



Application for an Award of Advocacy and Witness Fees

Entity Name: Health Access of California
Proceeding: Material Modification concerning the acquisition of Care1st Health Plan by Blue Shield
Date Submitted: 12/4/2015 1:42:11 PM
Submitted By: Tam Ma
Application version: Original App

1. For which proceeding are you seeking compensation?

Material Modification concerning the acquisition of Care1st Health Plan by Blue Shield

2. What is the amount requested?

\$29,906.00

3. Proceeding Contribution:

Provide a description of the ways in which your involvement made a substantial contribution to the proceeding as defined in California Code of Regulations, Title 22, Section 1010(b)(8), supported by specific citations to the record, your testimony, cross-examination, arguments, briefs, letters, motions, discovery, or any other appropriate evidence.

Health Access made a substantial contribution to this proceeding by submitting multiple letters and information that presented relevant issues, evidence and arguments that were helpful and seriously considered by the Department. Our involvement resulted in more relevant, credible, and non-frivolous information being available to the Director. The following materials were submitted to DMHC for this proceeding: Letter to DMHC requesting public meeting (4/9/2015) Joint Comment letter (5/29/15) Role of Nonprofit Insurer Paper (submitted with comment letter on 6/12/2015) Health Access comment letter (6/12/2015) Joint Comment Letter (7/16/15) Letter to DMHC (11/6/15) We also provided testimony at the public meeting on June 8, 2015 and participated in several phone and in-person meetings at DMHC regarding this proceeding.

Document Name	Date Uploaded	Uploaded By	
Letter to DMHC Requesting Public Meeting	12/4/2015 9:43:24 AM	Tam Ma	View
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Letter to DMHC (11/6/15)	12/4/2015 9:46:45 AM	Tam Ma	View

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I am authorized to certify this document on behalf of the applicant. By entering my name below, I certify under penalty of perjury under the laws of the State of California that the foregoing statements within all documents filed electronically are true and correct and that this declaration was executed at Sacramento (City), CA (State), on December 04, 2015 .

Enter Name: Tam M. Ma



April 9, 2015

Shelley Rouillard, Director
Department of Managed Health Care
980 Ninth Street
Sacramento, CA 95814

Re: Blue Shield of California's Proposed Acquisition of Care1st

Dear Director Rouillard:

The Department of Managed Health Care has the authority and the responsibility to review the acquisition of Care1st by Blue Shield of California, including consideration under Article 11 of the Health and Safety Code, commencing with section 1399.70. We view DMHC's role as especially critical at this juncture with the confluence of Blue Shield of California's proposed acquisition, the withdrawal of its state tax-exempt status by the Franchise Tax Board, and the concerns we have previously expressed about Blue Shield's surplus growth. Given our organizations' considerable experience with various types of transactions involving nonprofit entities, including both health plans and hospitals, we make the following requests to ensure the full breadth of the transaction and implications for Californians is made transparent and open to public scrutiny, and made in the best interest of Californians.

First, we request that the Department conduct a public hearing on the transaction at which Blue Shield, CareFirst, and any other entities involved in the acquisition should be required to provide detailed explanations of the impact of the transaction. We request this so that the public and consumer advocates such as ourselves have the opportunity to question the parties and to fully vet the transaction. This is likely a complex transaction and all the pieces need to be examined and evaluated to determine their effect under California law. A thorough public airing may in fact elicit information, such as the particulars of Blue Shield's creation of new holding companies, which may be probative of whether this transaction constitutes a restructuring of the sort envisioned under Article 11 of the Health and Safety Code that would subject it to an array of obligations.

Second, we ask that the Department obtain an independent valuation of the transaction. Media reports indicate that Blue Shield won the right to purchase Care1st through a bidding process, in which the Care1st Board picked the highest bidder, maximizing value for its shareholders. However, Blue Shield as a nonprofit mutual benefit corporation may have overpaid for the asset, thus harming the public interest represented by its non-profit corporate status.

If Blue Shield overpaid for Care1st rather than paying a fair price, then the over-valuation would raise substantial questions about the reasons for the over-payment. It would also deplete nonprofit assets, a legitimate concern for the public interest.

Third, the acquisition of a for-profit company by a nonprofit entity raises questions about potential self-inurement of the board and senior management of the nonprofit entity. For

example, did the board or senior management of Blue Shield receive ownership interest or stock options in Care1st or are these held by the nonprofit corporation for the benefit of the public? Did any compensation, other than the purchase price, flow between the two entities and if so, in what direction? It may be that in reviewing materials associated with the transaction the Department obtains information indicative of private inurement. If so, we ask that the Department share such information with the Attorney General and, if it does not jeopardize a potential investigation, the public.

Fourth, we ask that the Department use its full authority to scrutinize the transaction for its impact on consumers enrolled in health care service plans. Blue Shield has historically not participated in Medi-Cal managed care: one of its stated reasons for the acquisition is to buy its way into that business. But Medi-Cal managed care, is a very different game than commercial coverage. Medi-Cal managed care plans consistently rate poorly in consumer satisfaction and other quality measures. The difficulties with Medi-Cal managed care transitions, particularly for seniors and persons with disabilities as well as those dually eligible for Medi-Cal and Medicare, are well established. The health needs of low-income populations, because of the social determinants of health, are quite different than the more affluent, commercial population Blue Shield has traditionally served.

For all of these reasons, including Blue Shield's lack of experience with Medi-Cal managed care as well as the different needs of the Medi-Cal population, if the transaction is approved, we ask that the Department intensify its oversight of Blue Shield by conducting annual medical surveys for a period of at least five years in order to assure that consumers are receiving medically necessary care in a timely manner from adequate networks.

Of course, additional state officers and entities also have a role to play in the confluence of circumstances surrounding Blue Shield. We urge DMHC to share information it elicits with the relevant tax authorities, including the Franchise Tax Board, and with the Attorney General's Office to assure appropriate oversight of Blue Shield's responsibilities vis a vis its nonprofit assets, including whatever is revealed as a result of the Care1st transaction.

Sincerely,



Elizabeth M Imholz,
Special Projects Director
Consumers Union



Anthony Wright
Executive Director
Health Access



Elizabeth A. Landsberg
Director of Legislative Advocacy
Western Center on Law & Poverty



Emily Rusch
Executive Director
CalPIRG



Ms. Shelly Rouillard
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

May 29, 2015

Dear Ms. Rouillard

Our organizations, CalPIRG, Consumers Union, The Greenlining Institute, Health Access, and Western Center on Law and Poverty write to present information and raise a number of issues that we have identified in regard to California Physicians' Service (d.b.a. Blue Shield of California) and its proposal to purchase Care 1st, a California for-profit corporation.

Two recent developments have subjected Blue Shield to greater public scrutiny and raised concerns about Blue Shield of California's nonprofit obligations:

- In March 2015, news reports indicated that the Franchise Tax Board revoked Blue Shield's state tax-exempt status in August 2014;
- Blue Shield proposes to purchase the for-profit Medicaid plan, Care 1st Health Plan (and its subsidiaries, in Arizona and Texas), and to establish a nonprofit mutual holding company, Cumulus Holding Company, Inc.

We have identified a number of important issues relating to Blue Shield of California's charitable trust obligations that should be addressed during the Department of Managed Health Care (DMHC)'s review of the proposed transaction. These questions arise from Blue Shield's filings with DMHC in connection with the proposed purchase of Care 1st and more broadly from their loss of tax-exempt status.

In its DMHC filing for a Material Modification, Blue Shield of California states that it "does not currently hold and has not previously held assets subject to a charitable trust obligation."¹ This assertion is contrary to Blue Shield's articles of incorporation, its history, and its stated public purpose. As described more fully below, we contend that its articles of incorporation, its decades-long federal and state tax-exempt status, its decades-long status as a 501(c)(4) organization, and the clear intent of the original founders of the organization, illustrate that Blue Shield holds significant charitable assets subject to charitable trust obligations.

¹Exhibit E-1, DMHC File Number 933-0043, Notice of Material Modification to License Application, January 30, 2015.

DMHC has broad responsibility under California law to determine if Blue Shield holds any charitable assets and ensure that those assets are protected. We believe this issue is critical to determining which parts of the Health and Safety Code apply to DMHC's review of the proposed transaction and warrants intensive scrutiny by the Department.

Background on California Physicians' Service

The history of California Physicians' Service shows the organization was intentionally established, like virtually all Blue Cross and Blue Shield plans, to protect consumers from the high costs of health care. Furthermore, the California Supreme Court found that California Physicians' Service is a nonprofit corporation subject to the Attorney General's authority over public trusts.

California Physicians' Service was created as a nonprofit corporation in 1939. At the time, California had one general nonprofit corporation law, which included organizations established for "religious, charitable, social, educational, recreational, cemetery, or for rendering services, which do not contemplate the distribution of gains, profits or dividends to the members thereof, and for which individuals lawfully may associate themselves..."²

California Physicians' Service was "organized by the medical profession in 1939 to meet the needs of persons in the lower income groups for medical care and surgical service," as a health services corporation.³ The preamble to the articles of incorporation sets out a summary of the policies and purposes for establishing the nonprofit medical service plan:

[T]hat the very advances made by modern science have greatly increased the cost of good medical service and hospital care and will continue to increase that cost as new methods and equipment for diagnosis and treatment are discovered and perfected, and, therefore, the cost of always unpredictable injury or illness is a financial catastrophe too great to be borne by the few citizens of California thus always afflicted at any given time, though the total cost over any period is within the means of the total group; that a method which only the medical provision can most effectively provide is necessary properly to distribute this cost of medical service so as to relieve the intolerable financial burden heretofore falling on the unfortunate few in any given period of time; that the establishment by the profession of a voluntary medical service plan, participation by all doctors of medicine desiring to do so, will enable people of the State of California to obtain prompt and adequate medical attention and hospital care whenever needed on a periodic budgeting basis without injury to the standards of medical service, without disruption of the proper physician-patient relation and ***without profit to any agency, and will assure that all payments made by patients, except administrative costs, will be***

² *The Organization of California Physicians' Service*, Hartley F. Peart and Howard Hassard, Law and Contemporary Problems, Vol. 6, No. 4, Medical Care (Autumn, 1939), at page. 567, footnote 11 (citing California's General Nonprofit Corporation Law of 1931).

³ *California Physicians' Services v. Garrison*, 28 Cal. 2d 790 (1946).

*utilized for medical service and hospital care and not otherwise; that such a plan will create an efficient public and civic service without commercial exploitation of the patients or the profession or any restriction of an individual's fundamental right freely to select, when his need arises, the doctor of medicine and hospital desired by him; and finally, such a coordinated organized service can, upon the same fundamental basis, be the means which governmental agencies, federal, state, and local, may use to provide, at the lowest possible cost to the taxpayer, good medical service and hospital care for the indigent, needy or handicapped residents of California.*⁴ [Emphasis added]

The California Physicians' Service was created to "form a non-profit, social and civic corporation under the laws of the state of California"⁵ based on these ideals, principles and purposes. Specifically, the organization was established to provide quality, affordable health care to low-income Californians through the efficient use of taxpayer funds while ensuring that resources are directed toward the provision of medical care, not profits.

