DEPARTMENT OF Managed Health Care

State of California

Application for an Award of Advocacy and Witness Fees

Entity Name: Consumers Union of United States, Inc.
Proceeding: Blue Shield of California Purchase of Care 1st Health Plan
Date Submitted: 12/7/2015 11:31:48 AM
Submitted By: Julie Silas
Application version: Original App

1. For which proceeding are you seeking compensation?

   Blue Shield of California Purchase of Care 1st Health Plan

2. What is the amount requested?

   $61,901.25

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.

   Consumers Union of the United States, Inc., submits this request for reasonable advocacy fees for our substantial contribution to the decision of the Department of Managed Health Care (DMHC) regarding Blue Shield's purchase of Care 1st Health Plan. Consumers Union made a substantial contribution to this proceeding by providing DMHC with background research on issues involving the history and legal structure of Blue Shield of California ("Blue Shield"), important legal questions regarding the proceeding, submitting comments, and presenting in-person testimony. At the March DMHC stakeholder meeting, Consumers Union raised initial threshold questions about Blue Shield's history as a nonprofit organization with DMHC staff and offered to follow up with staff to provide more background information and details and suggestions of experts. A few weeks later, Consumers Union, along with other advocacy organizations, called for a public hearing and valuation regarding Blue Shield's purchase of Care 1st Health Plan in April 2015. Subsequently, DMHC granted the public hearing request and secured an independent valuation of the transaction. In mid-April, Consumers Union staff and DMHC staff discussed in more detail the implications of the proposed transaction, sharing relevant information about Blue Shield's history. We also provided historical documents to DMHC regarding Blue Cross and Blue Shield transactions in California and nationwide, providing background on an issue new to current DMHC staff. Consumers Union was compelled to request all of Blue Shield's articles of incorporation from the Secretary of State's office following the failure of the plan to include the articles in its filing. By sharing the file with the DMHC, Consumers Union ensured that crucial information was available for the Department's decision. In early May 2015, Consumers Union provided a series of detailed questions to DMHC regarding the transaction, based on our long history working on Blue Cross and Blue Shield transactions in California and in other states. On May 29, we submitted a joint letter with other consumer organizations to DMHC providing extensive background on Blue Shield's history and charitable obligations. Also in May, Consumers Union requested copies of Blue Shield's by-laws, which DMHC had to request from Blue Shield because they were also omitted from its material modification documents. Julie Silas, Senior Staff Attorney for Consumers Union, testified at the subsequent public hearing on June 8th, 2015 regarding the applicability of CA Health & Safety Code, Article 11 to the transaction, and other issues relevant to the consumer interest. During the public comment period following the hearing, Consumers Union submitted a brief in response to statements made by the parties at the public hearing and provided an analysis of the applicability of Article 11 of the Health and Safety Code to the proposed

purchase of Care 1st, aimed at ensuring full preservation of all Blue Shield's public and charitable obligations. We thus provided "relevant, credible" information to the Director, and believe that DMHC considered the extensive historical materials provided by Consumers Union in assessing the standard under which this proposed transaction would be reviewed. On July 16th, 2015, Consumers Union wrote a letter, to which we secured sign-on by four other consumer groups, urging the Department to ensure that the transaction was in the best interest of California consumers. The letter contained several recommendations, including: • 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; • 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. • Require Blue Shield 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. Consumers Union met again with DMHC staff on August 6, 2015, to review examples of inconsistencies in representations made by Blue Shield in various fora. In the end, the Undertakings that accompanied DMHC's approval of the purchase of Care 1st Health Plan by Blue Shield clearly reflect our recommendations by including significant investment in public benefits, increased transparency and accessibility, improved quality performance, and improvements to the Care 1st network of contracted specialty providers. More specific instances of where the guidance and advocacy of Consumers Union were reflected in the following Undertakings:• Our recommendation to require strong public benefit commitments from the plan and its subsidiaries/affiliates moving forward was addressed by Undertaking 21, which requires Blue Shield to make charitable contributions of $200 million. (It is our stance, as well, that the charitable Undertaking here was intended to be in addition to pre-existing charitable practices by Blue Shield).• Our recommendation that Blue Shield be obligated to heighten monitoring of Blue Shield's management of Medi-Cal enrollees was addressed by Undertaking 11, which requires Care 1st and Blue Shield to improve the Care 1st network of contracted specialty providers and Care 1st's enrollees' access to specialty care. Additionally, Undertaking 12 requires Blue Shield to provide DMHC with a plan to become proficient in the Medi-Cal program and to become an active and effective participant in Healthy San Diego.• Our recommendation to require Blue Shield to lower the incidence of and basis for consumer complaints in all lines of its business, and implement improvements in quality and access to care, patient satisfaction, and cost control are addressed by Undertaking 6, Undertaking 7, and Undertaking 8, which require that Blue Shield and Care 1st improve their ratings across several different quality and consumer satisfaction rating programs including both the commercial and the Medi-Cal markets. • In line with our advocacy for ensuring that health care costs are controlled following the merger of the two plans, Undertaking 15 obligates Blue Shield to constrain premium rate increases and to work with DMHC to address proposed rate increases deemed unreasonable or unjustified by the Department.• Throughout the review process, Consumers Union advocated to DMHC for increased oversight over provider directories, noting in particular the low accuracy rate of Blue Shield's directory. Undertaking 17 was responsive to our concerns, requiring Blue Shield to correct and remediate deficiencies in its directory as well as any found in a non-routine, billable, follow -up survey by DMHC.• In response to our presentation to DMHC of inconsistencies in Blue Shield's statements, both internally and with external evidence, Undertaking 18 requires that Blue Shield refrain from making false, misleading, or inconsistent statements to DMHC.• Undertaking 22 responds to issues Consumers Union flagged: the potential for Blue Shield executives or managers to financially benefit from this proposed transaction despite their positions within a nonprofit corporation and Bylaws restricting the distribution or payment of compensation to its directors or officers. Although DMHC did not make a finding on Blue Shield's charitable obligations, it is apparent that the Undertakings substantially integrate our recommendations and address a number of the concerns we raised via testimony, expert research, and input throughout the hearing and comments process.

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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 San Francisco (City), CA (State), on December 07, 2015 .

Enter Name: Geraldine C Slevin

JULIE L. SILAS, J.D.

