the reinsurance recoveries balance per Section II – Statewide of the HFMR to supporting documentation.

Expenses

Agree the line labeled “Total” on each regional HFMR schedule for the columns labeled “Hospital Inpatient Expenses,” “Hospital Outpatient: Other than Emergency Expenses,” “Hospital Outpatient: Emergency Expenses,” “Primary Care Expenses,” “Specialty Care Expenses,” “Pharmacy Expenses,” “Dental Expenses,” and “Other Medical Expenses” to the query reports and recalculated to include IBNR amounts.

Recalculate the line labeled “Grand Total” on the Statewide HFMR for the columns labeled “Hospital Inpatient Expenses,” “Hospital Outpatient: Other than Emergency Expenses,” “Hospital Outpatient: Emergency Expenses,” “Primary Care Expenses,” “Specialty Care Expenses,” “Pharmacy Expenses,” “Dental Expenses,” and “Other Medical Expenses” based on the amounts reported on the regional HFMRs.

Haphazardly select five categories from the columns labeled “Hospital Inpatient,” five categories from the columns labeled “Hospital Outpatient: Other than Emergency,” five categories from the columns labeled “Hospital Outpatient: Emergency Department,” five categories from the columns labeled “Primary Care,” five categories from the columns labeled “Specialty Care,” five categories from the columns labeled “Pharmacy,” five categories from the columns labeled “Dental,” and five categories from the columns labeled “Other Medical” for “Expenses” from each regional HFMR schedule and agree the balances to the query reports and recalculated to include IBNR amounts.

Select 100 claims from the medical claims database. Stratify the sample into five claim categories to include “Hospital Inpatient,” “Hospital Outpatient: Other Than Emergency,” “Hospital Outpatient: Emergency Department,” “Primary Care,” and “Specialty Care.” Select the number of claims for the claim categories based on a percent to total methodology, based on the expense reported in each claim category on the HFMR excluding any part of the claim category that are paid on a capitated basis and material to the overall sampling methodology. Each strata includes a high dollar sample, graduate medical education (GME) sample, and a randomly selected sample, including delivery claims. The high dollar sample includes the two highest dollar claim lines in each of the claim categories. The GME sample includes one claim from each of the providers included in the GME rate letter. The remaining

samples from the claim categories are selected at random from the remaining claims listing. To the extent possible, retracted claim lines or claim lines that net to less than $0 are avoided. If these claims are selected inadvertently, replace them with a different claim line from the medical claims database.

For non-delivery claims, verify that the transaction was recorded in the proper period, proper region, proper RAC, and the proper amount.

For delivery claims, verify that the transaction was recorded in the proper period, at the proper amount, and properly recorded as a delivery expense as defined in the delivery instructions provided by MDH.

If no claims errors are noted, no further testing is required. If any material variances are noted, discuss variances with the managed care organization (MCO) to determine the cause of the variance and any corrective actions taken by the MCO to correct the variance. Based on the cause obtained from the MCO, determine if the error is systemic or nonsystemic. If the error is systemic, obtain a claims listing showing the systemic error in the claims data as calculated by the MCO, test claims error listing for reasonableness on a sample basis, calculate the potential exposure of error (if the claim is not corrected/reprocessed), adjust medical expense based on potential exposure of error, and document the MCO's stated corrective actions to ensure the issue does not occur in future HFMR submissions. If the error is nonsystemic, verify correction has been made (if the claim is corrected/reprocessed), adjust medical expense based on the potential exposure of error, and document the MCO's stated corrective actions to ensure the issue does not occur in future HFMR submissions.

If the MCO is unable to provide a claims listing recalculating the error impact, the error impact will be calculated based on best data available. Notify MDH of nonresponsive plans to determine next steps.

Obtain a list of medical payments to or costs allocated from affiliates of parent companies. Compare medical payments made to affiliates and nonaffiliates to determine whether payments to affiliates for equivalent services are equal to or less than those made to nonaffiliates.

Admissions/Days/Visits/Scripts

Agree the line labeled “Total” on each regional HFMR schedule for the columns labeled “Visits,” “Admissions,” “Days,” and “Scripts” to the query reports.

Recalculate the line labeled “Grand Total” on the statewide HFMR for the columns labeled “Visits,” “Admissions,” “Days,” and “Scripts” for all categories based on the amounts reported on the regional HFMRs. Haphazardly select five hospital inpatient categories for “Admission,” five “Hospital Inpatient” categories for “Days,” five “Hospital Outpatient: Other Than Emergency” categories for “Visits,” five “Hospital Outpatient: Emergency Department” categories for “Visits,” five “Primary Care” categories for “Visits,” five “Specialty Care” categories for “Visits,” five “Pharmacy” categories for “Scripts,” and five “Dental” categories for “Visits” from each regional HFMR schedule and agree the balances to the query reports. If errors are noted in previous steps and MDH determines scope should be expanded, select an additional five transactions per applicable HFMR category and agree balances to query reports.

