Attachment A

Narrative Description of Violations by
California Physicians' Service, d/b/a Blue Shield of California

I. Summary

This Whistleblower Claim describes two separate violations by California Physicians' Service (CPS) resulting in a total tax underpayment of $89,018,332. Both of the violations involve failure to fully report premium revenue on Form 8963, which is used to determine the amount owed by an insurer under the premium tax imposed by the Affordable Care Act.[1] In brief, CPS improperly excluded on Form 8963 filed in 2016:

1) $3.1 billion in premiums from insurance it provided to large employers; and

2) $1.9 billion in premiums collected by its affiliate, Care 1st Health Plan.

Evidence of the violations consists of information contained in public documents and personal knowledge I gained while serving as Director of Public Policy for CPS. Each violation is described in detail below.

II. Unreported large group premiums

CPS underreported net premiums on its 2016 Form 8963 by omitting $3.1 billion in premiums for large group insurance that it provided in 2015, resulting in a tax underpayment of $55.4 million. Evidence of this violation consists of the differing premium amounts CPS reported to the IRS and its state regulator, the sudden change it made in how it classified a significant portion of its business in its reporting to the Centers for Medicare and Medicaid Services (CMS), and the details of a health care service plan that CPS determined in 2016 was not subject to the ACA tax.

CPS reported premiums to the IRS that aligned with premiums reported to its state regulator until amending its Form 8963 in 2016.

On Form 8963, CPS reported net premiums for data years 2013 and 2014 of $8.073 billion and $11.069 billion, respectively. (Fig. 1) These amounts are comparable to the 2013 and 2014 premium totals of $8.316 billion and $11.301 billion that it reported to its state regulator, the California Department of Managed Health Care (DMHC). In April 2016, CPS reported to the IRS $12.537 billion in net premiums for 2015, again closely tracking the premiums it had reported to the DMHC for that year—$12.531 billion.[2] As shown in the table below, these

[1] Although the tax is called the "Health Insurance Providers Fee," CFR §57.8(a) states: "The fee is treated as an excise tax for purposes of subtitle F (sections 6001–7874)."

[2] It is to be expected that IRS-reported premiums would approximate, but not match, DMHC-reported premiums since ACA tax-reportable premiums exclude Medicare Supplement revenue and include ACA risk adjustment and reinsurance receipts while DMHC-reportable premiums include the Medicare Supplement premiums and exclude the ACA-related receipts.

amounts are also comparable to what CPS reported to CMS on its Medical Loss Ratio (MLR) statements for 2013, 2014, and 2015.

But in July of 2016 CPS filed a "corrected" Form 8963 in which it reduced its reported net premiums to $9.444 billion. CPS gives no explanation in the filing of how it determined that it had previously reported over $3 billion in premiums in error. However, the MLR report CPS subsequently filed with CMS indicates that the insurer abruptly reclassified coverage accounting for some $3 billion in premiums as insurance not subject to the ACA tax.

Fig. 1: Comparison of CPS Premiums reported to the DMHC, CMS and IRS (Thousands of dollars)

	Premiums reported to DMHC[1]	Adjusted DMHC premiums[2]	MLR premiums[3]	Premiums reported to IRS[4]	IRS premiums as % of MLR premiums	IRS premiums as % of adjusted DMHC premiums
2013	$8,316,406	$8,316,406	$8,319,291	$8,072,658	97.0%	97.1%
2014	$11,300,553	$11,834,222	$11,761,905	$11,069,315	94.1%	93.5%
2015	$12,531,238	$13,155,469	$13,162,166	$12,537,116 (April filing)	95.3%	95.3%
				$9,444,483 (July filing)	71.8%	71.8%

Notes and sources:
1. DMHC premium amounts are from CPS' annual statements, attached as Exhibits A-1, A-2 and A-3. See premium amounts listed on "REPORT #2: REVENUE, EXPENSES AND NET WORTH," lines 1, 4, and 7.
2. I adjusted the DMHC premium amounts by adding ACA risk adjustment and reinsurance payments received, which are included in the premium totals reported on Form 8963 and the MLR statement. The risk adjustment and reinsurance payment amounts used for the adjustments were taken from CPS' annual statements. See amounts listed under "DETAILS OF WRITE-INS AGGREGATED AT ITEM 10" and "DETAILS OF WRITE-INS AGGREGATED AT ITEM 24." (Ex. A-2 & A-3)
3. Totals of premium amounts in CPS' MLR reports, Part 1, line 1.1, columns for coverage through 12/31. MLR reports are on the CMS website at: https://www.cms.gov/apps/mlr/mlr-search.aspx.
4. Amounts reported as Net Premiums Written on Form 8963. (Ex. A-4, A-5, & A-6)

On its 2015 MLR report, CPS moved a portion of its large group premium revenue to the "Other Health Business" column, where coverage that is not subject to the ACA is reported.