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EMPLOYMENT HISTORY

Consumers Union May 2011 to present
San Francisco, CA
Senior Attorney: Advocate for consumers and advise policymakers (at both the federal and state level) on a variety of health policy issues with a focus on Medicaid expansion, new insurance Marketplaces and insurance reform. Research, strategize, and develop positions around health policy issues affecting consumers, including standard benefit design, the single streamlined eligibility and enrollment system, privacy and security policy and functionality, language and disability access, standards and criteria for transitions between Medicaid and Exchange coverage, health insurance literacy, network adequacy, choice architecture, data collection, and protocol and content for consumer communication. Partner with a diverse group of community-based organizations representing a variety of constituencies before federal and state agencies, including Centers for Medicare and Medicaid Services, the Center for Consumer Information and Insurance Oversight (CCIIO), California's Department of Health and Human Services, the Department of Health Care Services, the Department of Managed Health Care, and Covered California. Provide technical support for and communication to state advocacy organizations where state-based exchanges are in development, including Washington, Oregon, Colorado, New York, Rhode Island, Connecticut and Maryland. Undertake research and write policy reports and issue briefs on a variety of topics, including premium aggregation, value-based design, standards for IT systems, consumer choice, pediatric dental coverage, and fair payment policies. Supervise and mentor graduate student and law student interns throughout the year. Represent Consumers Union in the media both nationally and in California. Develop and write regular grant applications and foundation progress reports.

Children's Defense Fund – California July 2010 to May 2011
Oakland, California
Senior Policy Associate: Coordinated the 100% Campaign, a collaboration between six to ten leading children's advocacy groups in California, as it undertook efforts to achieve health care coverage for all California children. Facilitated a series of weekly calls and represented the California coalition with federal partners. Undertook administrative and legislative advocacy to defend children's health coverage programs such as Medicaid and Healthy Families and represented the children's perspective before policymakers as the state implemented the Affordable Care Act. Participated in larger coalition work with organizations representing seniors, people of color, people with disabilities, faith-based organizations, community-based providers, and others. Developed media and communications outreach, including press releases, press advisories, and family stories. Wrote position papers for state and federal policymakers, specifically focused on ACA implementation.

Healthy Building Network October 2006 to July 2010
Oakland, California
Director, Health Care Projects: Built and implemented a formal program in the health care arena, working with large health care systems and architect and design firms to transform the building industry to offer healthier building materials. Conducted extensive literature reviews on chemicals of concern found in building materials, resulting in numerous white papers and fact sheets. Consulted and advised regulatory agencies, architect and design firms, health care systems, community-based organizations and others around environmental and human health concerns of toxics.

SF Bay Area Physicians for Social Responsibility July 2000 to October 2006
Oakland, Californ*ia*
Program Director: Developed, directed, and staffed environmental health program in conjunction with physician members. Conducted public education trainings, designed educational materials, participated on governmental committees, and testified before governmental agencies/legislative bodies. Partnered with federal and state community-based organizations and health providers on key public environmental health issues.

Consultant August 1999 to June 2000
Oakland, California
Policy Analyst/Writer/Advocate: Provide a variety of consultation services to nonprofit organizations, including advocacy, legal analysis, research, technical assistance, writing, and editing. Clients included the City of Berkeley, Consumers Union, and PolicyLink.

Consumers Union of U.S., Inc. August 1996 to August 1999
San Francisco, California
Co-Coordinator/Attorney and Policy Analyst: Provided technical, legal, policy and organizing expertise to community leaders, legislators, and regulators regarding the conversion of nonprofit health care corporations to for-profit status. Conducted trainings at the national, state and local level. Worked on conversion proposals in Colorado, Kentucky, Missouri, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, and Texas.

Legal Assistance Corporation of Central Massachusetts November 1994 to July 1996
Worcester, Massachusetts
Health Law Attorney (Medicare Advocacy Project): Represented low-income individuals, elders, and people with disabilities regarding access to services and due process rights in health care, particularly managed care. Represented plaintiffs in class action lawsuit that resulted in major negotiations with the former Health Care Financing Administration around monitoring and enforcement, access to care, and due process violations. Created and worked with large community coalition on nonprofit to for-profit health care conversions. Developed educational trainings for local, statewide, and national audiences. Provided technical assistance to legal services and human services advocates, as needed. Also represented individuals in SSI, Medicaid, AFDC, and General Relief programs**.**

Greater Boston Legal Services September 1992 to October 1994
Boston, Massachusetts
Health Law Attorney (Medicare Advocacy Project): Represented elders and people with disabilities around eligibility for and access to Medicare services. Provided statewide back-up to legal advocates around Medicare issues. Coordinated the statewide "Home Health Campaign," including media, legislative presentations and training for beneficiaries and health care providers. Co-counsel in nationwide class action lawsuit on Medicare outpatient billing issues.

Massachusetts Legal Services (Assorted) December 1991 to August 1992
Boston Area
Staff Attorney: Contract attorney with Cambridge and Somerville Legal Services and Massachusetts Law Reform Institute. Worked on a variety of human services and health care issues, as needed, including General Relief, AFDC, and Medicaid.

Health Care For All June 1990 to December 1991
Boston, Massachusetts
Media/Public Education and Development Coordinator: Directed and coordinated key components of organization: public education; media; grant writing; disability advocacy and a consumer hotline. Edited and produced health care policy journal and quarterly organizational newsletter. Developed and implemented formal intake system for organization. Other program work included health care reform, insurance discrimination, the Universal Health Care Law, and numerous health care access programs/issues.

EDUCATION

J.D., Northeastern University Law School, May 1990

Post-graduate certificate, Sign Language Interpretation, Western Oregon State College, May 1986

B.A. in English, Lewis and Clark College, August 1985

PROFESSIONAL MEMBERSHIPS

Member of the State Bar of Massachusetts

References available upon request

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.

[1] Exhibit 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 trusted 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:

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[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]

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[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

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[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 became 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 Care1st 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.

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

[25] The 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

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

ConsumersUnion®
POLICY & ACTION FROM CONSUMER REPORTS

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

June 11, 2015

Dear Ms. Rouillard

Consumers Union, the policy and advocacy division of Consumer Reports, writes in follow-up to the public hearing held June 8, 2015, regarding California Physicians' Service's (d.b.a. Blue Shield of California) proposal to purchase the for-profit insurer Care 1st. With this letter, Consumers Union responds to claims made by Blue Shield and Care 1st at the hearing and in filings that:

- DMHC should not apply Article 11 of the Health & Safety Code to the proposed transaction;
- Blue Shield has always been a nonprofit mutual benefit organization and that California law declares such organizations "non-charitable;" and
- Blue Shield "does not currently hold and has not previously held assets subject to a charitable trust obligation.

Consumers Union urges DMHC to ensure that the assets that Blue Shield amassed over the past 70-plus years based on its nonprofit status, goodwill, donations made over time, and the "Blue Shield" brand, continue to be used for nonprofit charitable trust purposes. We strongly believe that California lawmakers intended that transactions such as the one proposed by Blue Shield and Care 1st would be evaluated under Article 11. To do anything short of that would risk hundreds of millions, if not billions, of nonprofit assets.

