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Organizations listed for
identification purposes

June 12, 2015

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

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

Dear Ms. Rouillard:

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

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

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

DMHC has Jurisdiction to Review and Approve Transaction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

complaints from consumers who were having difficulty finding in-network physicians. The Department found that a significant percentage (18.2%) of the physicians listed in Blue Shield's provider directory were not at the location listed and that a significant percentage (8.8%) were not willing to accept members enrolled in the Blue Shield's Covered California products, despite being listed on the website as doing so. As a result, an unacceptably high number of consumers could not reach and/or did not have access to providers who were represented as being part of the Blue Shield's network.⁷

Blue Shield's obligation to provide an adequate network and accurate information about that network dates back to the enactment of the Knox-Keene Act in 1975: this is not a new or novel obligation yet Blue Shield was unable to fulfill it. Numerous consumer complaints about network adequacy led Covered California, a major purchaser of coverage, to require Blue Shield to alter its networks, particularly in the San Francisco Bay Area. Given Blue Shield's difficulty in providing satisfactory access to Covered California enrollees, will it be able to provide satisfactory access to Medi-Cal enrollees, a population with which it has no experience? Blue Shield's acquisition of Care1st should not be approved unless Blue Shield can show improvement in its network adequacy and ensuring timely access to care.

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

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

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

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

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

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

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

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

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

Lack of Experience with Medi-Cal.

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

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

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

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

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

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

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

Low Quality Ratings

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

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

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

Enforcement Actions

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

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

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

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

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

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

Enforceable Commitments Needed to Ensure Consumer Protection.

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

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

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

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

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

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

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

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

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

Sincerely,



Anthony Wright
Executive Director

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

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

² Health and Safety Code Section 1399.75(b).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

¹⁷ National Quality Forum on social determinants of health.

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

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

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

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

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

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