



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

Introduction

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

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

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

The Federal and State Obligations of Nonprofit Insurers

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

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

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

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

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

A Crossroads for Blue Shield as a Nonprofit Plan

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Continuing the Conversation

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

We would appreciate feedback on any of the following questions:

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

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

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

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

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

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

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

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