As shown below, Blue Shield's arguments fail to demonstrate that it can use long dedicated nonprofit assets as it pleases, with no accountability to the original purposes for which the nonprofit Blue Shield was founded. As regulators have concluded in many restructurings, conversions, and other transactions across the country over the past twenty years, these assets are impressed with nonprofit public and/or charitable purposes from their inception. They cannot be used for private gain or profit.

I. Article 11 was drafted to govern the very type of transaction proposed by Blue Shield

When Article 11 of the Health & Safety Code was passed by the legislature in 1995, those drafting the law recognized that at the time the Knox-Keene Act was passed, health care service plans were primarily organized as nonprofits with charitable trust obligations.[1] The bill, SB 445,

[1] Legislative History of SB 445 (Rosenthal), Senate Third Reading, As Amended September 8, 1995, page 4.

was drafted after Blue Cross of California attempted to transfer a significant portion of its nonprofit charitable trust assets to a for-profit subsidiary. It was written to make sure that California law was patently clear: nonprofit health service corporations, public and mutual benefit corporations organized under the Knox-Keene Act, had charitable obligations and those charitable obligations had to be preserved. The law was explicitly designed to address the "disposition of a substantial part of plan assets to a business or entity carried on for-profit."[2] The intent of Article 11 is clear: protection of charitable assets applies to nonprofit mutual benefit corporations. [3]

Today, Article 11 still applies in full force to protect nonprofit charitable assets held in nonprofit mutual benefit corporations, despite the arguments of Blue Shield and Care 1st to the contrary. This type of "material modification" involving $1.25 billion in nonprofit funds amassed during Blue Shield's history is the very type of transaction Article 11 was intended to cover. The transfer of $1.25 billion is undoubtedly substantial. Blue Shield proposes to use these nonprofit assets to purchase Care 1st, which is organized as a for-profit corporation. The direct implication of this transaction, therefore, is that more than a billion dollars of nonprofit assets will be reallocated to a for-profit business. Those assets will no longer be dedicated to nonprofit purposes. Charitable assets that were intended for the community benefit will be used instead to benefit the private shareholders of Care 1st. And Blue Shield and Care 1st propose to do it without *any* compensation to the public who were and remain the primary beneficiaries of Blue Shield's nonprofit assets.

The only way to ensure that this transaction does not violate the charitable trust doctrine is for DMHC to follow the requirements of Article 11 to ensure that the proposed "restructuring" of $1.25 billion of Blue Shield's assets is imbued with a charitable trust and the value of those assets is preserved for charitable purposes. That means, DMHC should require that Blue Shield:

- Provides a report of all its activities undertaken "to meet its nonprofit obligations" [4] identifying
    - The nature of its public benefit or charitable activities;
    - Expenditures incurred on public benefit or charitable activities; and
    - Its procedure for avoiding conflicts of interest involving public benefit or charitable activities (including any conflicts that have already occurred).[5]
- Provides a written plan that identifies how Blue Shield will accomplish the above for at least the year immediately following the transaction;[6] and
- Promptly supplement the report if DMHC requests additional information needed to "ascertain whether the plan's assets are appropriately being used by the plan to meet its nonprofit obligations."[7]

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[2] Legislative History of SB 445, page 3.

[3] California Health & Safety Code §1399.70(e), §1399.75. See also Legislative History of SB 445, page 3.

[4] California Health & Safety Code, §1399.70(a).

[5] California Health & Safety Code, §1399.70(b).

[6] California Health & Safety Code, §1399.70(c).

[7] California Health & Safety Code, §1399.70(d).

In addition, Blue Shield would be required to submit a public benefit program that identifies activities that the company will take after the transaction to meet its nonprofit public benefit obligations.[8] DMHC would then determine the fair value of the portion of Blue Shield's assets involved in the Care 1st transaction[9] and apply it to the public benefit program proposed by Blue Shield.[10] Of note, Article 11 states in no uncertain terms:

> Nothing in this section shall be construed to limit the director's, Attorney General's, or a court's authority under existing law to impose charitable trust obligations upon any or all of the assets of a mutual benefit corporation or otherwise treat a mutual benefit corporation in the same manner as a public benefit corporation.[11]

In summary, Article 11 was intended to apply to the transaction proposed between Blue Shield and Care 1st. The clear step forward is for DMHC to begin steps to evaluate the transaction and apply the requirements as set forth in Article 11 to undertake a thorough evaluation of the current and future public benefit activities of Blue Shield. The transaction between Blue Shield and Care 1st may go forward, but only after DMHC is satisfied that, as part of the transaction and going forward, the fair market value of nonprofit charitable assets are protected, there are no conflicts of interest, that the transaction avoids undue influence or control, and that a robust public benefit proram is established going forward.[12]

II. Blue Shield has not always been a nonprofit mutual benefit corporation; its change in the articles of incorporation did not eliminate its nonprofit charitable trust obligations

From its creation in 1939 until 1995, Blue Shield maintained nonprofit purposes in its articles of incorporation. Until 1995, the articles in effect established a medical services plan

> …***without profit to any agency***… [to] assure that all payments made by patients, except administrative costs, will be 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..."[13]
>
> [Emphasis added]

These articles of incorporation were consistent with California law when Blue Shield was founded, which categorized *all* nonprofit corporations as "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

[8] California Health & Safety Code, §1399.71(b).

[9] California Health & Safety Code, §1399.71(c) and §1399.72.

[10] California Health & Safety Code, §1399.71(c).

[11] California Health & Safety Code, §1399.75(e).

[12] California Health & Safety Code, §1399.75(d).

[13] California Physicians' Service (d.b.a Blue Shield of CA), articles of incorporation (1939-1994).

lawfully may associate themselves…"[14]

In 1980, California law changed to identify three types 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. Because Blue Shield's contemporaneous articles of incorporation stated that they had "members," it is likely that the Secretary of State deemed the corporation a nonprofit mutual benefit corporation. The 1980 law did not state that as a nonprofit mutual benefit corporation, Blue Shield cannot hold charitable assets subject to a charitable trust. And Blue Shield continued to do business under the articles of incorporation and by-laws that had been in place for 50 years or more.[15]

The articles of incorporation with a nonprofit charitable trust purpose remained in effect until 1995, when Blue Cross of California withstood scrutiny for its transfer of assets to a for-profit. Likely in response to regulators' oversight of Blue Cross' conversion, the new Blue Shield articles, which govern the corporation today, were and remain devoid of any description of the purpose of the organization, beyond "the promotion of social welfare."[16] All other provisions of its previous articles were ***withdrawn***. In essence, in 1995, Blue Shield attempted to erase its decades-long history of holding its nonprofit assets in a charitable trust.