Just a few weeks after filing its amended Form 8963, CPS submitted its 2015 MLR statement in which it reported both a big decrease in premiums from Large Group insurance and a similar-sized increase in premiums from "Other Health Business." CMS instructs filers to report in this latter category "health plan arrangements that are <u>not</u> group *or* individual health insurance coverage." (emphasis in original).[3] Since business required to be reported in this column, with the exception of vision and dental insurance, is not subject to the ACA tax, the Form 8963 instructions exclude this column from those which filers are directed to use as the sources for the total premium amount reported to the IRS.[4]

[3] CMS, "Medical Loss Ratio (MLR) Annual Reporting Form Filing Instructions for the 2015 MLR Reporting Year," p.11. (Ex. A-7)
[4] See Instructions for Form 8963 (Rev. February 2016), p. 3. "Generally, if the entity files an SHCE and/or an MLR form, enter the direct premiums written as reported for the data year on the SHCE (SHCE,

On its 2015 MLR statement, CPS reported $2.739 billion less in Large Group premiums than it had reported the previous year, a 38.6% reduction. (Fig. 2) Yet CPS also reported relatively stable Large Group enrollment, a decrease in member months of just 1.4%. On the same MLR statement CPS reported a $2.996 billion increase from the previous year in Other Health Business premiums, a more than 5-fold gain, yet reported only a 7.3% increase in enrollment.

As the implausibility of the resulting 2015 per-member-per-month (PMPM) premium amounts makes plain, changes in PMPM charges between 2014 and 2015 could not possibly have accounted for the reported revenue changes; business had to have been shifted from one column to the other in order to produce them. However, the absence of reported information about PMPM charges makes it impossible to tell exactly how much premium revenue was shifted. The shift in revenue out of the Large Group column would have matched the $3.1 billion removed from the amended Form 8963 if the increase in Large Group PMPM premiums was 6.4%.[5]

Fig.2: Premiums and enrollment reported to CMS

	Large Group	Other Health Business
2014 premiums	$7,087,986,866	$522,759,137
2015 premiums	$4,349,078,204	$3,519,131,722
Change	-$2,738,908,662	$2,996,372,585
% Change	-38.6%	573.2%
2014 enrollment (member mnths)	16,772,403	1,952,796
2015 enrollment (member mnths)	16,544,760	2,129,717
Change	-227,643	176,921
% Change	-1.4%	9.1%
2014 PMPM premium	$422.60	$267.70
2015 PMPM premium	$262.87	$1,652.39

Sources: CPS' MLR reports for 2014 and 2015, Part I, lines 1.1 and 7.4. PMPM premiums calculated by dividing premiums by member months.

CPS treated for state regulatory purposes the $3.1 billion it removed from its amended Form 8963 as health care service plan revenue, which is clearly subject to the ACA tax.

Despite reclassifying in its report to CMS a major portion of its Large Group business as Other Health Business (i.e., "health plan arrangements that are not group *or* individual health insurance coverage") CPS—and the state—treated that business as health care service plan business for state regulatory purposes. As such, that business clearly falls within the meaning of taxable "health insurance" under the ACA tax regulations: "benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical

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Part 2, line 1.1, columns 1-10 plus 12) and/or MLR (MLR form, Part 2, comparable lines and columns, amounts from the "Total as of 12/31/Data Year" columns only)."