The articles of incorporation themselves reiterated ideas introduced in the preamble, namely that the corporation:

- Does not "contemplate and is not formed for the pecuniary gain or profit of the members thereof or the distribution of gains, profits, or dividends to any of its members;"⁶
- Will "act as trustee under any trust incidental to the principal objects and purposes of the corporation, and to receive, hold, administer and expend funds and property subject to such trust;"⁷
- Will "accept gifts, trusts and donations and receive property by devise or bequest, subject to the laws regulating the transfer of property by will, and to apply the principle or interest as may be directed by the donor or as the board of trustees of the corporation may determine in the absence of such direction, in aid and furtherance of the objects and purposes set forth in [article] TWO."⁸

Soon after California Physicians' Service was established, an article was published in the Journal of Law and Contemporary Problems which was written by counsel to both the California Medical Association and California Physicians' Service. The article, "The Organization of California Physicians' Service," describes the founding of the new nonprofit organization and explains how the founders decided to create a non-profit corporation (as opposed to an insurance company or other business entity), designating three classes of members and the specific rights, roles and responsibilities of each class. California Physicians' Service's counsel acknowledges in the article that the nonprofit corporation holds a charitable trust and is subject to the supervision of the Attorney General's protection of charitable trusts:

⁴ Articles of Incorporation of California Physicians' Service, Department of State, Corporation Number 178531, Filed with the California Secretary of State, February 2, 1939.

⁵ Article Two of the Articles of Incorporation, Ibid.

⁶ Article Six of the Articles of Incorporation, Ibid.

⁷ Ibid.

⁸ Ibid.

It is apparent that an enterprise that collects funds from members to defray the cost of unpredictable medical and surgical needs may, like an insurance company or bank, be considered 'clothed with a public interest,' and, with respect to its administration of such funds, a 'public trustee.' If so, then California Physicians' Service is subject to the control of the California Attorney General. Cal. Civ. Code section 605c (supervision of Attorney General of any non-profit corporation holding property subject to any public trust)."⁹

Approximately seven years later, when the Department of Insurance appealed a lower court determination that California Physicians' Service was not engaged in the business of insurance, the California Supreme Court found that the nonprofit corporation was not providing indemnity insurance. The court looked to the purposes of the corporation and found that California Physicians' Service was organized and maintained with a

[W]ide scope in the field of social service. Probably there is no more impelling need than that of adequate medical care on a voluntary, low-cost basis for persons of small income. The medical profession unitedly is endeavoring to meet that need. Unquestionably, this is a "service" of a high order and not "indemnity."¹⁰

The court found that California Physicians' Service was subject to the Attorney General's authority over public trusts.¹¹

Until 1987, California Physicians' Service and other Blue Cross and Blue Shield (BCBS) Trademark holders, were recognized under federal law as 501(c)(4) organizations. At the time, the national BCBS Association, a nonprofit organization that holds the BCBS trademark, went to great lengths to distinguish BCBS plans from commercial insurers by stressing their dedication to charitable, community-based health care services.

As of January 1, 1987, the federal government removed the full tax-exempt status of BCBS plans because providing commercial insurance was a substantial part of their activities. The IRS created a new category of nonprofit organizations, Internal Revenue Code ("I.R.C.") 5833, or 501(m), which subjected BCBS plans to federal taxation while recognizing the unique role BCBS plans play.¹²

⁹ *The Organization of California Physicians' Service* at page 573, footnote 39.

¹⁰ *CPS v. Garrison*' Ibid.

¹¹ *CPS v. Garrison*' Ibid.

¹² Note that the federal tax status of a corporation does not dictate California's charitable trust rules. In fact, the 501(m) federal tax category was created in 1987 and the Blue Cross of California conversion, subject to full state scrutiny under the charitable trust doctrine, occurred in the 1990s. Indeed, the fact that an organization, such as a health services plan, may not be fully exempt under federal tax law, and therefore may escape IRS scrutiny, makes the application of California charitable trust rules to these entities all the more important-- the state may be the only level of government protecting charitable assets.

In 1994, when the National Blue Cross and Blue Shield Association permitted its affiliated organizations to become for-profit,¹³ California Physicians' Service asserted that it intended to remain a nonprofit Blue Cross and Blue Shield licensee. In recent press coverage disclosing the Franchise Tax Board's removal of state tax-exempt status for California Physicians' Service, the health care services plan continued to assert its intent to remain a nonprofit corporation.¹⁴ The corporation currently is organized with the purpose of promoting social welfare.¹⁵

In light of the Franchise Tax Board's decision to revoke California Physicians' Service's tax-exempt status, whether or not California Physicians' Service can continue doing business as it has and still preserve the charitable trust it has held since 1939, is now in question.

The Applicable Charitable Trust Law

Under current law, there are three types of nonprofit corporations in California: public benefit, mutual benefit, and religious. Public benefit corporations are organized for charitable (which includes educational or scientific) or public (which includes the broader category of social welfare) purposes.¹⁶ Generally, both types of public benefit corporations are subject to the jurisdiction of the Attorney General and may not engage in mergers, dissolutions, change in corporate status, or other reorganization transactions without the approval of the Attorney General.¹⁷ With regard to health care services plans, California law also gives DMHC wide authority over the nonprofit character and legal obligations of health care service plans, regardless of whether they are categorized as a public benefit or mutual benefit corporation.¹⁸

All assets of a public benefit corporation are subject to a charitable trust. Mutual benefit corporations—the type which California Physicians' Service is categorized—also may, and often do, hold *part of their assets in charitable trust*, and various sections of the Nonprofit Mutual Benefit Law specifically recognizes this fact.¹⁹ We believe the language previously cited from the articles of incorporation for California Physicians' Service and attendant documents evinces a clear charitable purpose.

Application of California Physicians' Service's Facts to Charitable Trust Law

California Physicians' Service was created with a public and social welfare purpose. For close to 50 years, it was recognized federally as a 501(c)(4) social welfare organization, free from

¹³ See Silas, et. al, *Blue Cross Conversions: Consumer Efforts to Protect the Public's Interest*, New York Academy of Medicine (1997).

¹⁴ *Blue Shield of California Loses its Tax Exempt Status*, National Public Radio, March 19, 2015. Accessed at <http://www.npr.org/2015/03/19/393982147/blue-shield-of-california-loses-its-tax-exempt-status>.

¹⁵ The IRS has stated that the promotion of social welfare is a charitable purpose. IRC 501(c)(4) Organizations (2003), page I-25. Accessed at <http://www.irs.gov/pub/irs-tege/eotopici03.pdf>.

¹⁶ Corporations Code Section 5111

¹⁷ In different cases, the corporation must either obtain written approval up front or simply provide notice to the Attorney General, giving it an opportunity to challenge the transaction.

¹⁸ Corporations Code, Section 10821, Health & Safety Code section 1340 et seq.

¹⁹ Corporations Code Sections 7238 and 7820.

taxes, able to accept tax-deductible donations, and receive special treatment from the federal government. During that same span of time, under California state law, California Physicians' Service was organized and incorporated under the state general nonprofit code, as a "religious, charitable, social, educational, recreational, cemetery, or for rendering services, which do not contemplate the distribution of gains, profits or dividends to the members thereof, and for which individuals lawfully may associate themselves..."²⁰

When the nonprofit law changed in 1980 to become more specific about the type of nonprofits—religious, public benefit, or mutual benefit—the Secretary of State's office classified all pre-1980 corporations according to the category that they most closely resembled. Given the vast number of nonprofit corporations, it is unlikely that any substantial level of analysis of each corporation was undertaken, and it may be that some entities, and perhaps California Physicians' Service is one, were simply misclassified as a mutual benefit corporation, while most other health care service plans were characterized as public benefit corporations (including Blue Cross of California and Kaiser Permanente). At the time, California Physicians' Service did not change its articles of incorporation or by-laws, but continued to do business under the same purposes as it originally articulated in 1939.

It seems implausible that one health care service plan, such as Blue Cross of California (originally a nonprofit public benefit corporation before its conversion to for-profit in the 1990s, now known publicly as "Anthem"), could be subject to the charitable trust rules, while another, such as California Physicians' Service, would not, even though both entities did the same basic work and were governed as nonprofits under the same general California nonprofit law for close to 50 years. The difference in the Secretary of State's classification may be attributable merely to the choice of a few words (in this case possibly the word "members") in the articles of incorporation.

If the provision of comparable health care services is a public benefit charitable activity for some nonprofit corporations, then it must be for all, even those that happen to be organized as mutual benefit corporations. Since most nonprofit health care service plans are public benefit corporations with charitable assets, all nonprofit health care service plans must be treated in the same way. Otherwise, the disparate treatment would provide the mutual benefit corporations with an unfair competitive advantage. The purposes and activities of California Physicians' Service and other mutual benefit health care service plans are not generally different from the charitable purposes and activities of Blue Cross, HealthNet, and other public benefit corporations and which were subject to the charitable trust rules until they converted to for-profit corporations.

Any argument that Blue Shield of California, which engages in exactly the same type of charitable or public activity as these other health care plans, should escape the charitable trust rules is illogical. As a general rule, California law, and all laws, should seek to elevate substance

²⁰ *The Organization of California Physicians' Service*, Ibid at page. 567, footnote 11 (citing California's General Nonprofit Corporation Law of 1931).

over form. It is, in part, for this reason the Mutual Benefit Code recognizes that mutual benefit corporations may have charitable assets,²¹ and that those assets will be subject to the charitable trust rules.²²

Charitable Trust Obligations Apply Regardless of How Blue Shield Frames Corporate Structure

Charitable trust restrictions, once imposed, continue to apply to assets impressed with a charitable trust even if a corporation later changes its purposes, dissolves, and distributes its assets, or transfers its assets to another charity without receiving full consideration. Charitable trust restrictions, once imposed, also continue to apply to the proceeds from the sale or lease of any charitable assets.²³ Given that Blue Shield's charitable assets must always be preserved and that charitable trust restrictions apply indefinitely, the obligation on Blue Shield to accumulate and use assets in a prescribed manner applies today, regardless of how it attempts to reframe its corporate structure.

We have seen a number of creative business arrangements of other Blue Cross and Blue Shield plans. The proposed transaction between Blue Shield and Care 1st is a complicated one. It involves setting up a new nonprofit corporation, Cumulus Holding Company, and having Blue Shield "grant" \$1.25 billion to that new company so that the new company can buy all the shares of a for-profit company, Care 1st. There are many details about the proposed purchase and about how the three companies will co-exist as affiliates after the transaction, which includes, among other things, a shared Board of Directors. The transaction requires great scrutiny to ensure that Blue Shield's nonprofit assets are protected and preserved.

Restructuring and conversions of Blue Cross and Blue Shield plans are never simple. In many cases, when these types of transactions were first proposed by other Blue Cross and Blue Shield plans across the country, they were not overtly engaging in restructuring or conversion. In our own backyard, in the 1990s when California Blue Cross converted from nonprofit to for-profit status, it did not explicitly state its intention to convert from a nonprofit to a for-profit. Rather the proposal was for the nonprofit to create a for-profit subsidiary. Only after careful scrutiny from the public, the media, and diligent regulators over a period of time and investigation, did it become clear that the proposal was actually a conversion; a conversion that at the end resulted in more than \$3 billion of nonprofit assets set aside in two charitable foundations, based on the charitable trust doctrine.