III. State law does not distinguish between nonprofit "charitable" and nonprofit "non-charitable" organizations

In a letter to Gabriel Ravel, General Counsel of DMHC, Blue Shield argues that California law distinguishes nonprofit public benefit corporations as "charitable" and nonprofit mutual benefit corporations as "non-charitable."[17] Not true - CA law makes no such distinction. In fact, California's Nonprofit Code recognizes that nonprofit mutual benefit corporations, like Blue Shield, can have assets that are impressed with a nonprofit charitable trust – that is, the assets must be used for nonprofit charitable purposes. Throughout the California Corporations Code there is recognition that nonprofit mutual benefit corporations can and often do hold assets subject to a charitable trust.

For example, while California Corporations Code states that nonprofit mutual benefit corporations can't hold *all* of their assets in a charitable trust, there are plenty of references in the Code that recognize that these corporations can have charitable assets subject to a charitable trust. For example §7135 recognizes that nothing in the law would prevent a court from "impressing a charitable trust upon any or all of the assets of a mutual benefit corporation or otherwise treat it as a public benefit corporation."[18] California Corporations Code §7142 states

[14] California Corporations Code, §5111.

[15] Consumers Union submitted a comment letter to DMHC in May 2015, along with our colleagues from CalPIRG, The Greenlining Institute, Health Access, and the Western Center on Law and Poverty, outlining in detail the history of Blue Shield of California and why its assets are subject to public benefit and/or charitable obligations, which is incorporated herein.

[16] Certificate of Amendment of Articles of Incorporation of California Physicians' Service, June 15, 1995.

[17] Letter from Seth Jacobs to Gabriel Ravel, April 20, 2015.

[18] California Corporations Code §7135.

that an enumerated list of interested parties have the right to bring an action against a nonprofit mutual benefit corporation "to enjoin, correct, obtain damages for or to otherwise remedy a breach of the charitable trust."[19] California Corporations Code §7223 grants the Attorney General authority to protect the charitable assets of a nonprofit mutual benefit corporation.[20]

The law governing health care service plans is also clear: whether it is a restructuring, a conversion, or a less sweeping material modification, DMHC has the explicit authority and responsibility to ensure that charitable assets of health care service plans, including Blue Shield, retain their nonprofit charitable trust obligations. The Health & Safety Code grants DMHC authority to impose charitable trust obligations on a nonprofit mutual benefit corporation "or otherwise treat a mutual benefit corporation in the same manner as a public benefit corporation."[21] The law was created to protect nonprofit charitable assets of *all* health service plans, including those long-held by Blue Shield

IV. Blue Shield "members" cannot privately benefit from the assets of Blue Shield

At the public hearing, Mr. Paul Markovich of Blue Shield, stated that the proceeds of any dissolution of Blue Shield would go to its members. This statement is confusing, given the filings Blue Shield submitted to DMHC, its articles of incorporation and by-laws, and California law governing nonprofit mutual benefit corporations. Upon examination, Blue Shield is a non-member organization.

In the 2015 filings with DMHC, all parties repeatedly state that Blue Shield is a non-member organization.[22] In their amended filings as of June 2, 2015, Blue Shield affirmed that it is a non-member organization.[23] California Corporations Code governing nonprofit mutual benefit corporations acknowledges that nonprofit mutual benefit corporations can exist even if they have no members. The Code states that:

> A corporation may admit persons to membership, as provided in its articles or bylaws, or may provide in its articles or bylaws that it shall have no members.[24]

The most recent articles of incorporation of Blue Shield filed with the California Secretary of State's Office are from 1995. The 1995 articles are silent on whether the corporation has members. The articles take up less than one full page. They declare that Blue Shield is now incorporated as a nonprofit mutual benefit corporation consistent with California law.[25] The presumption is that, unless the articles or by-laws specifically address membership, a nonprofit

[19] California Corporations Code §7142(a).

[20] California Corporations Code §7223(c).

[21] Health & Safety Code §1399.75(e).

[22] Notice of Material Modification, DMHC File No. 933-0043 (January 30, 2015) and Care 1st Health Plan Partner (QIF), Notice of Material Modification, DMHC File No. 933-0043 (January 30, 2015).

[23] California Physicians' Service Exhibit E-A, Filing #20150295, DMHC File No. 933-0043, June 2, 2015.

[24] California Corporations Code §7310(a).

[25] California Physicians' Service (d.b.a. Blue Shield of California) articles of incorporation, June 15, 1995.

mutual benefit corporation shall be deemed to have no members.[26]

The most recently available by-laws of Blue Shield are not silent on this issue. The by-laws, state that if the

> [C]orporation has no members within the meaning of Section 5056 of the California Corporations Code. The corporation may refer to persons associated with it as "members" even though such persons are not members within the meaning of 5056.[27]

Section 5056 "Members" are defined as those individuals who have the right to vote on the disposition of all or substantially all of the assets of a corporation or on a merger or dissolution, or the right to vote on changes to the articles or by-laws.[28]

The by-laws further state that beneficiary members are called "enrollees" and that

> ***[N]o beneficiary member shall have the right to vote or acquire or hold or possess any property right, or right, title in or to any property or assets of the corporation,*** nor shall any beneficiary member have any rights or privileges other than as are provided herein.[29]
>
> [Emphasis added.]

Mr. Markovich could not have been referring to Blue Shield's beneficiaries, subscribers or enrollees, since Blue Shield's by-laws expressly state that beneficiary members have no right to the assets.[30]

Given that Blue Shield has no official members under California law, and according to the by-laws, "beneficiary members" are prohibited from receiving the assets, the relevant question is what would happen to the assets of Blue Shield upon dissolution? Without regulatory oversight, the nonprofit charitable trust assets of Blue Shield are greatly at risk upon dissolution and could end up in the pockets of insiders[31] or for-profit shareholders. Article 11 was enacted to prevent this very type of corporate maneuvering designed to siphon off nonprofit assets to for-profit purposes.

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26 California Corporations Code §7310(a). "In the absence of any provision in its articles or bylaws providing for members, a corporation shall have no members."

27 California Physicians' Service/Blue Shield of California, by-laws, Chapter 2. Section 1: Classification of Members, revised January 1, 2013. Exhibit F-1-a-ii.

