Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
980 9th Street, Suite 500
Sacramento, CA 95814
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December 27, 2022 **Via eFile**

Ms. Beth Andersen, President
Blue Cross of California
DBA: Anthem Blue Cross
1121 L Street, Suite 500
Sacramento, CA 95814

FINAL REPORT OF ROUTINE EXAMINATION OF BLUE CROSS OF CALIFORNIA DBA: ANTHEM BLUE CROSS

Dear Ms. Andersen:

Enclosed is the final report (Final Report) of a routine examination of the Medical Loss Ratio Annual Reporting Form (MLR Reporting Form) of Blue Cross of California, dba: Anthem Blue Cross (Plan) for the medical loss ratio (MLR) reporting year ended December 31, 2020. The examination was conducted by the Department of Managed Health Care (Department), pursuant to Section 1382(a) of the Knox-Keene Health Care Service Plan Act of 1975.[1]

Section 1382(d) states, "If requested in writing by the plan, the director shall append the Plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and provide modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

Please indicate within 10 days from the date of the Plan's receipt of this letter whether the Plan requests the Department to append its response to the Final Report. If so, please indicate which portions of the Plan's response should be appended, and electronically file copies of those portions excluding information held confidential pursuant to Section 1382(c). If the Plan requests the Department to append a brief statement summarizing the Plan's response to the Final Report or wishes to modify any information provided to the Department, please provide an addendum no later than 10 days from the date of the Plan's receipt of this letter. Please file this addendum

[1] References to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in the California Health and Safety Code, Section 1340, et seq.

electronically via the corrective action plan (CAP) system within the Department's eFiling web portal at https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select “eFiling.”
- From the eFiling menu, select “Online Forms.”
- From the Online Forms menu, click on “Details” for “DFO Corrective Action Plan S22-F-303.”
- Go to the “Messages” tab:
    - Select “Addendum to Final Report” (note this option will only be available for 10 days after the issuance of the Final Report).
    - Select the deficiency(ies) that are applicable.
    - Create a message for the Department.
    - Attach and upload all documents with the name “Addendum to Final Report.”
    - Select “Send Message.”

As noted in the attached Final Report, no response from the Plan is required.

Questions or problems related to the electronic transmission of the response should be directed to Vijon Morales at (916) 255-2447 or email at Vijon.Morales@dmhc.ca.gov. You may also email inquiries to wpso@dmhc.ca.gov.

The Department will make the attached Final Report available to the public in 10 days from the Plan’s receipt of this letter. The Final Report will be located on the Department’s web site at http://www.dmhc.ca.gov/LicensingReporting/ViewFinancialExaminationReports.aspx.

If there are any questions regarding this Final Report, please contact me at (916) 330-5246 or via email at Jennifer.Clark@dmhc.ca.gov.

Sincerely,

SIGNED BY

Jennifer Clark
Supervising Examiner
Office of Financial Review
Division of Financial Oversight

cc: Terry German, Associate General Counsel, Blue Cross of California
Pritika Dutt, CPA, Deputy Director, Office of Financial Review
Benbin Feng, Senior Examiner, Division of Financial Oversight
Vasiliy Lopuga, Examiner, Division of Financial Oversight
Ankesh Jagur, Attorney III, Office of Plan Licensing
Laura Dooley-Beile, Supervising Health Care Service Plan Analyst, Office of Plan Monitoring
Chad Bartlett, Staff Services Manager II, Help Center

STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

OFFICE OF FINANCIAL REVIEW
DIVISION OF FINANCIAL OVERSIGHT

FINAL REPORT OF ROUTINE EXAMINATION

OF

BLUE CROSS OF CALIFORNIA
DBA: ANTHEM BLUE CROSS

FILE NO. 933 0303

DATE OF FINAL REPORT: DECEMBER 27, 2022

OVERSIGHT EXAMINER: JENNIFER CLARK

EXAMINER-IN-CHARGE: BENBIN FENG

BACKGROUND INFORMATION FOR
BLUE CROSS OF CALIFORNIA
DBA: ANTHEM BLUE CROSS

Date Plan Licensed:	January 7, 1993
Organizational Structure:	Blue Cross of California, dba: Anthem Blue Cross (Plan), is a for-profit, wholly-owned subsidiary of WellPoint California Services, Inc., which is an indirect wholly-owned subsidiary of Anthem, Inc., a publicly traded company. The Plan has two wholly-owned subsidiaries: Blue Cross of California Partnership Plan, Inc., which is licensed as a health care service plan, and WellPoint Information Technology Services, Inc.
Type of Plan:	The Plan is a full service health care plan licensed to provide managed care health plans to large employer, small employer, individual, Medi-Cal, and Medicare markets. The managed care plans include health maintenance organizations, preferred provider organizations, point-of-service plans, and specialty managed care networks.
Provider Network:	The Plan contracts with participating medical groups (PMGs) to provide health care services, and compensates them on a capitated basis. The Plan also contracts with hospitals to provide hospital services on a capitated, per diem, case rate, or other reimbursement basis. In addition, the Plan contracts with a number of skilled nursing facilities, home health agencies, and freestanding ambulatory surgical centers. Specialty care services are provided by the PMGs through contracted specialists.
Plan Enrollment:	The Plan reported 1,657,966 covered lives for the medical loss ratio reporting year ended December 31, 2020; this includes 118,920 individual, 386,950 small group, and 1,152,096 large group enrollees.
Service Area:	The Plan operates in all major counties in California.
Date of Prior Final Routine Examination Report:	January 28, 2020