On the face of it, Blue Shield's proposal to purchase the for-profit Care 1st is quite similar to Blue Cross of California's transaction. Blue Cross of California proposed to *create a for-profit* with some of its assets. Blue Shield is proposing to *purchase a for-profit*. In the 1990s, the regulator successfully protected the charitable assets of Blue Cross that had accrued for over 50 years. (That experience was the genesis of the Health & Safety Code, Article 11, relevant to Blue Shield's proposed transaction.) The public deserves the same level of scrutiny from regulators today to ensure that nonprofit, charitable assets of Blue Shield of California are protected similarly.

²¹ Corporations Code Section 7111

²² See also, Health & Safety Code Section 1399.75(e).

²³ *Pacific Homes v. County of Los Angeles*, 41 Cal.2d 844, 854 (1953).

DMHC Role in Protecting Charitable Assets

The Department's responsibility to protect charitable or public assets is more than a ministerial responsibility. The California Health & Safety Code charges this Department with the obligation to protect charitable assets held by health service corporations, including Blue Shield of California. Whether it is a restructuring, conversion or a simple material modification, the DMHC must ensure that charitable assets of health service corporations continue to be used to further their original purposes, and no other.

Blue Shield of California should bear the burden of proving its assertion that it "does not currently hold and has not previously held assets subject to a charitable trust obligation."²⁴ Its articles of incorporation, its history, and its stated public purpose, its decades-long federal and state tax-exempt status, its decades-long status as a 501(c)(4) organization, and the clear intent of the original founders of the organization, all indicate otherwise, i.e. that Blue Shield of California holds significant charitable assets subject to charitable trust obligations. It should not be able to evade the Health and Safety Code's protections, and any other duties under California law, by simply asserting it has no such charitable trust obligation.

Although Blue Shield of California does not characterize its purchase of the for-profit Care 1st through a newly created nonprofit as a restructuring or conversion, DMHC still bears responsibility for protecting Blue Shield's charitable assets. Since Blue Shield claims in its filings for the Care 1st transaction that it does not now, nor has it ever held any charitable assets, advocates are very concerned that assets of Blue Shield may not be protected, preserved and used as they should be, whether in the context of the proposed purchase of Care 1st or otherwise. At the beginning of 2014, Blue Shield of California held a surplus in excess of \$4 billion, well above the amount required by the state and the BCBS Association. It added to that surplus in 2014 and raised insurance premiums in 2015 with a clearly stated intent to grow additional surplus.²⁵ DMHC should ensure that the surplus is used consistent with the charitable trust doctrine.

Also in the material modification filing, Blue Shield has said it is purchasing Care 1st because it wants to be in the Medi-Cal market. Blue Shield claims that the purchase of Care 1st will further Blue Shield's mission to serve low-income people. Just because Blue Shield is proposing to purchase a for-profit company that serves poor people, does not in anyway release the company from DMHC scrutiny to ensure that its charitable assets are protected.

We look forward to hearing from Blue Shield of California how the revocation of its tax exempt status, the proposed grant of more than one billion dollars to a new affiliated holding company that will then purchase the shares of Care 1st (which will become another affiliated company), and the claim that Blue Shield does not now nor has it ever held any charitable assets, can be reconciled with the history and facts of this long-standing California nonprofit corporation.

²⁴Exhibit E-1, DMHC File Number 933-0043, Notice of Material Modification to License Application, January 30, 2015.

²⁵The California Physicians' Services actuarial memorandum stated their intent to increase contribution to surplus from 1.15% to 1.95% of revenue.

If you have any questions or concerns, please contact Julie Silas (415) 431-6747 ext 106 or jsilas@consumer.org.

Sincerely,

Emily Rusch, CalPIRG
Julie Silas, Consumers Union
Tahira Cunningham, Greenlining Institute
Tam Ma, Health Access
Elizabeth Landsberg, Western Center on Law and Poverty

What is the Role of a Nonprofit Insurer? Should the Affordable Care Act Change The Expectations of Insurers With a Public Service Mission?

Introduction

New questions have arisen about what it means to be a nonprofit health insurer in California, starting with Blue Shield of California, one of the state's largest health plans. Last March, the *Los Angeles Times* reported that the state Franchise Tax Board (FTB) had quietly revoked Blue Shield of California's tax-exempt status in August of 2014 and asked the insurer to file returns going back to 2013.ⁱ Blue Shield has actually been paying federal taxes since 1986, when Congress stripped all Blue Cross-Blue Shield plans of their tax-exempt status. Blue Shield is appealing the FTB's decision.

Blue Shield has also made a \$1.25 billion bid to acquire Care1st, a for-profit Medi-Cal managed care plan based in Monterey Park. This particular transaction would bring Blue Shield into the Medicaid (Medi-Cal) managed care market. Blue Shield's bid, together with longstanding concerns about its surplus growth, prompted several consumer advocacy groups to request a public hearing on the proposed transaction. The Department of Managed Health Care (DMHC), which oversees managed care plans, has scheduled a hearing for June 8, 2015 (see the agenda [here](#)).ⁱⁱ

Californians have a lot of stake in Blue Shield's tax-exempt status and its community benefit obligations as a nonprofit. DMHC's hearing will bring these issues into the public arena for full debate. This issue brief seeks to contribute to the discussion on Blue Shield's public service mission in light of its bid for Care1st and the state's recent revocation of its tax-exempt status, and asks how and to what extent the Affordable Care Act (ACA) reframes those obligations.

The Federal and State Obligations of Nonprofit Insurers

Charitable organizations are supposed to be mission-driven institutions established to benefit the communities they serve. As such, they are typically exempt from paying federal and sometimes other taxes. To maintain that privilege, non-profits must continually demonstrate how they operate in the community's interest and how they serve the community's needs. Federal law is murky on the public service obligations of nonprofit health plans. A recent law review article finds little evidence of community benefit provided by traditional nonprofit insurers such as Blue Shield.ⁱⁱⁱ

State law, by contrast, is more explicit about what a nonprofit insurer must do to not only maintain its nonprofit and tax-exempt status, but also about how it conducts itself in the disposition of assets when it comes to transactions such as Blue Shield's bid to acquire Care1st. Although nonprofit health plans currently pay federal taxes, California-based plans have maintained tax-exempt status at the state level.

[Article 11 of Chapter 2.2 of the California Health and Safety Code](#) spells out the obligations of nonprofit health plans in elaborate detail. Among other requirements, health plans must:

- Submit lengthy reports on their public benefit activities in fulfillment of their nonprofit obligations; the value of those activities; the procedures for avoiding conflicts of interest;
- Seek approval for plans to restructure their activities, including any transactions involving the plan's assets; and
- Demonstrate that all transactions, including sales, investments, and purchases involving the assets of the nonprofit health plan do not interfere with the plan's ability to meet its public benefit obligations.^{iv}

Finally, DMHC has broad responsibility under California law to protect non-profit health plans' charitable assets and ensure that they fulfill their charitable trust obligations.

A Crossroads for Blue Shield as a Nonprofit Plan

Also earlier this year, Blue Shield executive Michael Johnson resigned from his post as director of public policy. Upon his departure, Johnson raised a number of questions about Blue Shield's conduct and whether the public is adequately benefiting from its \$10 billion in assets.^v Pointing to the creation of two large healthcare foundations following the conversion of non-profit Blue Cross to for-profit Anthem Blue Cross, Johnson concludes that the state and communities-in-need would be better off if Blue Shield fully converted to a for-profit entity. Its charitable assets could similarly be dedicated to more direct efforts to improve health in California.

In calling for a public hearing, consumer advocates have raised additional questions as to whether Blue Shield, in seeking to acquire Care1st, a for-profit entity, is meeting its obligation under Article 11. Article 11 is intended to guard against self-dealing and self-inurement—how do we know the transaction meets these standards? Did Blue Shield overpay for this asset, tapping into its considerable \$4.2 billion in excess reserves, which is four times the amount recommended by the Blue Cross Blue Shield Association? Concerns about excessive surplus have been raised over many years, and the details are well documented by Consumers Union and others.^{vi}

Scrutiny of the Care1st transaction should also address broader questions about Blue Shield's role as a non-profit insurer. Since Blue Shield argues it would be a better manager of Care1st, in part as a non-profit, a comprehensive review of how Blue Shield fulfills its non-profit obligations is in

order. In addition, should these obligations look any different given the Affordable Care Act's new rules for insurance companies or changes in the landscape of community needs and who needs help accessing health care?

Blue Shield's Status—Before and After the Affordable Care Act

Prior to the ACA, Blue Shield argued (with some justification) that it needed to engage in practices common amongst its for-profit competitors in order to remain competitive, even if those tactics kept affordable health coverage out of reach for millions of Americans. These practices include denying coverage for people with pre-existing conditions; pursuing rescissions to cancel coverage for patients; scaling back on medically necessary benefits including maternity coverage; and otherwise trying to avoid enrolling sick people in its plan. Blue Shield's executives argued they needed to employ these practices in order to avoid adverse selection. Otherwise, Blue Shield would end up with a disproportionate enrollment of high-risk, high-cost individuals, resulting in higher costs and still higher premiums thus making it less competitive than its for-profit counterparts.

While Blue Shield's policy positions have been aligned with other insurers in opposition to rate regulation and some other consumer protections, it deserves credit for actively advocating for certain health reforms that would have set a level playing field between insurers. Blue Shield did push for maternity care as a basic benefit, and for broad health reforms against pre-existing condition denials (with guaranteed issue and the individual mandate), as set forth in the ACA. These particular actions reflected nonprofit Blue Shield's willingness to explore a different business model where the competition between insurers would no longer be based on avoiding risk. Until that point in the reform process, however, the insurer had acted as aggressively on rescissions or other practices as its for-profit rivals, if not more so.

Now that the ACA's market reforms and consumer protections are in effect, Blue Shield's conduct seems indistinguishable from that of its for-profit brethren, in both practice and public policy. For example, both for-profit Anthem Blue Cross and nonprofit Blue Shield of California opposed rate regulation, and proceeded with rates that a state regulator found to be unreasonable; both participated in Covered California, but pursued particularly "narrow networks" and to such an extent that they engendered significant complaints from consumers. DMHC found significant network adequacy violations arising from those complaints.

Items for Discussion: What a White Hat Insurer Might Look Like, Post-ACA

Most of Blue Shield's 3.4 million enrollees are not able to tell if their insurer is non-profit or for-profit. Neither can the staff of the Franchise Tax Board. Those who do not see a difference are

correct in asking if Blue Shield's charitable dollars are better utilized by investing in a health care consumer foundation.

These issues also raise the following question: What would an insurer with a public service mission do *today*, several years into ACA implementation that is different from a for-profit insurer?

- It wouldn't go ahead with rate increases deemed unreasonable by state regulators, especially while holding onto billions in excess reserves.
- It wouldn't withdraw from over 200 zip codes in rural areas, leaving patients in those communities with limited options for coverage.
- It wouldn't have such geographically circumscribed networks and thin formularies that end up unduly inconveniencing patients and forcing them to shoulder burdensome out-of-pocket costs for medically necessary care that is out-of-network or off formulary.

Blue Shield of California has done all of these things. For this reason, consumer advocates have asked for a public hearing on its proposed acquisition of Care1st.