28 California Corporations Code, §5056

29 By-laws, Chapter 4, Section 1: Beneficiary Members. Exhibit F-1-a-ii.

30 Chapter 12: Section 3 of the by-laws states that beneficiary members can receive assets or property upon dissolution of the corporation. But this section conflicts directly with the provision that prohibits beneficiary members from acquiring any rights to Blue Shield's assets.

31 "All rights which would otherwise vest in the members to share in a distribution upon dissolution shall vest in the directors." California Corporations Code §7310(b)(2).

V. Contrary to Blue Shield and Care 1st Statements, Blue Shield may have been the highest bidder for Care 1st

At the public hearing on June 8, 2015, Blue Shield and Care 1st emphasized the fact that Blue Shield was not the highest bidder. They argued that the fact that others would pay more for Care 1st demonstrates that Blue Shield is paying fair market value or less. This argument turns the analysis of fair market on its head. The question is not whether others would pay more for Care 1st, but rather whether Care 1st shareholders are getting the benefit of Blue Shield's $1.25 billion in nonprofit assets without appropriate compensation to the public for the loss of those nonprofit assets from their nonprofit charitable purposes.

Moreover, Care 1st is getting something immensely valuable. In addition to $1.25 billion in nonprofit charitable assets – the use of the "Blue Shield" brand. As Ms. Tran, CEO of Care 1st, stated repeatedly at the public hearing, one of the benefits of partnering with Blue Shield is the name brand – the "Blue Shield" trademark. It is not just the monetary bid that Blue Shield brings to Care 1st, it is also the intangible value of the nonprofit charitable assets including (but not limited to) its goodwill and intellectual property invested in the use of the "Blue Shield" brand. When the monetary bid and the value of the intangible assets of the bidder are taken together, Blue Shield likely overbid for this purchase. At the very least, DMHC should be sure that Blue Shield is not paying more than a billion dollars to give away a license to use the Blue Shield brand to Care 1st.

The Blue Shield brand is highly coveted and very valuable. For more than 50 years, all Blue Cross and Blue Shield companies were nonprofit. The history of these unique organizations, including Blue Shield of California, has led to the high value of the brand. Consumers Union wrote an extensive history that describes the establishment and unique role in addressing the needs of health care communities that Blue Cross and Blue Shield plans had across the country.[32] DMHC should review this historical summary to better understand the context for which Blue Shield, in the 21st century, has built up its assets – both tangible and intangible – in order to be able to purchase Care 1st. In states such as Washington, New Mexico, and Missouri, regulators ensured that the tangible *and* intangible assets of the Blue Cross and Blue Shield plans were considered when denying or permitting a nonprofit restructuring or conversion to go forward.

VI. Blue Shield's vague premise of increased contributions to its Foundation does not justify a stealth transaction

At the June 8th hearing, Mr. Markovich stated that Blue Shield's purchase of Care 1st would result in increased income and therefore increased contributions to the California Physicians' Service Foundation (d.b.a Blue Shield of California Foundation, hereinafter the "Foundation"). This claim does not withstand scrutiny.

[32] Blue Cross and Blue Shield: A Historical Compilation. Accessed at https://consumersunion.org/wp-content/uploads/2013/03/yourhealthdollar.org_blue-cross-history-compilation.pdf

Consumers Union evaluated the contributions Blue Shield made to the Foundation over time. For the first 15+ years, the Foundation was organized as a public charity and acted as a small investor in the California nonprofit community. There is little public information about the Foundation before 1999, which is the oldest year that their Form 990 is publicly available.[33]

The historical data makes one thing clear, while Blue Shield of California's income has increased several times over a ten year period, these increases in income were not matched by increases in contributions to the Foundation.[34] Over the ten year period between 2003 and 2013, Blue Shield contributed a fairly steady amount of assets to the Foundation, ranging from a low of approximately $25 million in 2009 to a high of $40 million in 2012. During the same ten year period, Blue Shield's income fluctuated much more widely. Its tangible net equity (TNE), [35] however, has steadily risen during the ten year period, starting at approximately $780 million in 2003 and ending at approximately $4.2 billion at the end of 2014.[36]

While Mr. Markovich asserted that more income to Blue Shield would result in increased contributions to the Foundation, a better barometer to measure what Blue Shield has available to contribute to its Foundation is an evaluation of its TNE. In 2003, Blue Shield reported its TNE as approximately $780 million. [37] It contributed $39 million of that to the Blue Shield Foundation.[38] The following year, 2004, the company's TNE increased 42%.[39] Blue Shield's contribution to the Foundation, however, decreased by 24%, to approximately $30 million.

In a more recent comparison, from the year 2012, Blue Shield's TNE increased 12% above 2011 TNE. However, the contribution made to the Foundation during that time period only increased by 5%.[40] Notably, in only one calendar year in the decade between 2003 and 2013 did we find that the percent change in income to Blue Shield mirrored the percent change in income to the

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[33] 501(c)(3) grant-making foundations are classified as either publicly supported organizations or private foundations described in I.R.C. § 509(a)(1). I.R.C. § 509(a)(1) (Deering 2015). Publicly supported organizations generally receive broad public support. Private foundations generally receives support from relatively few sources. The IRC requires private foundations to pay a small excise tax on their investment income. Additionally, a private foundation must generally expend at least five percent of the annual average market value of its total assets for charitable purposes. 2014 IRS Instructions for Form 990-PF. Accessed at http://www.irs.gov/pub/irs-pdf/i990pf.pdf (last visited June 4, 2015). From 2000-2003, the IRC classified the Blue Shield Foundation as a publicly supported organization. In 2003 the Foundation indicated that it changed its articles of incorporation to become a private foundation in an attachment labeled "Statement 8A." In 2004, and every year since, the Foundation began filing a Form 990-PF "Return of Private Foundation."

[34] California Physicians' Service Foundation Form 990-PF (2012). Accessed at http://www.blueshieldcafoundation.org/sites/default/files/u14/2012_990_tax%20return.pdf (May 20, 2015).

[35] Tangiblenet equity (TNE), as defined by sec. 1300.76, is the carrier's equity minus such intangibles and obligations such as unsecured receivables from officers, directors, and affiliates

[36] Annual Financial Reporting Form, California Physicians' Services, for the year ending December 31, 2014.

[37] California Physician's Service Annual Report, 2003. Accessed at http://wpso.dmhc.ca.gov/fe/search/#top. (June 10, 2015).

[38] Forms 990-PF (Return of Private Foundation) for each year are accessed at http://rct.doj.ca.gov/Verification/Web/Search.aspx?facility=Y. (June 10, 2015).

[39] California Physician's Service Annual Report, 2004. Accessed at http://wpso.dmhc.ca.gov/fe/search/#top. (June 10, 2015).