FINAL REPORT OF A ROUTINE EXAMINATION OF BLUE CROSS OF CALIFORNIA DBA: ANTHEM BLUE CROSS

This is the final report (Final Report) of the routine examination of the Medical Loss Ratio Annual Reporting Form (MLR Reporting Form) of Blue Cross of California, dba: Anthem Blue Cross (Plan) for the medical loss ratio (MLR) reporting year ended December 31, 2020. The examination was conducted by the Department of Managed Health Care (Department), pursuant to Section 1382(a) of the Knox-Keene Health Care Service Plan Act of 1975.[1]

The Department performed this routine examination to verify the Plan's representations in the MLR Reporting Form for the MLR reporting year ended December 31, 2020 in accordance with Rule 1300.67.003(c).

The Department conducted this routine examination to ensure the Plan's compliance with the MLR provisions and reporting instructions then in effect, namely those set forth in Part 158 of Title 45 of the Code of Federal Regulations (2020). Accordingly, the Department performed a detailed review of the documents and data that were used by the Plan in completing the MLR Reporting Form.

The Department's findings are presented in this Final Report as follows:

Part I.	Medical Loss Ratio Annual Reporting Form
Part II.	Calculation of Medical Loss Ratio and Rebate
Part III.	Compliance Issues

The Department's examination did not find any material deficiencies in the MLR Reporting Form for the MLR reporting year ended December 31, 2020. Therefore, no response is required from the Plan regarding this Final Report.

[1] References to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in the California Health and Safety Code, Section 1340, et seq. References to "Rule" are to regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act of 1975 contained within title 28 of the California Code of Regulations.

PART I. MEDICAL LOSS RATIO ANNUAL REPORTING FORM

The Plan reported a MLR of 80.9 percent for its individual market, 77.3 percent for its small group market, and 88.0 percent for its large group market. The MLR for its individual market and large group market are above the MLR standard of 80 percent and 85 percent, respectively. The MLR for its small group market is below the MLR standard of 80 percent for the small group market, and the Plan reported a MLR rebate of $66,676,788.

The Department's examination did not result in any adjustments or reclassifications to the Plan's MLR Reporting Form for the MLR reporting year ended December 31, 2020 filed with the Department. A copy of the Plan's MLR Reporting Form can be viewed by selecting "Blue Cross of California" from the Health Plan drop-down menu and "Annual Medical Loss Ratio" from the Statement Type drop-down menu available on the Department's website at http://wpso.dmhc.ca.gov/fe/search.

No response is required to this Part.

PART II. CALCULATION OF MEDICAL LOSS RATIO AND REBATE

Section 1367.003(a) states that each health care service plan that issues, sells, renews, or offers health care service plan contracts for health care coverage, including grandfathered health plans, but not including specialized health care service plan contracts providing only dental or vision services, must provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expensed by the plan on the costs for reimbursement for clinical services provided to enrollees under such coverage and for activities that improve health care quality to the total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance, is less than the following:

(1) With respect to a health care service plan offering coverage in the large group market, 85 percent.

(2) With respect to a health care service plan offering coverage in the small group market or in the individual market, 80 percent.

Federal MLR requirements are set forth in Part 158 of Title 45 of the Code of Federal Regulations (2020). The Plan's MLR and rebate calculations from the MLR Reporting Form for the MLR reporting year ended December 31, 2020, are as follows:

MLR Components	Individual	Small Group	Large Group
MLR Numerator ***Note 1***	$1,855,064,312	$5,466,540,888	$16,685,955,594
MLR Denominator ***Note 1***	$2,293,217,411	$7,072,674,268	$18,957,737,045
Preliminary MLR before Credibility Adjustment	80.9%	77.3%	88.0%
Credibility Adjustment Factor	0.0%	0.0%	0.0%
Credibility-Adjusted MLR ***Note 2***	**80.9%**	**77.3%**	**88.0%**
MLR Standard	**80.0%**	**80.0%**	**85.0%**
Rebate Amount	**$0**	**$66,676,788**	**$0**

Note 1: The federal MLR regulation requires the Plan to use three years accumulated data to calculate the medical loss ratio. Thus, the MLR Numerator and Denominator represent data from 2020, 2019, and 2018 for the MLR reporting year ended December 31, 2020.

Note 2: Rounded to the nearest one tenth of one percent.

No response is required to this Part.

PART III. COMPLIANCE ISSUES

The Department did not find any material deficiencies in the MLR Reporting Form for the MLR reporting year ended December 31, 2020.

No response is required to this Part.