Meeting Unmet Needs: Like a public broadcaster that competes with its commercial network competitors but has a distinct identity and niche, a public service insurer should seek to fill health care needs that would otherwise go unmet. At this time, well into full implementation of the Affordable Care Act, unmet needs in California's health care system include:

- **Geographic Needs:** A public service insurer could make a commitment to serve all corners of the state, and to figure out how to build networks in challenging rural or inner-city places—even if it means operating at a thinner margin there.
- **Program:** A public service insurer should make a point of participating in programs like Medi-Cal and Covered California. The acquisition of Care1st moves Blue Shield in this direction, though it is unclear whether moving into the Medicaid market simply by purchasing a Medi-Cal managed care plan—without adding new capacity or choice—helps or hurts. Regardless, serving Medi-Cal's low-income population and adding access points for cost-effective care must be a key goal.
- **Disease:** Before the ACA, no health plan would want to have a reputation of being particularly good at treating a specific disease, like AIDS or MS, because if a plan attracted a disproportionate number of "sick" people, it would face a death spiral. The ACA now prevents people from being denied for pre-existing conditions, but it does not require insurers to actively seek out those with chronic conditions. But with the risk adjustments and reinsurance and other measures in the ACA, depending on how well they are working, a public service-oriented insurer could arguably seek to serve consumers with chronic conditions. For example, our health system would be better served if an insurer were to actively recruit patients living with diabetes because it specializes in treating the condition by setting up a network of the best providers and systems for treating and managing

diabetes. In industry terms, they could present themselves as “Centers of Excellence,” and actively market themselves to patient populations that previously have been shunned.

- **Language access, cultural competency and health equity:** As one of the largest insurers in the most populous and diverse state in the nation, Blue Shield could be the leader in offering culturally appropriate and responsive health care by guaranteeing access to interpreters and providers with cultural competency training, which is already required by law. In addition, Blue Shield could provide robust networks that allow communities of color to access providers and facilities that meet their needs in a timely manner. In an increasingly diverse state, they may find competitive advantages in serving diverse populations well.
- **The remaining uninsured:** A public service non-profit insurer could support coverage for the remaining uninsured, including the undocumented. In some states, Blue Cross/Blue Shield plans have “insurer of last resort” status. Non-profit insurers such as Blue Shield should find a new role in addressing the needs of the remaining uninsured in the post-ACA world.

In addition to filling the gaps such as those identified above, a nonprofit insurer could fulfill other roles as well, including:

Downward Pressure on Rates: While the typical insurer will have to charge premiums in line with its expenses and the overall marketplace, a non-profit insurer has a responsibility to offer an affordable option *as a public service* and to use excess reserves to exert a downward pressure on rates on its for-profit competitors. To this point, Blue Shield often cites its “2% pledge” to limit its revenues to 2 percent and provide refunds accordingly. Yet Blue Shield’s premiums are usually on par or above its for-profit rivals, and were deemed by state regulators to be “unreasonable” by a three-fold margin.^{vii} While consumers always appreciate a check in the mail, consumer advocates note (as with the Medical Loss Ratio refunds), it is better for the market if consumers get the price break at the beginning rather than a rebate on the back end. It is unclear how the “2% pledge” lines up with the Consumers Union’s critique of Blue Shield’s excess reserves, or of state regulators’ determination that rates are unreasonable.

Blue Shield Foundation: While we are most interested in an insurer’s practices in the marketplace rather than in its philanthropy, Blue Shield cites the work of its Foundation as evidence of its nonprofit credibility. The Blue Shield of California Foundation *has certainly* supported important work on domestic violence and safety-net issues. For-profit insurers have also established their own philanthropic departments and foundations, though often as extensions of brand, marketing, and efforts to build goodwill in the community. It is unclear whether Blue Shield’s initiatives are on a scale or scope commensurate with its nonprofit obligations.

Governance: At the end of the day, the most significant difference in non-profit mission and direction might be the governance structure of the insurer: rather than answer to a board of directors made up of shareholders looking to increase value, revenues and dividends, a non-profit

health plan should be accountable to a board of community leaders and individual patients, elected or otherwise. We ask if Blue Shield's board of less than a dozen people provides sufficient accountability to meet its mission. Any board will have fiduciary responsibility to keep the insurer sustainable, but the board should also balance those needs with its public service goals.

Continuing the Conversation

Health Access welcomes further discussion on these issues and will look forward to incorporating input from coalition allies and community stakeholders into a future version of this paper. Please send comments on what should be the activities and governance of a health plan with a public service mission to Judi Hilman at jhilman@health-access.org.

We would appreciate feedback on any of the following questions:

- What would a health insurer with a public service mission look like?
- If Blue Shield of California embraces any or all of these roles, would that be a better benefit to the health of Californians than redirecting the value of Blue Shield's assets more directly toward these goals?
- What are the possible impacts on the health care market overall? What are the implications for other nonprofit health insurers, and other health institutions in general? And how can this discussion advance California toward an improved health system and a healthier state?

This paper was written by Anthony Wright (awright@health-access.org) and Judi Hilman (jhilman@health-access.org), with assistance from Tam Ma (tma@health-access.org) of Health Access Foundation, the statewide health care consumer advocacy coalition. As a point of information, Health Access does not receive, nor would we accept, funding from Blue Shield of California or Blue Shield of California Foundation. Our Sacramento office address is 1127 11th Street, Suite 234, Sacramento, CA 95814.

ⁱ Chad Terhune, "With Billions in the Bank, Blue Shield of California Loses Its Tax-Exempt Status," Los Angeles Times, March 18, 2015. Retrieved at <http://www.latimes.com/business/la-fi-blue-shield-california-20150318-story.html#page=1>.

ⁱⁱ Consumers Union, Health Access, Western Center on Law and Poverty, and CALPIRG, "Letter to DMHC Re-Blue Shield of California Proposed Acquisition of Care 1st," April 9, 2015.

ⁱⁱⁱ Thomas Greaney and Kathleen Boozang, "Mission, Margin, and Trust in the Nonprofit Health Care Enterprise," Yale Journal of Health Policy, Law, and Ethics, February 25, 2013. Retrieved from <http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1098&context=vjhple>.

^{iv} California Health and Safety Code, Article 11. <http://www.leginfo.ca.gov/cgi-bin/displaycode?section=hsc&group=01001-02000&file=1399.70-1399.76>

^v Jenny Gold, "Blue Shield of California Loses Exemption From State Taxes," NPR and Kaiser Health News, March 18, 2015. Retrieved from <http://www.npr.org/sections/health-shots/2015/03/18/393909850/blue-shield-of-california-loses-its-exemption-from-state-taxes>.

^{vi} Consumers Union, "How Much Is Too Much: Have Nonprofit Blue Cross Blue Shield Plan Amassed Excessive Amounts of Surplus?" July 2010. Retrieved from http://consumersunion.org/pdf/prescriptionforchange.org-surplus_report.pdf.

^{vii} Chad Terhune, "Blue Shield of California is under new pressure to lower rates" Los Angeles Times March 27, 2015 <http://www.latimes.com/business/la-fi-blue-shield-rates-20150328-story.html>



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Executive Director

Organizations listed for
identification purposes

June 12, 2015

Shelley Rouillard
Director, Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, California 95814-2725
Via e-mail to: publiccomments@dmhc.ca.gov

RE: Acquisition of Care1st Health Plan by Blue Shield of California

Dear Ms. Rouillard:

Health Access California, the state health care consumer advocacy coalition, offers the following comments on the proposed acquisition of the Care1st Health Plan by Blue Shield of California. This letter supplements comments we previously submitted in a joint-letter with other consumer advocacy organizations.¹

Health Access urges you, as the Director of the Department of Managed Health Care (DMHC), to use your authority to deny the Applications for Material Modification submitted by Blue Shield and Care1st unless Blue Shield commits substantial resources to increasing access to health care and improving the quality of health coverage provided to its current and future enrollees, particularly Care1st's 500,000 patients. As detailed herein, both Blue Shield and Care1st have had significant problems providing quality care to its respective enrollees, and these issues must be addressed if this transaction is approved. Additionally, Blue Shield has proceeded with rate increases that both your department and the other regulator found to be unreasonable: it should not be permitted to do so if this transaction is approved.

It is imperative that DMHC requires Blue Shield to agree to address consumer concerns, irrespective of the conclusions the Department makes regarding whether Blue Shield's assets are subject to charitable trust obligations. California should not let Blue Shield get bigger without getting better.

DMHC has Jurisdiction to Review and Approve Transaction

Section 1399.75(b) of the Health and Safety Code gives the Department of Managed Health Care (DMHC) jurisdiction over this proposed transaction regardless of whether Blue Shield has held or currently holds assets subject to a charitable trust obligation.²

Health Access urges DMHC to rigorously protect the public's interest in Blue Shield's charitable trust assets. Our contention that Blue Shield has held and currently holds assets subject to a charitable trust obligation is detailed in the aforementioned joint letter, as well as in comments submitted by Consumers Union.

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Blue Shield's Bid to Purchase Care1st is a Restructure Within the Meaning of Section 1399.71.

In its application for material modification³, Blue Shield erroneously claims that its proposal to acquire Care1st and the associated structure of the transaction is not a "restructure" subject to Section 1399.71. The statute defines a nonprofit health care service plan restructuring as "the sale, lease, conveyance, exchange, transfer, or other similar disposition of a substantial amount of a nonprofit health care service plan's assets, as determined by the director, to a business or entity carried on for profit."⁴ First, Blue Shield is using a substantial amount of its assets for this transaction by dedicating one-quarter of its over \$4 billion in tangible net equity (TNE), or over ten percent of its estimated \$10 billion in assets, to acquire Care1st. Second, the substantial assets are being used to acquire a for-profit entity whose directors and shareholders would profit from the transaction. As a result, this transaction falls under the meaning of a "restructure" as defined by Section 1399.71(d)(1).

The material modifications requested should not be approved unless this transaction is reviewed and considered as a restructuring of a nonprofit health care service plan.

Blue Shield's Restructure Is Not Exempted Under Section 1399(e)(2).

In order to avoid being deemed a restructuring as defined by Section 1399.71(d)(1), Blue Shield must demonstrate that its acquisition meets the conditions set forth in Section 1399.71(e)(2) of the Health and Safety Code, which provides that a "restructuring" does not include "sales or purchases of plan assets, including interests in wholly owned subsidiaries" if all of the following conditions occur:

- (A) Any profit from the sale will not inure to the benefit of any individual.
- (B) The sale or purchase is fundamentally consistent with and advances the public benefit, charitable, or mutual benefit purposes of the plan.
- (C) The plan receives all proceeds from the sale.
- (D) No officer or director of the plan has any financial interest constituting a conflict of interest in the sale or purchase.
- (E) The transaction is conducted at arm's length and for fair market value.
- (F) The sale or purchase does not adversely impact the plan's ability to fulfill its public benefit, charitable, or mutual benefit purposes.⁵

Blue Shield recently amended its filings with DMHC to assert that Cumulus, the holding company that would acquire and manage Care1st, is a wholly-owned subsidiary of Blue Shield. Blue Shield has not demonstrated that its acquisition of Care1st meets all of the aforementioned conditions. We believe the following conditions deserve heightened scrutiny.