Delivery Expenses

Obtain a narrative that summarizes the methodology for reporting delivery-related expenses on the HFMR.

Major Sub-Capitated Providers

Review Section III of the HFMR (Major Sub-Capitated Provider Schedule) and obtain support for the amount paid by MCO to provider or vendor and claims paid by provider or vendor. Determine whether the amount paid by the MCO to provider or vendor exceeded the claims paid on behalf of the provider or vendor. If so, ensure additional expense is reported with administrative expenses rather than claims expense.

Medical Management Expense

Agree the line labeled “Medical Management Expense” per Section II – Statewide of the HFMR to supporting documentation. Ensure the Medical Management expense is reported in accordance with NAIC guidelines.

Review Section III B.1 through B.4 to ensure administrative costs included with Medical Management are reported in the proper category on the financial template.

Pharmacy Rebates

Review Section III of the HFMR to verify that the rebate revenue reported is accurate. Verify the amount of the rebate revenue that relates to hepatitis C drugs. Verify that rebate revenue has been properly offset against Pharmacy Expenses.

Pharmacy Benefit Manager Expense

Review Section III, Part E of the HFMR to verify if PBM expense information reported is accurate.

Non-State Plan Services

Document the procedures used to determine the amounts reported on Section IVa of the HFMR for Non-State Plan Services and verify the amounts reported are correct.

Federally Qualified Health Center Payments and Visits

Determine whether FQHC visits and total expenses were properly reflected on Section III and V of the HFMR, respectively. Confirm whether FQHC payments made above the market rate were excluded from Gross Premium Revenue and Medical Expenses Paid on the HFMR.

Trauma Fund

Determine that the costs reimbursed through the Trauma Fund were properly reflected on Section V of the HFMR. Ensure Trauma Fund expense and revenue was excluded from the HFMR.

COVID Vaccine Ingredients

Determine that expenses and payments made for COVID Vaccine Ingredients were properly reflected on Section V of the HFMR. Ensure COVID Vaccine Ingredients expense and revenue was excluded from the HFMR.

COVID Vaccine Administration

Determine that expenses and payments made for COVID Vaccine Administration practices were properly reflected on Section V of the HFMR. Ensure COVID Vaccine Administration expense and revenue was excluded from the HFMR.

Maryland Quality Innovation Program

Determine that expenses and payments related to the M-QIP were properly reflected in Section V of the HFMR. Ensure M-QIP expense and revenue was excluded from the HFMR.

High-Cost Low-Volume Drugs

Determine that expenses and payments related to the HCLV drugs were properly reflected in Section V of the HFMR. Ensure HCLV expense and revenue was excluded from the HFMR.

Investment Income

Agree the investment income balance per the trial balance for the year ended December 31, 2024, to the Annual Statement and audited financial statements and explain any variances. Review the investments that produce investment income reported by the MCO and determine if investment income has been properly allocated among the various payor sources and the amount allocated to the HealthChoice program is correct.

Administrative Expenses

Obtain an understanding of the nature of the Administrative Expenses reported on the analysis of operation of lines of business on the Annual Statement. Compare Administrative Expenses for the year ended December 31, 2024, to the prior year and obtain explanations for any changes greater than 10%. Obtain an understanding of any trial balance account allocated between Administrative Expenses and Medical Expenses and document the procedure for the allocation. Obtain a listing of payments to, or costs allocated from, affiliates or parent companies and agree this list to the audited financial statements prepared by the Health Plan's independent accountant for the year ended December 31, 2024.

Medical Expenses/Incurred But Not Reported

Obtain documentation of the procedures regarding the receipt, processing, and reconciliation of claims from outside providers. Obtain and review the independent internal control reports, if applicable. Agree unpaid expense per Section II – Statewide of the HFMR to supporting documentation. Determine if unpaid expenses include items other than IBNR. Obtain IBNR report and opinion from independent actuarial firm.

Cost Avoidance and Third-Party Liability Recoveries

Review the policies and procedures for cost avoidance and post-payment recoveries to assess the compliance of effort to maximize third-party payments. Test the accuracy of the quarterly TPL reports submitted by the Health Plan and verify that recoveries are properly recorded in Section II – Statewide of the HFMR. Report the total TPL recovery amount received for services provided during fiscal year (FY)

2024, collected during 2024, and the total TPL recovery amount received for services provided during FY 2024 collected through June 30, 2025.

Non-Allowable Expenses

Independent Review Organization Review Expense

Determine the amount paid for IRO reviews, if any, and remove from expense.

Maryland Managed Care Organization Association Dues

Determine the amount paid for dues to the MMCOA and remove from expense.

Special Projects

Taxes

Report submitted Premium Taxes and ACA Stabilization Fees (also known as Maryland Health Care Assessment Fees) separately from Administrative Expenses. Ensure ACA Insurer Fees are not included on the HFMR since these were repealed effective January 1, 2021.