[40] Forms 990-PF (Return of Private Foundation) for each year are accessed at http://rct.doj.ca.gov/Verification/Web/Search.aspx?facility=Y.

Foundation.[41]

Blue Shield'sstatement at the June 8th hearing that the purchase of Care 1st would result in increased contributions to the Foundation rests on the assumption that increases in Blue Shield's income result in corresponding increases in contributions to the Foundation. As shown above, an examination of Blue Shield's income, TNE, and contributions to the Foundation suggest that Blue Shield's purchase of Care 1st will not necessarily result in a subsequent increase in contributions to the Foundation without a careful Article 11 review by DMHC, putting specific requirements on Blue Shield going forward.

Consumers Union has actively advocated in California and nationwide to ensure that assets of Blue Cross and Blue Shield plans are not used to benefit private individuals. We were at the forefront of the fight, working alongside Attorneys General as they preserved charitable assets in transactions where Blue Cross or Blue Shield plans disposed of substantial assets in businesses or entities organized for-profit.

We call on DMHC to undertake rigorous scrutiny of the transaction between Blue Shield and Care 1st. The agency should:

- Review the transaction in light of California Health & Safety Code Article 11;
- Require Blue Shield to report all activities undertaken to meet its nonprofit obligations;
- Obtain a written plan from Blue Shield that describes its committed public benefit obligations moving forward, with detail for the first year immediately following the transaction;
- Ensure that there are no conflicts of interest;
- Ascertain whether sufficient assets are committed to meeting Blue Shield's nonprofit public benefit and/or charitable benefit obligations;
- Determine the fair value of the assets used to purchase Care 1st ; and
- Be sure the fair value is applied to the public benefit program proposed by Blue Shield.

Modifications of Blue Cross and Blue Shield plans are never simple. Time and again, state regulators have learned that close review is required to prevent the kind of "stealth conversion" that occurred with Blue Cross of California. When Blue Cross of California transformed to a for-profit company, it did not state its intention to convert. Rather the proposal was for the nonprofit to remain and to create a for-profit subsidiary. Only after pressure from the public and media, and careful scrutiny by diligent regulators over a period of time and investigation, was it deemed a conversion that in the end resulted in more than $3 billion of nonprofit assets set aside in two charitable foundations.

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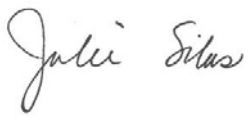
[41] In 2005, the change in net income for Blue Shield was a decrease of 1% and the contributions made to the Foundation also decreased by 1%. This is not the most accurate measure of actual assets available to contribute to the Foundation.The income Blue Shield brings in during a year is not as relevant as the "extra" money it has at the end of the year, i.e., TNE, which is available for contribution. In 2005, while Blue Shield's income decreased and they decreased their contribution to the Foundation, the TNE actually increased 23% over 2004. Income available from California Physician's Service Annual Report, 2011 and 2012. Available from http://wpso.dmhc.ca.gov/fe/search/#top.

The similarities between Blue Shield's proposal to purchase Care 1st and Blue Cross of California's transaction in the '90s are striking: 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 both cases, a health care service plan proposed to dispose of substantial assets to a for-profit company. In the 1990s, the regulator successfully protected the nonprofit charitable assets of Blue Cross that had accrued for over 50 years. The public deserves the same level of scrutiny from DMHC today to ensure that nonprofit charitable assets of Blue Shield are protected similarly.

Sincerely,



Julie Silas
Senior Attorney

Consumers Union
POLICY & ACTION FROM CONSUMER REPORTS

HEALTH ACCESS

WESTERN CENTER ON LAW & POVERTY

CALPIRG
Standing Up To Powerful Interests

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.

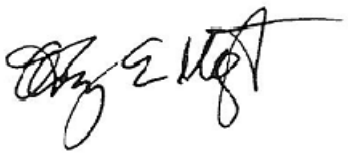
Fourth, we ask that the Department use its full authority to scrutinize the transaction for its impact on consumers enrolled in health care service plans. Blue Shield has historically not participated in Medi-Cal managed care: one of its stated reasons for the acquisition is to buy its way into that 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

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Woodacre, California 94973-0286
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EXPERIENCE

Oct. 2006-present **Special Projects Director, Consumers Union of U.S., Inc.**
Serves as liaison on health policy work between CU's Advocacy and Editorial Divisions, including Health Ratings Center. Provides strategic advice on, develops and leads consumer engagement-oriented health projects. Focuses on implementation of the Affordable Care Act and shifting health care and health insurance marketplace.

Jan. 1999-Sept. 2006 **Director, Consumers Union of U.S., Inc., West Coast Office**
Developed and supervised implementation of policy agenda for regional office of national nonprofit; specialty focus on health policy and community engagement; provided leadership among consumer and other nonprofit groups across the country; developed and oversaw annual budget of $2.1 million; led fundraising that resulted in $10 million in foundation grants and other outside funds; supervised staff of 16; engaged in and supervised lobbying, media work, and development of reports and studies.

Dec. 1994-Dec. 1998 **Senior Attorney/Policy Analyst, Consumers Union of U.S., Inc., West Coast Office**
Directed office's health team, focusing on access, quality and affordability of health care. Included extensive project development, media work, hearing testimony, advocacy before government agencies, trainings, lobbying and coordination of consumer group allies. Developed and managed highly successful project on enlisting local residents and their schools to assume leadership role in enrolling enroll children in government-sponsored health insurance.

Nov. 1991 to Dec. 1997 **Director, Higher Education and Training Access Project, National Consumer Law Center**
Established national network of public interest groups and consumers involved in advocacy on behalf of low-income students on higher education and job training funding issues. Drafted proposals for reauthorization of federal Higher Education Act, the principal legislation dealing with federal involvement in postsecondary education, including for consumer representation in negotiated rulemaking. Secured consumer participants in subsequent negotiated rulemaking proceedings. From 1991 through 1994, the project operated under aegis of Legal Services for New York City and South Brooklyn Legal Services.

June 1993 to Dec. 1994 **Special Consultant, California Council for Private Postsecondary and Vocational Education**
Acted as liaison between state agency that licenses proprietary trade schools and federal and other state agencies. Trained agency staff on student loan and other legal issues.

Sept. 1990 to Nov. 1991 **Consumer Law Coordinator, Legal Services for New York City**
Organized and chaired consumer law task force for attorneys serving low-income consumers. Conducted training for citywide Legal Services staff and pro bono private attorneys. Served as consumer law resource for neighborhood programs. Lobbied state and federal agencies and legislatures for consumer law reform. Testified before committees of U.S. Senate and House of Representatives concerning fraudulent practices within proprietary trade school industry.