- 1. Any profit from the sale should not inure to the benefit of any individual; No officer or director of the plan has any financial interest constituting a conflict of interest in the sale or purchase.**

Section 1399.71(e)(2) calls for heightened scrutiny of private inurement and conflicts of interest. The statute requires a demonstration that "any profit from the investment will not inure to the benefit of *any individual* (emphasis added). This qualification includes the

leadership of both Blue Shield and Care1st, including members of their respective board of directors as well as senior leadership. Blue Shield claims there will be no potential for private inurement simply because Blue Shield and Cumulus will both be constituted as nonprofit mutual benefit corporations with a common public mission. Blue Shield has the burden of demonstrating that none of its directors or staff working on the transaction are shareholders of Care1st and that there are no bonuses, salaries, or severance packages for Blue Shield employees as a result of the transaction. Blue Shield has stated that it intends to retain all of Care1st's leadership after the acquisition. While the leadership of Care1st is plainly pleased to have offered their "baby" to Blue Shield, any additional compensation should be limited to that psychic income and not monetary compensation. DMHC should ensure that Care1st employees, including senior leadership, do not receive excess compensation as a result of this transaction and in future employment arrangements with Blue Shield. Otherwise, this transaction will result in private inurement to individuals.

2. The sale or purchase should be found to be consistent with and advance the public benefit, charitable, or mutual purposes of the plan. The sale or purchase should not adversely impact the plan's ability to fulfill its public benefit, charitable, or mutual benefit purposes.

The questions of whether the acquisition of Care1st is fundamentally consistent with and advances Blue Shield's purpose and whether Blue Shield will be able to fulfill its public benefit, charitable, or mutual benefit purposes are interrelated and inextricably linked to its track record. This obligation stands whether or not the Department finds that Blue Shield has a charitable trust obligation: Section 1399(e)(2) plainly encompasses "mutual benefit purposes" as well as "public benefit" or "charitable" purposes.

DMHC should not approve this transaction unless Blue Shield can meet its existing commitments to its current enrollees. Should this transaction be approved, is Blue Shield equipped to serve Care1st's 500,000 consumers, in addition to any planned growth in the Medi-Cal market? Blue Shield is required by law to provide its 3.5 million enrollees with care that meets the standards set forth by the Knox-Keene Act and other relevant law. DMHC's medical surveys, targeted surveys, and enforcement actions raise serious concerns about Blue Shield's failure to meet its existing obligations to enrollees and its ability to serve additional enrollees.

Routine Medical Survey (2013): In its most recent routine medical survey of Blue Shield, DMHC found the plan to have three major deficiencies out of the eight areas assessed.⁶ They include deficiencies in quality management (assess and improve the quality of care provided to enrollees); grievances and appeals (resolve all grievances and appeals in a professional, fair, and expeditious manner); and utilization management (manage the utilization of services through a variety of cost containment mechanisms while ensuring access and quality care.) Of these three deficiencies, only one (grievances) was corrected at the time the survey was released to the public. Blue Shield should be allowed to proceed with this transaction only after a demonstration that it has remedied existing deficiencies in its obligations to its current members.

Non-Routine Survey of Provider Directories – Network Adequacy (2014): DMHC conducted a survey of Blue Shield's provider directory in response to numerous

complaints from consumers who were having difficulty finding in-network physicians. The Department found that a significant percentage (18.2%) of the physicians listed in Blue Shield's provider directory were not at the location listed and that a significant percentage (8.8%) were not willing to accept members enrolled in the Blue Shield's Covered California products, despite being listed on the website as doing so. As a result, an unacceptably high number of consumers could not reach and/or did not have access to providers who were represented as being part of the Blue Shield's network.⁷ Blue Shield's obligation to provide an adequate network and accurate information about that network dates back to the enactment of the Knox-Keene Act in 1975: this is not a new or novel obligation yet Blue Shield was unable to fulfill it. Numerous consumer complaints about network adequacy led Covered California, a major purchaser of coverage, to require Blue Shield to alter its networks, particularly in the San Francisco Bay Area. Given Blue Shield's difficulty in providing satisfactory access to Covered California enrollees, will it be able to provide satisfactory access to Medi-Cal enrollees, a population with which it has no experience? Blue Shield's acquisition of Care1st should not be approved unless Blue Shield can show improvement in its network adequacy and ensuring timely access to care.

Enforcement actions: Since 2000, Blue Shield has been subject over 275 enforcement actions from DMHC. The Kaiser Foundation Health Plan, which has almost three times the number of enrollees as Blue Shield, has had the same number of enforcement actions during the same time period. Significant enforcement actions include:

- \$35,000 fine for failure to resolve grievances relating to request for residential care services for an enrollee with mental health diagnoses (November 2014).⁸
- \$400,000 fine for failure to comply with the Knox-Keene Act governing claims payment, provider disputes, and unfair payment patterns (November 2010).⁹
- \$300,000 fine for failure to maintain a 95% compliance rate with regards to claims processing and engaging in an "unfair payment pattern" (October 2010).¹⁰
- \$1.25 million fine for deficiencies in its Health Care Service Plan Quality Assurance Program (December 2008).¹¹

Unreasonable rate increases: State regulators, both DMHC and California Department of Insurance (CDI), have found Blue Shield's rate increases to be unreasonable since the inception of a rate review program established by SB 1163 (Leno), Chap. 661, Statutes of 2010. By proceeding with rate increases in spite of regulators' findings, California consumers in the individual and small group market have spent tens of millions of dollars more than necessary for coverage from Blue Shield.

- In March 2013, DMHC declared Blue Shield's 11.8 percent health plan premium increase to be unreasonable, impacting 27,000 consumers. At the same time, other health plans reduced their rate increases in response to DMHC's rate review process. Blue Shield was unwilling to bring its proposed rate increase down to a reasonable level.¹²
- In 2012, DMHC negotiated a lower rate increase with Blue Shield, which had initially proposed a 14.8 percent average rate increase for 55,000. Blue Shield agreed to lower its increase to 8.9 percent.¹³
- In January 2014, Insurance Commissioner Dave Jones found that Blue Shield's 10 percent average increase for the 81,000 policyholders with policies regulated by

CDI, to be unreasonable and that a 4 percent increase would have been appropriate. As a result, consumers paid \$10 million more for insurance than that year because Blue Shield proceeded with the 10 percent rate increase.¹⁴

- In March 2013, CDI found Blue Shield's 11.7 percent average rate increase to be unreasonable. Blue Shield proceeded with the unreasonable increase, which impacted approximately 268,000 individual enrollees, costing them an estimated \$16.5 million more than the prior year.¹⁵

Blue Shield has pursued these rate increases in spite of its \$4.2 billion in excess reserves. Blue Shield is now spending these reserves on a major purchase rather than lowering excessive premiums for individuals and small businesses. In addition, there is no transparency of excessive premiums for larger purchasers so it is not possible to know whether they too face such excessive rate increases from Blue Shield. Blue Shield should not be allowed to complete this transaction and spend its reserves on entering a new market unless it commits not to proceed with rates deemed unreasonable by DMHC.

Complaint Data: The rate at which HMO members contact DMHC with information inquiries and complaints is one measure of how well a plan meets their members' needs and solve problems when they occur. DMHC should review its complaint data on Blue Shield on a per 1,000 enrollee basis compared to other health plans to assess Blue Shield's performance in this area. Complaints about Care 1st should also be reviewed. If Blue Shield's per 1,000 complaints are significantly higher than most health plans, should Blue Shield be required to reduce the problems that lead to consumer complaints before taking on a major acquisition? As a condition of the approval of this deal, Blue Shield should work to remove the sources of consumer complaints to reduce these complaints.

The deficiencies found in Blue Shield's routine medical survey, its significant challenges meeting network adequacy requirements, extensive history of enforcement actions, and repeated practice of pursuing unreasonable rate increases pose significant concerns about the quality and affordability of services provided to its existing enrollees. If Blue Shield is unable to provide quality, affordable care to its existing enrollees, should it first improve its performance for its current members before embarking on a major acquisition?

Lack of Experience with Medi-Cal.

Blue Shield has never participated in the state's Medicaid (Medi-Cal) program, in spite of several relevant facts: (1) Blue Shield is the third largest managed care plan in California; (2) Three-quarters of California's 12 million Medi-Cal beneficiaries are enrolled in managed care plans; and (3) Blue Shield was organized nearly eight decades ago to "meet the needs of persons in the lower income groups for medical care and surgical service."¹⁶ As consumer advocates, Health Access supports having insurers who can provide quality, affordable health care that is responsive to the unique needs of the diverse, low-income Californians who rely on Medi-Cal for their health care. Because Blue Shield has no experience serving this population, DMHC should examine Blue Shield's capacity for providing quality services to beneficiaries and request Blue Shield to submit detailed plans and strategies for serving these consumers. Relevant questions include how Blue Shield will provide language access and culturally

competent care, adequate networks with sufficient primary care and specialist providers equipped to treat conditions common to the Medi-Cal population in a timely manner, and plans to improve quality and customer satisfaction.

We appreciate Blue Shield's desire to finally enter the Medicaid market and serve a low-income population. Blue Shield's entry into the Medi-Cal market through purchase of another entity does not, however, expand the number of plans participating in Medi-Cal managed care: it simply substitutes a plan with no experience in Medi-Cal managed care and an above average record of complaints in the commercial market, for another plan with long history in the Medi-Cal managed care business.

Blue Shield may be buying Care 1st's networks and its expertise in Medi-Cal but does Blue Shield understand the needs of the Medi-Cal population, a lower income population with greater diversity, than Blue Shield has typically served? Acquisitions throughout the corporate world are often problematic when the company taking over another enterprise lacks sufficient institutional understanding of the market served by the acquired company. These issues are the basis of business school case studies. These concerns are significant in this instance because Medi-Cal managed care enrollees are lower income, more diverse, and have greater health care needs because of the social determinants of health¹⁷. Someone who lives in Boyle Heights faces a different reality in terms of social supports and resources than someone who goes home to Beverly Hills: these facts matter when it comes to accountable care organizations, readmission penalties and any number of other attempts to meet the "triple aim."

Attempting to meet the triple aim of lower costs, better health and better health care without taking into account the social determinants of health worsens health equity, punishing health care providers who care for those most in need and rewarding those who care for the healthier and more affluent. These inequities are of concern when a corporate entity without deep experience in care for the Medi-Cal population enters the Medi-Cal market through an acquisition. Can Blue Shield, which lacks experience serving the Medi-Cal population, understand the needs of that population when it is not fully meeting the needs of its current members in the commercial market?

How will Blue Shield Address Care1st's Problems, Particularly Its Low Quality and Patient Satisfaction Ratings?

In addition to scrutinizing Blue Shield's capacity to serve Medi-Cal patients, DMHC should also consider what plans, if any, Blue Shield has to improve Care1st. Care1st has received low quality ratings from the 500,000 patients enrolled in its plan, and has been subject to serious enforcement actions in recent years.

Low Quality Ratings

Care1st's health plans in both Los Angeles and San Diego have received less than average ratings by the National Committee for Quality Assurance.

- In a national ranking of Medicaid health plans, Care1st's L.A. County plan ranked 107th out of 136 plans rated. Its San Diego County plan was ranked No. 102.
- In both regions, Care1st received a 1 out of 5, the lowest score possible, on consumer satisfaction.

