Arnold Schwarzenegger, Governor
State of California
Business, Transportation and Housing Agency

Department of Managed Health Care
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Via: UPS

October 13, 2006

Mr. Douglas Shur, V.P. Deputy General Counsel
BLUE CROSS OF CALIFORNIA
21555 Oxnard Street
Woodland Hills, CA 91367

RE: FINAL REPORT OF THE NON-ROUTINE EXAMINATION OF BLUE CROSS OF CALIFORNIA

Dear Mr. Shur:

Enclosed is the Final Report of the non-routine examination of Blue Cross of California, (the "Plan") conducted by the Department of Managed Health Care (the "Department") pursuant to Section 1382 (a) and Rule 1300.82 (a). [1] The Department issued a Preliminary Report to the Plan on July 25, 2006. The Department accepted the Plan's response electronically on September 8, 2006, with additional information received by email on October 5, 2006 and October 9, 2006.

This Final Report includes a description of the compliance efforts included in the Plan's responses, in accordance with Section 1382 (c).

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 ten (10) days 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 shall be appended and provide copies (hardcopy and electronically) of those portions of the Plan's response exclusive of information held confidential pursuant to Section 1382 (c), no later than ten (10) days from the date of the Plan's receipt of this letter.

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Division 1 of Chapter 1, Title 28, and California Code of Regulations, beginning with Section 1300.43.

If the Plan requests the Department to append a brief statement summarizing the Plan's response to the report or wishes to modify any information provided to the Department in its response, please provide the documentation (hardcopy and electronically) no later than ten (10) days from the date of the Plan's receipt of this letter.

As noted in the attached Final Report, the Plan's response and additional information was not fully responsive to the corrective actions required in the Preliminary Report issued by the Department on July 25, 2006. Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for the corrective actions required in this report, within thirty (30) days of receipt of this report.

Please file the Plan's response or statement electronically, just as you do for regular licensing filings via the Department's eFiling web portal <https://wpso.dmhc.ca.gov/secure/login/>. Please note this process is separate from the electronic financial reporting and is for the response to this final report only. From the drop-down menu, select "Report/Other: Response to Final Routine Financial Examination Report-Public (RX004)", and then upload your response. Questions or problems related to the electronic transmission of the response should be directed to Siniva Pedro at (916) 322-5393 or email at spedro@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 ten (10) days from the Plan's receipt of this letter.

The Executive Summary to the Department's most recent Medical Survey Report is located at the Department's web site at www.dmhc.ca.gov.

If there are any questions regarding this report, please contact me.

Sincerely,

JANET NOZAKI
Supervising Examiner
Office of Health Plan Oversight
Division of Financial Oversight

cc: Peter Moren, Senior Counsel, Blue Cross of California
Edward Davis, Director of Internal Audit, Blue Cross of California
Amy Dobberteen, Chief Counsel, Office of Enforcement, DMHC
Linda Azzolina, Senior Counsel, Division of Licensing, DMHC
Mark Wright, Chief Examiner, Division of Financial Oversight, DMHC
Agnes Dougherty, Senior Examiner, Division of Financial Oversight, DMHC

CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE

DIVISION OF FINANCIAL OVERSIGHT

FINAL REPORT OF THE NON-ROUTINE EXAMINATION OF BLUE CROSS OF CALIFORNIA

FILE NO. 933 0303

DATE OF FINAL REPORT: OCTOBER 13, 2006

SUPERVISING EXAMINER: JANET NOZAKI

EXAMINER-IN-CHARGE: AGNES DOUGHERTY

FINANCIAL EXAMINER:

MARIA MARQUEZ

GIL RIOJAS

BACKGROUND INFORMATION FOR BLUE CROSS OF CALIFORNIA

Date Plan Licensed:	January 1993
Organizational Structure:	The Plan is a wholly owned subsidiary of WellPoint, Inc. when its parent company, WellPoint Health Networks, Inc. was acquired by Anthem, Inc. on November 30, 2004 and Anthem, Inc. subsequently changed its name to WellPoint, Inc.
Type of Plan:	The Plan is a for-profit, full service health care plan offering a variety of health services, including specialty managed care networks (i.e., dental, behavioral). These services are provided to individuals, small and large groups, senior, and state-sponsored programs.
Provider Network:	The Plan contracts with participating medical groups (PMG) to provide health care services (such as primary care, specialty care and some ancillary 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 basis. The Plan contracts with a number of skilled nursing facilities, home health agencies, and freestanding ambulatory surgical centers. Specialty care is provided by the PMG through contracted specialists. Enrollees access primary and specialty care through their selected medical groups. The Plan also contracts with physicians statewide to provide services to its preferred provider organization (PPO) enrollees.
Plan Enrollment:	4,454,469 enrollees for the quarter ended June 30, 2006, including 1,528,678 PPO enrollees.
Service Area:	All major counties within the State of California
Date of Last Final Report of a Follow-up Examination:	August 17, 2005