Hepatitis C

Report total submitted hepatitis C expense, including the number of scripts as reported on the HFMR. Ensure that hepatitis C expense is net of any rebates received.

Primary Care Physician Expenses

Verify the Primary Care Expenses reported meet the following PCP criteria included in the HFMR instructions revised as of July 15, 2025:

1. **Criterion #1:** If any identifier (i.e., Practitioner/Rendering NPI, Provider/Reimbursement NPI, or Medicaid Provider Number) can be matched to either of the eMedicaid / MCO Cross-Reference File or MCO Self-Reported PCP Assignment file and under one of the codes from appendices D1-D3, then the claims should be categorized as a PCP.
2. **Criterion #2:** All care provided under CPT in appendices D4-D7.

Non-HealthChoice Expenses

Inquire whether behavioral health, REM, and incarcerated individuals' expense is excluded from the HFMR. Determine and remove expense if included.

Denied and Zero Pay Encounters

Obtain a list of denied encounters and zero paid encounters from MDH/Actuary. Verify that denied encounters and zero paid encounters identified by MDH/actuary are excluded in claims data reported in HFMR. Report total denied and zero paid encounters included in the HFMR by denied reason.

Exhibit II: Consolidated Underwriting Exhibit

Consolidated Underwriting Exhibit

Services for the Calendar Year Ending December 31, 2024

Experience through June 30, 2025

(Maryland HealthChoice Business Only)

Financial Summary and Supplemental Data	Description	Health Plan Submitted Total	Myers and Stauffer Adjusted Total
Revenues	Gross Premium Revenue	$ 7,486,582,293	$ 7,451,339,660
Revenues	Less Reinsurance Premiums	$ (7,632,356)	$ (9,632,356)
Revenues	Net Premium Revenue	$ 7,478,949,937	$ 7,441,707,304
Medical Expenses	Medical Expenses Paid	$ 6,563,632,252	$ 6,430,108,956
Medical Expenses	Medical Expenses Unpaid	$ 44,947,505	$ 43,286,482
Medical Expenses	Gross Medical Expenses	$ 6,608,579,757	$ 6,473,395,438
Medical Expenses	Less Reinsurance Recoveries	$ (15,673,812)	$ (17,684,969)
Medical Expenses	Net Medical Expenses	$ 6,592,905,945	$ 6,455,710,469
Medical Management Expenses[1]	Medical Management in Claims (Provider Incentives)	$ 24,395,840	$ 16,278,227
Medical Management Expenses[1]	Medical Management in Claims (All Other)	$ 49,987,326	$ 44,065,001
Medical Management Expenses[1]	Medical Management in Administrative	$ 64,913,202	$ 40,326,645
Administrative Expenses	Administrative Expenses	$ 589,957,576	$ 562,547,144
Taxes	Premium Taxes	$ 138,357,411	$ 149,186,554
Taxes	ACA Ind. Market Stabilization Fees	$ 70,863,174	$ 76,804,775
Net Underwriting Gain (Loss)	Net Underwriting Gain (Loss)	$ 86,865,831	$ 96,788,489
Additional Data	Member Months	$ 16,999,667	$ 16,999,667
Additional Data	Total Deliveries	$ 29,977	$ 29,977

[1] Medical Management is included in submitted Medical and/or Administrative Expenses. Shown separately for presentation purposes.

Exhibit III: Comparison of IBNR Independent Estimate

Comparison of IBNR Independent Estimate

Services for the Calendar Year Ending December 31, 2024

Experience through June 30, 2025

Plans	Health Plan Submitted	Miller & Newberg, Inc. Actuarial Estimate
Total (9 Plans)	$ 44,947,505	$ 41,604,063

The estimates prepared by Miller & Newberg, Inc. were based upon statutory accounting practices. Estimates were made only of Incurred But Not Reported (IBNR) claims, which are the liability for future payments on claims which have already occurred, but have not yet been reported to the MCOs. IBNR may also include future development (or additional costs) associated with reported claims. IBNR does not include known or identifiable claims that remain unpaid as of the valuation date.

Note: Variances between submitted IBNR on Exhibits II and III are as follows:

MCO (Blinded)	Submitted per Financial Template	Actuarial Estimate	Variance
MCO A	$ 8,925,915	$ 7,981,711	$ (944,204)
MCO B	$ 1,000,181	$ 1,247,651	$ 247,470
MCO C	$ 5,370,663	$ 5,457,564	$ 86,901
MCO D	$ 318,635	$ 322,075	$ 3,440
MCO E	$ 1,528,088	$ 1,713,250	$ 185,162
MCO F	$ 12,065,335	$ 10,404,313	$ (1,661,022)
MCO G	$ 3,287,596	$ 2,989,391	$ (298,205)
MCO H	$ 6,553,986	$ 5,873,851	$ (680,135)
MCO I	$ 5,897,106	$ 5,614,257	$ (282,849)
Total	**$ 44,947,505**	**$ 41,604,063**	**$ (3,343,442)**