- Among 10 Medicaid plans rated in California, Care1st's L.A. County plan ranked sixth and its San Diego County plan was fourth.¹⁸

Enforcement Actions

Care1st has also been subject to DMHC enforcement actions, including the following recent and significant fines:

- \$9,000 fine for failure to adequately and timely communicate with a patient regarding the plan's decisions relating to an urgent request for authorization for treatment of terminal stage 4 colon cancer. (June 2014)¹⁹
- \$75,000 fine for failure to provide continuity of care, delay in processing request for medical procedures, and failure to maintain an adequate grievance system in relation to a special-needs patient's prostate cancer diagnosis. (May 2014)²⁰
- \$120,000 fine for outsourcing a significant portion of its claims processing overseas to China without first obtaining approval from the Department. (March 2013)²¹
- \$50,000 fine for failure to correctly and accurately pay claims within time period required by law. (December 2012)²²

We know how this deal benefits Blue Shield and Care1st—they should have to show how it actually pro-actively benefits Care1st patients, especially given these issues. The transaction documents claim that the management and networks for Care1st will be the same, but cite no improvements. This deal should not be approved unless Blue Shield agrees to specific benchmarks in improving the access to care and customer service for Care1st's 500,000 patients.

Summary: Blue Shield's Acquisition of Care1st Raises Concerns for Consumers.

Blue Shield's troubling track record and its inexperience serving Medi-Cal patients, coupled with Care1st's lackluster quality ratings and low customer satisfaction, raises questions about whether this transaction is in the best interest of consumers. As DMHC reviews this transaction, it should consider the following questions:

- Should Blue Shield be permitted to increase its enrollment by 15 percent and enter an entirely new segment of the health care market if it faces significant challenges providing an adequate provider network for its existing 3.5 million enrollees, among other problems?
- How will Blue Shield adequately serve the unique needs of Medi-Cal beneficiaries, and does it have the capacity to manage the care of Care1st enrollees according to complicated rules and procedures of the Medi-Cal program?
- Acquisition of Care1st allows Blue Shield to serve Medi-Cal beneficiaries who are already enrolled in Care1st. Is Blue Shield committed to covering additional Medi-Cal enrollees, and how does it plan to do this?
- What impact will the proposed transaction have on the state's or a region's health care delivery system for both Medi-Cal and commercial enrollees?
- What elements protecting the delivery of care to enrollees need to be included in the transaction? What mechanisms are necessary to ensure that promises are kept over time?

Enforceable Commitments Needed to Ensure Consumer Protection.

If Blue Shield's acquisition of Care1st is to be approved, it must include clear and enforceable conditions to ensure that Blue Shield's existing enrollees, and the Medi-Cal enrollees it will assume, are able to access the quality care they are entitled to under the Knox-Keene Act. These conditions must be in place irrespective of whether Blue Shield's assets are found to be subject to charitable trust obligations. DMHC must require Blue Shield to:

- Meet its existing commitments to current enrollees by remedying deficiencies found in DMHC surveys and enforcement actions, including providing adequate networks and timely access to care;
- Commit to not pursuing unreasonable rate increases;
- Work to reduce sources of complaints from enrollees; and
- Undertake efforts to improve its quality of care ratings as reported in the Office of the Patient Advocate's health care quality report cards.

In addition, Blue Shield must pledge to take the responsibility of providing quality care to Medi-Cal enrollees seriously. DMHC should require Blue Shield to:

- Demonstrate how it will serve the unique needs of the diverse Medi-Cal population;
- Show how it will improve upon issues leading to Care1st's low quality ratings;
- Agree to benchmarks in improving access to care and customer service;
- Commit to investing sufficient resources to achieving these goals for Medi-Cal, and reinvest profits earned from its Medi-Cal product line in Medi-Cal, instead of using them for other parts of the Blue Shield company.

Finally, Blue Shield should embrace its public mission as a non-profit insurer by committing to the following actions:

- Maintain a healthy, but not excessive, level of reserves;
- Continue to be an active participant in public health care programs such as Covered California and Medi-Cal;
- Invest 5 percent of its current investment portfolio to improve access to care in rural and underserved communities for 25 years;
- Contribute funds to its Blue Shield Foundation at a rate commensurate with the rate of its revenue growth;
- Support efforts to provide comprehensive health coverage for the remaining uninsured, including the undocumented;
- Provide full transparency for the pricing of premiums, executive compensation, and costs associated with acquiring Care1st.

Incidentally, these commitments should be expected of any insurer licensed by DMHC, regardless of whether they are for-profit or not-for-profit. The aforementioned conditions must be reinforced for a non-profit insurer proposing to expand its business using substantial assets that were acquired through its tax-exempt status and from premium dollars paid by consumers. Finally, in the post-Affordable Care Act world, non-profit insurers with a public service mission are expected to help fulfill unmet health needs, offer affordable options for coverage, and conduct their business with transparency.²³

Shelley Rouillard
Page 9
June 12, 2015

We appreciate the focus of DMHC's June 8, 2015 public meeting on "DMHC's jurisdiction and authority to oversee the transaction." As DMHC reviews this transaction, we request the department to hold additional public meetings that focus on relevant questions and details of this transaction, including the ones raised in this letter.

Please contact Tam Ma, Health Access' Policy Counsel, at tma@health-access.org or (916) 835-5177 if we can be of assistance in this process. Thank you for giving these issues your highest level of scrutiny and for protecting the interests of consumers in this process.

Sincerely,



Anthony Wright
Executive Director

cc: Secretary Diana Dooley, California Health and Human Services Agency
Senator Ed Hernandez, Chair, Senate Health Committee
Assemblyman Rob Bonta, Chair, Assembly Health Committee

¹ CalPIRG, Consumers Union, The Greenlining Institute, Health Access, and Western Center on Law and Poverty letter to Director Shelley Rouillard, May 29, 2015.

² Health and Safety Code Section 1399.75(b).

³ Exhibit E-1, DMHC File Number 933-0043, Notice of Material Modification to License Application, January 30, 2015.

⁴ Health and Safety Code Section 1399.71(d)(1).

⁵ See Health and Safety Code Section 1399.71(e)(1) and (e)(2).

⁶ DMHC: Routine Medical Survey of Blue Shield of California, Publicly Filed September 5, 2013, available at: <http://dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/043fs090513.pdf> (Accessed June 7, 2015).

⁷ DMHC: *Non-Routine Survey of Blue Shield of California*, Publicly Filed November 18, 2014, available at: <http://dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/043fsnr111814.pdf> (Accessed June 7, 2015).

⁸ DMHC: *Letter of Agreement, Enforcement Matter #13-115*. Available at: <http://wpsso.dmhc.ca.gov/enfactions/docs/2198/1416943613413.pdf> (Accessed June 7, 2015).

⁹ DMHC: *Letter of Agreement, Enforcement Matter #18-582*. Available at: <http://wpsso.dmhc.ca.gov/enfactions/docs/1306/1291835391635.pdf> (accessed June 7, 2015).

¹⁰ DMHC: *Letter of Agreement, Enforcement Matter #08-515*. Available at: <http://wpsso.dmhc.ca.gov/enfactions/docs/1286/1288126313940.pdf> (accessed June 7, 2015).

¹¹ DMHC: *Letter of Agreement, Enforcement Matter #06-179*. Available at: <http://wpsso.dmhc.ca.gov/enfactions/docs/811/1231196357700.pdf> (accessed June 7, 2015).

¹² Department of Managed Health Care: *Department of Managed Health Care Declares Health Plan Rate Increases by Blue Shield and Aetna Unreasonable*. Available at: <https://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/NewsRoom/PressReleases/2013/prrates030613.pdf> (accessed June 7, 2015).

¹³ DMHC: *Unreasonable Rate Filings Quarterly Report (July 31, 2012)*. Available at: <http://dmhc.ca.gov/Portals/0/DataAndResearch/Legislative/LegislativeReports/urfrQ22012.pdf> (accessed June 7, 2015).

¹⁴ Los Angeles Times: *Blue Shield of California rate hike is excessive, regulator says* (January 7, 2014). Available at: <http://articles.latimes.com/2014/jan/07/business/la-fi-mo-blue-shield-rates-20140107> (accessed June 7, 2015).

¹⁵ California Department of Insurance: *Department of Insurance Determines Blue Shield Rate Increase Is Unreasonable*. Available at: <http://www.insurance.ca.gov/0400-news/0100-press-releases/2013/release025-13.cfm> (accessed June 7, 2015).

¹⁶ California Physicians' Service v. Garrison, 28 Cal.2d 790 (1946).

¹⁷ National Quality Forum on social determinants of health.

¹⁸ Los Angeles Times: *Blue Shield moves into Medicaid with Care1st deal* (December 8, 2014). Available at: <http://www.latimes.com/business/la-fi-blue-shield-deal-20141209-story.html> (Accessed June 7, 2015).

¹⁹ DMHC: *Letter of Agreement, Enforcement Matter #11-407* (June 6, 2014). Available at: <http://wpsso.dmhc.ca.gov/enfactions/docs/2144/1405634879231.pdf> (Accessed June 7, 2015).

²⁰ DMHC: *Letter of Agreement, Enforcement Matter #12-032* (May 19, 2014). Available at: <http://wpsso.dmhc.ca.gov/enfactions/docs/2116/1401321115685.pdf> (Accessed June 7, 2015).

²¹ DMHC: *Letter of Agreement, Enforcement Matter #11-060* (March 4, 2013). Available at: <http://wpsso.dmhc.ca.gov/enfactions/docs/1952/1363812790697.pdf> (Accessed June 7, 2015).

²² DMHC: *Letter of Agreement, Enforcement Matter #11-265* (November 28, 2012). Available at: <http://wpsso.dmhc.ca.gov/enfactions/docs/1929/1362079700126.pdf> (Accessed June 7, 2015).

²³ See Health Access' Issue Brief entitled, *What is the Role of a Nonprofit Insurer? Should the Affordable Care Act Change the Expectations of Insurers with a Public Service Mission?* (Discussion Draft, June 5, 2015). Available at: http://www.health-access.org/images/pdfs/health_access_brief_nonprofit_insurer_blueshield_6-5-15.pdf.



Blue Shield of California's proposed acquisition of Care1st, a for-profit Medi-Cal/Medicare company, and Blue Shield's loss of state tax-exempt status together present critical issues with far reaching implications for health care coverage and delivery in California. The Department of Managed Health Care (DMHC) is currently reviewing the proposed acquisition. We, the undersigned organizations, urge DMHC to ensure that the public's long held assets are preserved and, should the acquisition be approved, strong consumer protections included to ensure that the transaction is in the best interest of California consumers. In this vein, we urge DMHC to:

- **Find that Blue Shield of California, like virtually all nonprofit health care service plans, holds assets subject to a charitable trust;**
- **Encourage Blue Shield to disclose to DMHC and the public the facts before the Franchise Tax Board (FTB) and the findings of the FTB regarding revocation of Blue Shield's tax-exempt status;**
- **Guard against private inurement in the proposed transaction that may benefit either Blue Shield or Care 1st's officers, trustees, board members, or staff;**
- **Review the proposed transaction under CA Health & Safety Code §1399.71, rigorously evaluate Blue Shield's current public benefit obligations, and require strong public benefit commitments from the plan and its subsidiaries/affiliates moving forward;**

- **Impress public benefit obligations on Blue Shield to ensure that it maintains healthy but not excessive reserves, and performs other activities that benefit the needs of lower-income and vulnerable consumers;**
- **Carefully evaluate the price offered in the transaction to ensure that Blue Shield is not overpaying for Care 1st, especially given the non-monetary, intangible benefits that Care 1st will obtain by joining with Blue Shield (including the brand);**
- **Ensure that Blue Shield has the skills, expertise, and community engagement needed to serve a low-income, diverse population, including being an active and effective participant in Healthy San Diego;**
- **Require Blue Shield to contribute resources to its Blue Shield Foundation at a rate at least commensurate with the rate of its revenue growth;**
- **Require heightened monitoring of Blue Shield's management of Medi-Cal enrollees, should DMHC approve the transaction, and take any needed corrective action;**
- **Impose enforceable conditions on Blue Shield to ensure it fulfills its commitment and responsibilities to its commercial enrollees, including remedying deficiencies and providing adequate networks.**
- **Should this transaction be approved, Blue Shield must be required to lower the incidence of and basis for consumer complaints in all lines of its business, and implement improvements in quality of and access to care, patient satisfaction, and cost control; and**
- **Require Blue Shield to commit to not move forward with rate increases the Departments deem to be unreasonable.**

Please contact Betsy Imholz, Consumers Union (bimholz@consumer.org) or Tam Ma, Health Access (TMa@health-access.org) with any questions.