FINAL REPORT OF THE NON-ROUTINE EXAMINATION OF BLUE CROSS OF CALIFORNIA

This is the Final Report of the non-routine examination of Blue Cross of California's (the "Plan") process for paying interest and penalties on late claim payments. The Plan's process was revised following an examination in June 2005 that resulted in the Plan filing a Corrective Action Plan (CAP) to resolve deficiencies that were referred to the Department's Office of Enforcement. The deficiencies and CAP are summarized in the Department's Final Report dated November 30, 2005. A Letter of Agreement penalizing the Plan for its interest and penalty violations was issued by the Office of Enforcement on June 14, 2006.

The Department issued a Preliminary Report to the Plan on July 25, 2006. The Department accepted the Plan's response electronically on September 8, 2006, with additional information received by email on October 5, 2006 and October 9, 2006. The Plan's response and additional information are noted in *italics*.

This Final Report includes a description of the compliance efforts included in the Plan's responses to the Preliminary Report, in accordance with Section 1382 (c).

Our findings are presented in the accompanying attachment as follows:

Section I.	Compliance Issues
Section II	Non-Routine Examination

As noted in the attached Final Report, the Plan's responses were not fully responsive to the corrective actions required in the Preliminary Report issued by the Department on July 25, 2006. Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for the corrective actions required in this report, within thirty (30) days of receipt of this report.

SECTION I. COMPLIANCE ISSUES

INTEREST ON LATE CLAIMS

Section 1371 states that a health care service plan shall reimburse claims or any portion of any claim, whether in state or out of state, as soon as practical, but no later than 45 working days after receipt of the claim if the health care service plan is a health maintenance organization, unless the claim or portion thereof is contested by the plan in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 45 working days after receipt of the claim by the health care service plan. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.

This section also states that if an uncontested claim is not reimbursed by delivery to the claimant's address of record within the respective 45 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 45-working-day period. A health care service plan shall automatically include in its payment of the claim all interest that has accrued pursuant to this section without requiring the claimant to submit a request for the interest amount. Any plan failing to comply with this requirement shall pay the claimant a ten-dollar ($10) fee.

Rule 1300.71 states that a plan shall reimburse all claims relating to or arising out of non-HMO lines of business within thirty (30) working days, as well as, sets forth various definitions and compliance requirements for claim settlement practices.

Section 1371.35 (b) refers to claims resulting from emergency services and requires that if an uncontested claim is not reimbursed within the respective 30 or 45 working days after receipt, the plan shall pay the greater of $15.00 or interest at the rate of 15% per annum, beginning with the first calendar day after the 30 or 45 working day period.

Our examination disclosed that the Plan did not pay interest and fees correctly on some of the late claims that we reviewed. We reviewed a random sample of 100 claims and adjusted claims paid in the first quarter 2006, from a population of potentially late claims.

Our review of 100 claims disclosed the following deficiencies:

1. Interest was not paid correctly on the following Non-Emergency claims:

Sample No.	Amount Paid on Claim	Interest Paid	Interest Owed	Fee Owed
4	$43.34	$ .77	$0.93	$10.00
16	$13.48	$ .00	$0.35	$10.00
45	$14.98	$ .00	$0.52	$10.00
35	$1,302.34	$ .00	$150.93	$10.00
4 (ISG)	$90.00	$11.70	*	*
31(ISG)	$78.13	$15.04	*	*

*Interest and fees were paid after sample selection was provided to the Plan.

Our review indicates that the majority of these interest and fee errors are due to processor error, rather than due to systemic reasons. Therefore, the Plan was required to implement the following:

- Training procedures to ensure that processors are identifying the correct receipt dates for purposes of interest calculation on all late and late adjusted claims.

- Audit procedures to be performed at least quarterly to determine whether interest and fees are calculated correctly on all late claims, including late adjusted ER and non-ER claims.