Oct. 1984 to Nov. 1991 **Director, Consumer and Employment Unit, South Brooklyn Legal Services**
Supervised consumer and employment law unit of attorneys, paralegals, and law students. Initiated national vocational school watch project consisting of federal and state legislative and administrative advocacy; class action litigation; community education and engagement; and substantial media coverage. Engaged and coordinated services of pro bono counsel. Notable decisions: Minino v. Perales, 79 N.Y. 2d 883 (1992); U.S. v. Grundhoefer, et al., 916 F. 2d 788 (2d Cir. 1990); Figueroa v. Market Training Institute, et al., 562 A.D. 2d 175 (2d Dept. 1990).

Sept. 1980 to Sept. 1984 **Staff Attorney, South Brooklyn Legal Services**
Handled consumer, employment, and government benefits (Social Security Disability, public assistance, and unemployment benefits) cases before federal and state courts and administrative tribunals. Notable decisions: Robinson v. Secty of Health and Human Services, 733 F. 2d 255 (2d Cir. 1984); Dartmouth Plan, Inc. v. Valle, 117 Misc. 2d 534 (Sup. Ct. Kings Co. 1983).

Jan. 1979 to Jan. 1980 **Research Assistant, Professor Arthur Kinoy, Rutgers School of Law**, Newark, New Jersey
Researched and wrote memoranda on constitutional and civil rights issues. Helped compile materials for Professor Kinoy's book, Rights on Trial (1983).

Summers, 1978 and 1979 **Law Clerk, Reproductive Freedom Project, American Civil Liberties Union Foundation**
Researched and wrote briefs, legal memoranda, motions, and affidavits for federal litigation on reproductive rights.

May 1976 to Sept. 1977 **Legislative Assistant, Office of the City Council President, Hon. Paul O'Dwyer**
Assisted in development of Ombudsman Office to handle citizen complaints against New York City agencies. Wrote reports for New York City Charter Revision Commission. Analyzed contracts presented for approval by Board of Estimate and ordinances introduced before City Council.

EDUCATION

June 1980 **Rutgers University School of Law**, Newark, New Jersey
Juris Doctorate
Clinical Experience: Women's Rights Litigation Clinic (1978)
Urban Legal Clinic (1980)

Honors: Articles Editor, *Women's Rights Law Reporter,* (1979-1980)
G.A. Moore Prize for distinguished work in equal employment opportunity law.

May 1976 **Columbia University**, New York, New York
Bachelor of Arts, Political Science and Urban Studies
Honors: *Magna Cum Laude*
Columbia University Scholarship (1973-1976)
Phi Beta Kappa

BAR MEMBERSHIPS

New York State (1981); Federal District Court, Southern and Eastern Districts of N.Y. (1981); Federal Court of Appeals, Second Circuit (1989)

PROFESSIONAL AWARDS, HONORS, MEMBERSHIPS

National Consumer Law Center, Vern Countryman Consumer Law Award (1996)
For "outstanding efforts to strengthen and affirm the rights of low-income Americans through the practice of consumer law."

Association of the Bar of the City of New York, Legal Services Award (1991)
For "outstanding work in providing civil legal assistance to the poor in New York City and equal access to justice."

California Department of Managed Health Care , Advisory Committee on Managed Care, Gubernatorial Appointee (2000-2005).

Insure the Uninsured Project, Award
For " Thoughtful Leadership on Value Purchasing and Quality Improvement." (2009)

U.C.L. A. California Health Information Survey (CHIS), Board Member. (2010-date)

Covered California, Plan Management and Delivery System Reform Advisory Committee (2013-date)

California Department of Managed Health Care, Financial Solvency Standards Board Member (2014-date)

PUBLICATIONS

Caveat Venditor, a New York consumer law manual, with Stephen Newman, Professor of Law at New York Law School (1994).

"Jobs, Education, Employment and Training," *Clearinghouse Review*, January 1994 co-author on advocacy opportunities.

Consumers Union Time and Billing Record for Award of Advocacy and Witness Fees

Blue Shield of California Purchase of Care 1st Health Plan

JULIE SILAS, SENIOR STAFF ATTORNEY RATE: $425.00/hour			
Date	**Activity**	**Time Spent in Hours**	**Amount**
3/18/2015	Read and review news of Blue Shield	0.25	106.25
3/20/2015	Meet with CU colleagues to discuss Blue Shield news	0.75	318.75
3/23/2015	Draft initial letter to DMHC, Attorney General	0.5	212.50
3/24/2015	Edit initial letter to DMHC, Attorney General	0.15	63.75
3/24/2015	Conference call to discuss strategy for Blue Shield with other advocates	1	425.00
3/25/2015	Research history of Blue Shield	3	1275.00
3/26/2015	Meeting with DMHC – noting CU experience on conversions/transactions, suggesting a follow-up meeting with DMHC	0.25	106.25
3/27/2015	E-mail as follow-up to meeting 3/26 – sent NY Academy of Medicine article on history of Blue Cross and Blue Shield	0.25	106.25
3/27/2015	Research H&S Code and Corporations Code	1	425.00
3/31/2015	Review draft letter calling for hearing from advocacy groups	0.25	106.25
4/1/2015	Research legislative history of SB 445 and other background materials	1.5	637.50
4/2/2015	Meeting with Blue Shield	1	425.00
4/2/2015	Edit letter to DMHC and Attorney General	0.25	106.25

4/3/2015	Review memo from R. Wexler about np mutual benefit corporations	0.5	212.50
4/6/2015	Sign-on letter to advocates – circulate	0.25	106.25
4/13/2015	Further research on Blue Shield history and CA law	2	850.00
4/13/2015	E-mail to G. Ravel requesting Blue Shield's articles of incorporation	0.25	106.25
4/13/2015 – 4/15/2015	Research and draft paper on Blue Shield history	6	2550.00
4/15/2015	To Secretary of State's office to obtain articles of incorporation for Blue Shield	0.75	318.75
4/15/2015	Meeting with DMHC on Blue Shield, expert recommendations, history conversation	1	425.00
4/23/15 – 4/29/15	Review transaction between Blue Shield and Care First and prepare memo on Blue Shield History	14	5950.00
4/30/2015	Strategy call with other advocates re: next steps Blue Shield	1	425.00
5/1/2015	Telephone call with Ele Hamburger and G. Siegler, experts on CA nonprofit law	0.25	106.25
5/1/15 – 5/4/15	Draft and finalize memo to DMHC with questions asked	5.25	2231.25
5/3/2015	Telephone call with Evans and Rosen about consulting with us	0.25	106.25
5/5/2015	Revise Blue Shield history to share at AG meeting	0.5	212.50
5/6/15 – 5/7/15	Prep response to questions raised by G. Ravel	1	425.00
5/7/15 – 5/11/15	Continue drafting and editing memo on history of Blue Shield of CA and share with DMHC	4	1700.00