Thank you.

Sincerely,

Asian Americans Advancing Justice
 Asian Law Alliance
 California Black Health Network
 California Pan-Ethnic Health Network
 Cal PIRG
 Community Health Councils
 Consumers Union
 Greenlining Institute
 Health Access
 Maternal and Child Health Access
 National Health Law Program
 National Immigration Law Center
 Western Center on Law and Poverty



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Paul Knepprath
Planned Parenthood Affiliates of CA

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Joshua Pechthalt
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Cary Sanders
CA Pan-Ethnic Health Network

Rev. Rick Schlosser
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Reshma Shamasunder
CA Immigrant Policy Center

Joan Pirkle Smith
Americans for Democratic Action

Horace Williams
CA Black Health Network

Sonya Young
CA Black Women's Health Project

Jon Youngdahl
SEIU State Council

An'hony Wright
Executive Director

Organizations listed for
identification purposes

November 6, 2015

Shelley Rouillard
Director, Department of Managed Healthcare
980 Ninth Street, Suite 900
Sacramento, CA 95814-2725

RE: Blue Shield Acquisition of Care1st

Dear Ms. Rouillard:

On behalf of Health Access California, the statewide health care consumer advocacy coalition, I write to respectfully request that the Department of Managed Health Care (DMHC) clarify an issue that has arisen relating to Blue Shield's acquisition of Care1st.

On October 8, 2015, the DMHC publicly announced the approval of the acquisition. As a condition of approval, the DMHC negotiated undertakings to ensure that the deal was in the public interest. The DMHC press release announcing the approval heralded \$200 million in commitments by Blue Shield to increase transparency and accessibility in health care—which included \$140 million to the Blue Shield Foundation, \$14 million per year for ten years.

During a telephone briefing with consumer advocates on the day the approval was announced, my first question to you was to clarify if the \$14 million commitment supplements what Blue Shield currently contributes to its Foundation, or if it is intended to simply set a floor for those contributions. You clearly responded that the \$14 million commitment was in addition to the amount Blue Shield already contributes to the Foundation, which varies from year to year based on a pre-existing formula.

I have recently heard from partners, and now directly from Blue Shield executives themselves, that Blue Shield is now asserting that the undertaking only requires the insurer to contribute a minimum of \$14 million per year to the Foundation—which is significantly less than what they normally have contributed. In recent years, Blue Shield has provided \$30 to \$40 million per year to its Foundation, which has in turn funded efforts to increase access to health care and support survivors of domestic violence.

We find it stunning and disheartening that Blue Shield is backtracking on one of the key conditions of the acquisition, just weeks after the deal was approved by the DMHC. Blue Shield's interpretation would mean that the company is being required to invest less than half of what it currently does, an absurd result that we

Capitol Headquarters: 1127 11th Street, Suite 243, Sacramento, CA 95814 PH: 916.497.0923 FAX: 916.497.0921

Northern California: 1330 Broadway, Suite 811, Oakland, CA 94612 PH: 510.873.8787 FAX: 510.873.8789

Southern California: 121 West Lexington Drive, Suite 246, Glendale, CA 91203 PH: 818.480.3262 FAX: 818.480.6595

www.health-access.org

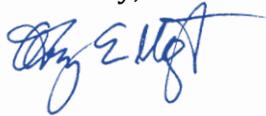
Shelley Rouillard
Page 2
November 6, 2015

do not believe the DMHC intended when it approved the \$1.2B acquisition. Blue Shield's bad faith on this issue raises concerns about their intended compliance on the other conditions and undertakings.

On behalf of California's health care consumers, we respectfully request that the DMHC resolve this issue by writing to Blue Shield to clarify the commitment required by the undertaking. We hope a pro-active declaration by the DMHC will ensure that the letter and spirit of the undertaking is met without corrective actions being necessary, that these commitments are upheld, and that California consumers benefit as a result.

Thank you for your prompt consideration. Please contact me with any questions.

Sincerely,



Anthony Wright
Executive Director

Cc: The Honorable Senator Ed Hernandez, Chair, Senate Health Committee
The Honorable Assemblyman Rob Bonta, Chair, Assembly Health Committee
Secretary Diana Dooley, California Health and Human Services Agency
Gabriel Ravel, General Counsel, Department of Managed Health Care

Blue Shield Acquisition of Care1st

Beth Capell					
Date	Work Performed	Time Spent	Deliverable	Hourly Rate	Total
3/24/2015	Consumer advocate call on Blue Shield-Care 1st.	1		\$420	\$420
4/30/2015	Consumer advocate call on Blue Shield-Care 1st acquisition.	1	Testimony @ DMHC public meeting; Comment letter submitted 6/12/15	\$420	\$420
5/19/2015	Consumer advocate call to prep for DMHC public meeting.	1	DMHC public meeting 6/8/15	\$420	\$420
5/27/2015	Emails with consumer advocates coordinating joint letter.	0.5	Joint comment letter submitted 5/29/15	\$420	\$210
5/26/2015	Review and edit joint-letter from Consumers Union, WCLP, Greenlining, and Health Access	1	Joint comment letter submitted 5/29/15	\$420	\$420
6/6/2015	Review Blue Shield/Care 1st filings	1	Health Access testimony @ DMHC public meeting; Comment letter submitted 6/12/15	\$420	\$420
6/7/2015	Review and edit Health Access comment letter.	1	Comment letter submitted 6/12/15	\$420	\$420
6/8/2015	Attend DMHC public meeting.	2.5	DMHC public meeting 6/8/15; testimony provided by Tam Ma and Anthony Wright	\$420	\$1,050
6/11/2015	Review and edit Health Access comment letter.	2	Comment letter submitted 6/12/15	\$420	\$840
6/12/2015	Edit Health Access comment letter.	1	Comment letter submitted 6/12/15	\$420	\$420
6/29/2015	Review and edit draft consumer advocate joint letter to DMHC	0.5	Comment letter submitted 7/16/15	\$420	\$210
10/8/2015	Review DMHC press release and undertakings	0.5		\$420	\$210
10/16/2015	Review full order approving acquisition	0.5		\$420	\$210
11/6/2015	Review and edit letter to DMHC re: undertakings	0.5	Letter to DMHC submitted 11/6/15	\$420	\$210
	TOTAL	14			\$5,880
Anthony Wright					
Date	Work Performed	Time Spent	Deliverable	Hourly Rate	Total
3/24/2015	Consumer Advocate call (1:30-2:30pm) on Blue Shield-Care 1st.	1		\$350	\$350
4/8/2015	Drafted & circulated joint consumer advocate letter on public hearings	1.5	Letter to DMHC requesting public hearing	\$350	\$525

Blue Shield Acquisition of Care1st

4/9/2015	Finalized and sent joint consumer advocates letter requesting public hearing on BlueShield-Care1st	1	Letter to DMHC requesting public hearing	\$350	\$350
4/29/2015	Review April 23 letter from DMHC and reviewed & approved HA response.	0.5	Letter to DMHC sent 4/29/15	\$350	\$175
4/30/2015	Consumer advocate call (3pm-4pm) on Blue Shield-Care 1st acquisition.	1	Testimony @ DMHC public meeting; Comment letter submitted 6/12/15	\$350	\$350
5/19/2015	Meet (12:30pm) with Blue Shield executive Tom Epstein on merger	1		\$350	\$350
5/19/2015	Consumer advocate call to prep for DMHC public meeting.	1	DMHC public meeting 6/8/15	\$350	\$350
5/23/2015	Outline paper on Blue Shield's nonprofit status	1	Paper on Blue Shield's nonprofit status	\$350	\$350
5/26/2015	Emails with advocates coordinating joint letter.	0.5	Joint comment letter submitted 5/29/15	\$350	\$175
5/26/2015	Draft Paper on Blue Shield's nonprofit status	2.5	Paper on Blue Shield's nonprofit status	\$350	\$875
5/26/2015	Review and edit joint-letter from Consumers Union, WCLP, Greenlining, and Health Access	0.5	Joint comment letter submitted 5/29/15	\$350	\$175
6/3/2015	Edit and finalize paper on Blue Shield's nonprofit status	1.5	Paper on Blue Shield's nonprofit status	\$350	\$525
6/5/2015	Copyedit and publish paper on Blue Shield's nonprofit status, and related expectations, one of the related issues of the merger.	0.5	Paper on Blue Shield's nonprofit status	\$350	\$175
6/7/2015	Review Blue Shield/Care 1st filings	1	Testimony @ DMHC public meeting; Comment letter submitted 6/12/15	\$350	\$350
6/7/2015	Review & edit Health Access comment letter: Research statutes; review enforcement actions against Blue Shield & Care1st	1.5	Comment letter submitted 6/12/15	\$350	\$525
6/8/2015	Advocates meeting to prep for public meeting	1	Testimony @ DMHC public meeting	\$350	\$350
6/8/2015	Attend DMHC public meeting and testify on behalf of Health Access.	2.5	Testimony @ DMHC public meeting	\$350	\$875
6/8/2015	Follow-up with reporters about DMHC public meeting	1		\$350	\$350
6/10/2015	Edit HA comment letter	0.5	Comment letter submitted 6/12/15	\$350	\$175
6/12/2015	Final edits on comment letter	2	Comment letter submitted 6/12/15	\$350	\$700
6/22/2015	Submit request for meeting with DMHC	0.5	7/1/15 meeting with DMHC	\$350	\$175
6/29/2015	Review and edit draft consumer advocate joint letter to DMHC	0.5	Comment letter submitted 7/16/15	\$350	\$175
6/30/2015	Received letter from DMHC re: PRA request.	0.5		\$350	\$175
7/1/2015	Prep for meeting with DMHC	0.5	7/1/15 meeting with DMHC	\$350	\$175
7/1/2015	Meet with DMHC re: Health Access concerns	1	7/1/15 meeting with DMHC	\$350	\$350