In addition, the Plan was required to provide the date of implementation for each of the items listed above, the management position(s) responsible for overseeing each item, and a description of the monitoring system implemented to ensure ongoing compliance.

The Plan responded that as of July 21, 2006, all Plan claims processors and adjusters completed training sessions on AB1455 that included instruction on identifying the correct receipt dates for purposes of interest calculation on all late and late adjusted claims. Additional training will be scheduled based upon the Plan's compliance monitoring.

The Plan identified the Vice President -Technical Operations and Support; Director I - Customer Care and Manager II - Customer Care as the individuals responsible for overseeing the above activity

The Plan also stated that its Customer Quality Review (CQR) Department implemented audit procedures to determine whether interest and penalties are calculated correctly on late claims (emergency and non-emergency) from the Plan's claim systems for all three business areas, i.e. individual/small group, large group and state-sponsored business.

The Plan identified the Vice President - Accounting/Finance, Director - Quality Assurance, and Manager - Business Change as the individuals responsible for oversight of the activity by the CQR Department.

The Department finds that the Plan's compliance efforts are responsive to the deficiency cited and the corrective actions required.

2. Interest was not paid correctly on the following Emergency claims:

Sample No.	Amount Paid on Claim	Interest Paid	Interest Owed	Fee Owed
6	$107.14	$ .00	$15.00	$10.00
8 (ISG)	$259.20	$ .00	$15.00	$10.00
43(ISG)	$678.50	$4.74	$15.00	$10.00

The Plan stated that the underpayment of interest for Sample No. 43 was caused by a systemic error in one of the two claims processing systems tested. The error resulted in the underpayment of interest on late ER claims, originally believed to have been corrected in June 2005, but was not corrected until May 22, 2006. Therefore, the Plan was required to submit a Corrective Action

Plan ("CAP") to substantiate the actions implemented to comply with Section 1371.35 and Rule 1300.71. If the Plan was not able to complete the CAP or portions of the CAP within 45 days of receipt of this report, the Plan was required to submit a timeline with its response and monthly status reports to the Department until the CAP is completed.

The CAP was to include the following:

a. Identification of all claims and adjusted claims for emergency services within the system in which the error was found, where interest and fees were not paid correctly. The time period for identification should begin with September 1, 2005, the date through which the Plan last identified claims requiring remediation, and ending with the date of the Plan's response to this report.

b. Evidence that interest and fees, as appropriate, were paid retroactively for the claims identified in paragraph "a", above. This evidence is to include an electronic data file (Dbase, Access or Excel) schedule that identifies the following:

    - Service type
    - Date of service
    - Claim number
    - Date original claim received
    - Date new information received (date claim was complete)
    - Total billed
    - Original total paid
    - Original paid date
    - Adjustment paid
    - Adjustment paid date
    - Original interest paid
    - Original interest paid date
    - Additional interest (w/ formula)
    - Additional interest paid date
    - Fee paid
    - Fee paid date
    - Provider name
    - PPO or Non-PPO indicator
    - Electronic payment indicator

    The data file is to provide the total number of claims and the total additional interest and fee paid, as a result of remediation.

The Plan submitted spreadsheets as evidence that they had paid the remediation as required above. There were some payments that were not made for the following reasons:

- *Interest and fee payments were "not paid to the provider, but instead clipped to apply to the overpayment on record."*

- *Interest and fee payments received from some out-of-state providers were calculated using another state's "prompt pay logic" rather than California's prompt payment requirements.*

In order to determine the Plan's compliance efforts in resolving the deficiency cited, the Plan is required to provide the following confirmations:

- **For all interest and fee payments that were clipped, the Plan is required to confirm in writing that they were applied in accordance with Rule 1300.71 (d)(6).**

- **For all interest and fee payments that were calculated using prompt pay regulations other than Sections 1371 and 1371.35, the Plan is required to confirm that these claims were not the Plan's responsibility and were not claims for a California subscriber.**

The findings of this non-routine examination were reported to the Office of Enforcement.

SECTION II. NON-ROUTINE EXAMINATION

The Plan is advised that the Department may conduct a non-routine examination, in accordance with Rule 1300.82.1, to verify representations made to the Department by the Plan in response to this report. The cost of such examination will be charged to the Plan in accordance with Section 1382 (b).

No response was required to this Section.