5/7/2015	Meeting with Attorney General Charitable Trust Division – King and Lamerdin	1.5	637.50
5/14/2015	Prep testimony BS before Betsy leaves	2	850.00
5/19/2015	Strategy call with other advocates to prep for DMHC BS hearing	1	425.00
5/19/2015	Telephone call with Evans & Rosen on nonprofit corporations code	0.5	212.50
5/19/2015	Complete and provide to Betsy review of draft testimony before she leaves	6	2550.00
5/20/2015	Telephone call with Mary Watanabe to discuss Blue Shield hearing in June	0.5	212.50
5/20/15 – 5/27/15	Prep sign-on letter on Blue Shield history for other advocates to join and then submit to DMHC	2.5	1062.50
5/27/2015	Telephone call with Evans & Rosen	1	425.00
5/29/15 – 6/7/15	Prepare testimony for hearing	13	5525.00
6/3/2015	PRA to M. Watanabe for full file on BS transaction	0.25	106.25
6/3/2015	Telephone call with M. Watanabe re: hearing	0.5	212.50
6/8/2015	Public testimony in BS hearing (including transportation)	2.5	1062.50
6/9/15 – 6/11/15	Review notes from BS hearing to prep f-up and then submit comments to DMHC	14	5950.00
6/11/2015	Correspondence with E. Hamburger on follow-up comment letter	0.5	212.50
6/12/15 – 6/19	Email PRA for updated documents , C. Dutro	0.25	106.25
6/24/2015	Mtg with Tam Ma	0.5	212.50
6/25/2015	Internal strategy conversation with Betsy	0.5	212.50

6/26/15 – 7/1/15	Prep sign-on letter for Blue Shield on policy to wide group of advocates	6.25	2656.25
7/2/15 – 7/3/15	Prep list of conditions	1.5	637.50
7/22/2015	Email strategy with advocates around conditions	0.25	106.25
8/3/15 – 8/5/15	Supervise law student researching messaging from BS executives	2	850.00
8/6/2015	Conflicting statements research – BS executives	0.5	212.50
8/6/2015	Meeting with DMHC follow-up and update – learned they would conduct a valuation and was in process	1	425.00
TOTAL		**105.65**	**$ 44,901.25**

ELIZABETH M. IMHOLZ, Special Projects Director RATE: $425.00/hour			
Date	**Activity**	**Time Spent in Hours**	**Amount**
3/17/2015	Review FTB news re Blue Shield	0.5	212.50
3/20/2015	Meet with CU colleagues to discuss Blue Shield news; conversation with merger expert re. Blue Shield (J. Bell)	1	425.00
3/23/2015	Draft letter to DMHC/AG on Blue Shield	1	425.00
3/24/2015	Conference call to discuss strategy for Blue Shield with other advocates; editing letter to DMHC	1	425.00
4/1/2015	Conversation with expert (J. Bell)	0.25	106.25
4/1/2015	Research SB 445 and other background materials	1.5	637.50
4/2/2015	Meeting with Blue Shield (Tom Epstein, Andrew Keifer) re transaction	1	425.00
4/2/2015	Email to DMHC informing of KALW radio show on Blue Shield	0.25	106.25

4/2/2015	Edit letter to DMHC and Attorney General	1	425.00
4/3/2015	Retrieve and review memo from R. Wexler about np mutual benefit corporations	0.75	318.75
4/6/2015	Re-draft sign-on letter from advocates to DMHC to request hearing	0.75	318.75
4/7/2015	Edit sign-on letter	0.25	106.25
4/8/2015	Research on nonprofit mutuals	1	425.00
4/9/2015	Research and edit letter	0.5	212.50
4/10/2015	Research charitable trust law and Corp Code	1	425.00
4/10/2015	Email joint letter to DMHC (S. Rouillard et al.) requesting public hearing	0.25	106.25
4/15/2015	Meeting with DMHC on Blue Shield, expert recommendations, history conversation	1	425.00
4/30/2015	Strategy call with other advocates re: next steps Blue Shield	1	425.00
5/4/2015	Edit and finalize memo to DMHC with questions re. Blue Shield; send email to G. Ravel, S. Rouillard , M. Green re questions	2	850.00
5/5/2015	Prepare for meeting with AG	0.5	212.50
5/6/2015	Research and edit memo on nonprofit mutuals	2.5	1062.50
5/6/2015	Received and read email from G. Ravel with additional questions; and received email announcing public hearing	1	425.00
5/7/2015	Edit memo on history of Blue Shield and charitable obligations	1.5	637.50
5/7/2015	Meeting with Dep. Attorneys General, Charitable Trust Division (King and Lamerdin), with J. Silas	1.5	637.50

5/8/2015	Research on history of Blue Shield and edits to history memo to DMHC	1.75	743.75
5/11/2015	Finalize history of Blue Shield memo to DMHC	2	850.00
5/11/2015	Email to G. Ravel, S. Rouillard, and M. Green with responses to questions and providing memo on nonprofit mutuals	1.5	637.50
5/14/2015	Prepare testimony with J. Silas	2	850.00
5/14/2015	Emails to and from G. Ravel re process for public hearing	0.25	106.25
5/19/2015	Strategy call with other advocates to prep for DMHC Blue Shield hearing	1	425.00
5/20/2015	Review draft of written testimony	1.5	637.50
5/21/2015	Review Blue Shield by-laws shared from M. Watanabe	0.5	212.50
6/15/2015	Email to S. Rouillard, M. Green, G. Ravel re. Blue Shield surplus with report	0.25	106.25
6/25/2015	Strategy conversation with J. Silas	0.5	212.50
6/29/2015	Edit sign-on letter for Blue Shield on policy to a wider group of advocates	1	425.00
7/3/2015	Refine list of recommended conditions to be imposed on Blue Shield transaction	1	425.00
7/16/2015	Email letter to DMHC (S. Rouillard et al.) from large group of advocates	0.75	318.75
8/4/2015	Review research on conflicting statements by Blue Shield re charitable obligations	1	425.00
8/6/2015	Meeting with DMHC follow-up and update re. valuation in process	1	425.00

10/8/2015	Teleconference with DMHC re Blue Shield/Care 1st decision	1	425.00
TOTAL		**40**	**$ 17,000.00**

TOTAL HOURS	**145.65**
TOTAL AWARD REQUESTED	**$ 61,901.25**