Blue Shield Acquisition of Care1st

7/1/2015	Email with CU re: circulating sign-on letter amongst consumer advocates	0.5	Joint comment letter submitted 7/16/15	\$350	\$175
7/12/2015	Brief and recruit other consumer groups to sign-on to letter	2	Joint comment letter submitted 7/16/15	\$350	\$700
7/31/2015	Received letter from DMHC re: production delay for 6/25/15	0.5		\$350	\$175
8/6/2015	Reviewed documents received from PRA request	1		\$350	\$350
8/21/2015	Received letter from DMHC declining to hold additional public meetings	0.5		\$350	\$175
10/8/2015	DMHC briefing for consumer advocates re: approval of acquisition	0.5	10/8/2015 phone meeting with DMHC	\$350	\$175
10/8/2015	Review DMHC press release and undertakings	0.5		\$350	\$175
10/16/2015	Review full order approving acquisition	0.5		\$350	\$175
10/29/2015	Phone calls/meetings with organizations confirming concerns re: undertakings	1.5	Letter to DMHC submitted 11/6/15	\$350	\$525
11/1/2015	Phone meeting with Blue Shield re: undertakings	0.5	Letter to DMHC submitted 11/6/15	\$350	\$175
11/3/2015	Phone meeting with DMHC re: undertakings	0.5	Letter to DMHC submitted 11/6/15	\$350	\$175
11/6/2015	Edit letter to DMHC re: undertakings	1	Letter to DMHC submitted 11/6/15	\$350	\$350
11/12/2015	Received and reviewed DMHC letter to Blue Shield	0.5		\$350	\$175
11/13/2015	Phone meeting with DMHC re: undertakings	0.5		\$350	\$175
	TOTAL	36.5			\$12,775
Tam Ma					
Date	Work Performed	Time Spent	Deliverable	Hourly Rate	Total
3/24/2015	Consumer Advocate call on Blue Shield-Care 1st.	1		\$250	\$250
4/8/2015	Reviewed and edited joint consumer letter	0.5	Letter to DMHC requesting public hearing sent 4/9/15	\$250	\$125
4/29/2015	Review April 23 letter from DMHC and drafted response.	0.25	Letter to DMHC sent 4/29/15	\$250	\$63
4/30/2015	Consumer advocate call on Blue Shield-Care 1st acquisition.	1	Testimony @ DMHC public meeting; Comment letter submitted 6/12/15	\$250	\$250
5/6/2015	Received letter from DMHC re: public meeting	0.25	DMHC public meeting 6/8/15	\$250	\$63
5/19/2015	Consumer advocate call to prep for DMHC public meeting.	1	DMHC public meeting 6/8/15	\$250	\$250
5/21/2015	Research; review court cases re: authority to enforce charitable trust obligations	1	Joint comment letter submitted 5/29/15	\$250	\$250

Blue Shield Acquisition of Care1st

5/27/2015	Emails with advocates coordinating joint letter.	0.5	Joint comment letter submitted 5/29/15	\$250	\$125
5/26/2015	Review and edit joint-letter from Consumers Union, WCLP, Greenlining, and Health Access	1.75	Joint comment letter submitted 5/29/15	\$250	\$438
5/29/2015	Received and reviewed agenda for public meeting	0.25		\$250	\$63
6/2/2015	Outline Health Access comment letter and research	1	Comment letter submitted 6/12/15	\$250	\$250
6/4/2015	Edit Role of a Nonprofit Insurer paper	2	Health Access Paper on Role of Nonprofit Insurer	\$250	\$500
6/5/2015	Review CU research on Blue Shield Foundation and WCLP research on Care1st.	1.5	Testimony @ DMHC public meeting; Comment letter submitted 6/12/15	\$250	\$375
6/6/2015	Review Blue Shield/Care 1st filings; Research statutes; Begin drafting Health Access Comment letter.	3	Testimony @ DMHC public meeting; Comment letter submitted 6/12/15	\$250	\$750
6/7/2015	Continue drafting Health Access comment letter: review enforcement actions and regulatory activity.	7	Comment letter submitted 6/12/15	\$250	\$1,750
6/7/2015	Prepare testimony for public meeting	1	Testimony @ DMHC public meeting	\$250	\$250
6/8/2015	Revise testimony for public meeting	0.5	Testimony @ DMHC public meeting	\$250	\$125
6/8/2015	Advocates meeting to prep for public meeting	1	Testimony @ DMHC public meeting	\$250	\$250
6/8/2015	Attend DMHC public meeting and testify on behalf of Health Access.	2.5	Testimony @ DMHC public meeting	\$250	\$625
6/10/2015	Additional research and drafting for comment letter: review DMHC routine and non-routine medical reviews; findings of unreasonable rate increases.	3	Comment letter submitted 6/12/15	\$250	\$750
6/11/2015	Revise comment letter; additional research on quality ratings, conditions of prior mergers.	2.5	Comment letter submitted 6/12/15	\$250	\$625
6/12/2015	Final edits on comment letter; format & prepare for submission	2	Comment letter submitted 6/12/15	\$250	\$500
6/22/2015	Received letter from DMHC requesting more time to consider request for additional public meetings	0.25		\$250	\$63
6/22/2015	Submit request for meeting with DMHC	0.25	7/1/15 meeting with DMHC	\$250	\$63
6/24/2015	Call with Consumers Union re: Blue Shield's amended filings	0.5		\$250	\$125
6/25/2015	Submit PRA request for filings submitted since last PRA request.	0.25		\$250	\$63
6/29/2015	Review and edit draft consumer advocate joint letter to DMHC	0.75	Comment letter submitted 7/16/15	\$250	\$188
6/30/2015	Additional edits to consumer advocate joint letter to DMHC	0.5	Comment letter submitted 7/16/15	\$250	\$125
6/30/2015	Received letter from DMHC re: PRA request.	0.25		\$250	\$63

Blue Shield Acquisition of Care1st

7/1/2015	Reviewed notes to prep for meeting with DMHC	0.75	7/1/15 meeting with DMHC	\$250	\$188
7/1/2015	Meet with DMHC re: Health Access concerns	1	7/1/15 meeting with DMHC	\$250	\$250
7/1/2015	Email with CU re: circulating sign-on letter amongst consumer advocates	0.25	Joint comment letter submitted 7/16/15	\$250	\$63
7/31/2015	Received letter from DMHC re: production delay for 6/25/15 PRA request	0.25		\$250	\$63
8/6/2015	Reviewed documents received from PRA request	1.25		\$250	\$313
8/21/2015	Received letter from DMHC declining to hold additional public meetings	0.25		\$250	\$63
10/8/2015	DMHC briefing for consumer advocates re: approval of acquisition	0.5		\$250	\$125
10/8/2015	Review DMHC press release and undertakings	1		\$250	\$250
10/16/2015	Review full order approving acquisition	0.5		\$250	\$125
10/30/2015	Phone conversation with DMHC re: undertaking	0.25	Letter to DMHC submitted 11/6/15	\$250	\$63
11/3/2015	Phone meeting with DMHC re: undertaking	0.5	Letter to DMHC submitted 11/6/15	\$250	\$125
11/6/2015	Draft letter to DMHC re: undertakings	1	Letter to DMHC submitted 11/6/15	\$250	\$250
11/12/2015	Received and reviewed DMHC letter to Blue Shield	0.25		\$250	\$63
	TOTAL	39.5			\$11,251

BETH CAPELL, PH.D., *Capell & Assoc.* has been the principal and owner of Capell & Assoc. since its founding in 1995. She has thirty-eight years of experience in Sacramento, working in the Legislature, various Administrations, and with various interest groups.

Beth Capell provides policy analysis, legislative advocacy, and other strategic input to Health Access and to other consumer, labor and public interest organizations on health care issues.

Health Access California sponsored the package of legislation known as the HMO Patient Bill of Rights from 1995 to its enactment in 1999. Health Access Foundation led a collaborative of consumer groups that monitored initial implementation of the more than 20 pieces of legislation enacted between 1995 and 2000 intended to protect consumers from HMOs. Health Access Foundation has continued to work on implementation and ongoing monitoring of the law with respect to consumer protections against HMOs. Beth Capell has been an architect and active advocate throughout the two decades of these efforts.

Beth Capell has worked on issues including prescription drugs, universal access, hospital overcharging, balance billing by physicians, nursing home regulations, hospital standards, health insurance regulation, and other health care issues.

Prior to establishing Capell & Assoc. Beth Capell represented the California Nurses Association from 1986 to 1995, first as the legislative advocate and later as the Director of Government Relations for the association. From 1983 to 1986, Ms. Capell worked at the California Manufacturers Association, working on job training and human resource issues, including health insurance. From 1977 to 1983, Ms. Capell worked in various positions in the Legislature, the Administration, and other efforts.

Ms. Capell has Ph.D. in political science from the University of California, Berkeley, and continues to publish articles and present papers on political science, specifically interest groups, legislatures, and the impact of legislative term limits.

Billing classification: Experts: 13+ years of experience. \$420/hour.

ANTHONY WRIGHT serves as Executive Director for Health Access California, the statewide health care consumer advocacy coalition, working on behalf of the insured and uninsured, made up of over 200 organizations representing seniors, children, working families, people with disabilities, immigrants, people of faith, labor, and communities of color.

Under Wright's leadership since 2002, Health Access has been a leader in efforts to fight health care budget cuts, to expand both employer-based coverage and public insurance programs, to advance consumer protections, and to address the causes of medical debt. For example, his work on hospital overcharging and abusive billing and collections practices led to both to legislative action and hospital guidelines on the issue. Recently, he served as co-chair and campaign manager for the No on 78/Yes on 79 initiative effort, facing the prescription drug industry and the most expensive ballot campaign in the nation's history.

Wright's background is as a consumer advocate and community organizer, and he has been widely quoted in local and national media on a range of issues. He served as Program Director for New Jersey Citizen Action. As coordinator of New Jersey's health care consumer coalition, he ran successful campaigns to win HMO patient protections, defeat for-profit takeovers of nonprofit hospitals and Blue Cross Blue Shield, pass a law to govern hospital conversions and acquisitions, and expand coverage for low- and moderate-income children and parents.

Wright also worked at the Center for Media Education in Washington, DC, *The Nation* magazine in New York, and in Vice President Gore's office in the White House. Born and raised in the Bronx, Wright graduated from Amherst College magna cum laude in both English and Sociology.

Billing classification: Experts: 13+ years of experience. \$350/hour.

Tam M. Ma is Policy Counsel at Health Access California, where she represents health care consumers in the Legislature and before administrative and regulatory entities. Tam has over thirteen years' experience crafting state public policy. She started her career as a California Senate Fellow and was previously senior staff to Senators Mark Leno and Sheila Kuehl, where she advised the Senators on policy and state budget issues relating to health and human services, consumer protection, housing, judiciary, and women's issues.

Tam has crafted and worked for passage of legislation to protect consumers from unfair out-of-pocket costs, increase transparency in health care premiums, streamline state public benefits programs, help people living with HIV/AIDS to transition between new forms of health coverage under the Affordable Care Act, enhance consumer awareness of toxic flame retardant chemicals in home furnishings, strengthen the rights of low-income tenants, and increase protections for survivors of domestic violence, sexual assault, and human trafficking.

Tam was honored by the California Partnership to End Domestic Violence and the California Coalition Against Sexual Assault for her work to strengthen protections for survivors of these crimes. Tam advocated for the rights of low-income tenants when she was a trial attorney with Legal Services of Northern California's Sargent Shriver Civil Counsel Act project.

Tam sits on the board of the Women's Foundation of California and has served as a trainer and mentor for the foundation's award-winning Women's Policy Institute since its inception in 2003. She also serves on the board of the Asian/Pacific Bar Association of Sacramento and is Past President of My Sister's House, a domestic violence shelter serving women throughout the Central Valley. Tam received her B.A. (2002) and J.D. (2011) from the University of California, Berkeley, and has served as a lecturer at the law school.

Billing classification: Attorney: 3-4 years of experience. \$250/hour.