[5] An increase of 6.4% would have resulted in a 2015 PMPM premium of $449.79, which based on the reported enrollment for 2015 would have totaled $7.4 billion, or $3.1 billion more than the premium revenue CPS reported in the Large Group column.

service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract…"[6]

Evidence that CPS and the state treated the $3.1 billion at issue as health care service plan premium revenue consists of the fact that CPS included this amount in premiums that it reported to the DMHC. In its Annual Statement filed in March of 2016, CPS reported to the DMHC its premium revenue for 2015, which aligned with what it reported to the IRS in April 2016, as noted in Figure 1. Yet despite later amending its IRS filing to subtract $3.1 billion in premiums, CPS never adjusted the 2015 premium amount it had reported to the DMHC.[7]

In its never-amended 2015 Annual Statement to the DMHC, CPS reported a total of $12.5 billion in premiums on three lines: Commercial premiums, Medicare, and Point of Service.[8] Per the instructions for the Annual Statement, amounts required to be reported on these lines are as follows:[9]

> Premium (Commercial) – Revenue recognized on a prepaid basis from individual and groups for provision of specified range of health services over a defined period of time, normally one month.
>
> Title XVIII - Medicare – Revenue resulting from an arrangement between the reporting entity and the Health Care Financing Administration (HCFA), for services to a Medicare beneficiary.
>
> POS Premiums – Revenue recognized by the reporting entity for the provision of health care services to enrollees that are enrolled in a point of service plan. [Refers to POS plan contracts pursuant to Article 5.6 of the Knox Keene Act]

For 2015, CPS reported (in thousand of dollars) commercial premiums of $11,065,517; Medicare premiums of $1,197,245; and POS premiums of $268,476. Pursuant to DMHC regulations, these amounts were used to determine CPS' required minimum reserves, making clear that the state regarded all of this revenue as payment for the assumption of health insurance risk.[10]

CPS also never made any changes to the enrollment figures it reported to the DMHC, despite amending the premiums it reported to the IRS. In its 2015 Annual Statement, it reported having 755,363 Large Group Commercial enrollees at the end of 2015, and one year later, in its 2016 Annual Statement, it reported having the same number of enrollees at the end of the previous year.[11] The DMHC's instructions for the Annual Statement require insurers to report with respect

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[6] CFR §57.2(h)

[7] See financial filings listed for CPS on the DMHC's website at http://wpso.dmhc.ca.gov/fe/search/#top.

[8] See CPS 2015 Annual Statement, Report #2: Revenue, Expenses, and Net Worth, lines 1, 4 and 7. (Ex. A-3)

[9] DMHC, Financial Form Reporting Instructions, Report #2: Revenue, Expenses, and Net Worth (Ex. A-8)

[10] CPS 2015 Annual Statement, Required Tangible Net Equity (TNE) Calculation. (Ex. A-3)

[11] See Report #4: Enrollment and Utilization Table in CPS' 2015 Annual Statement (Ex. A-3) and 2016 Annual Statement (Ex. A-9). Note that CPS also did not adjust the enrollment it reported in self-funded

to Large Group Commercial enrollment: "Number of enrollees that are covered by a large employer group contract."[12]

At least some of the $3.1 billion in premiums that CPS removed from its 2016 Form 8963 were for a product that CPS improperly treated as a self-funded plan not subject to the ACA tax.

Documents posted online by one of CPS' largest customers, the San Francisco Health Services System (HSS), show that in 2016 CPS redefined a product that it had previously treated as subject to the ACA tax as a self-funded plan not subject to the tax. In a 2017 internal memo HSS reported that CPS had refunded to it the $9.9 million it had charged in 2016 to cover the cost of the tax (referred to as the "Health Insurance Tax") because:

> When the 2016 rates were approved, it was assumed that the HIT would be applicable to the BSC Flex Funded Plan due to the California Department of Managed Health Care (DMHC) filing as a fully insured plan. Blue Shield of California and the DMHC revisited the definition and as a result flex-funded plans are being treated as not fully insured by Blue Shield and DMHC and therefore were not required to pay the HIT, for 2016.[13]

However, HSS documents regarding the Flex Funded Plan show that it is a health care service plan clearly falling within the definition of taxable "health insurance" under the ACA tax regulations. Among the facts revealed by the documents are these:

Risk assumed by CPS. The Flex Funded Plan includes significant assumption of health insurance risk by CPS, according to a description of the Plan provided to the HSS by its benefits consultant, Aon Hewitt. One feature of the Plan is "maximum liability," which is described as follows: "The maximum liability caps the aggregated costs for HSS across membership for the entire year. This limits the potential for the HSS Trust Fund to have to absorb excessive loss experience. Any cost in excess of this cap is the responsibility of Blue Shield."[14] The cap was set at 125% of expected claims costs.[15]

In addition, the Plan includes a "Pooling Point: The threshold over which the insurer is at risk for a specific claim. It is $1,000,000 for flex-funded inpatient claims."[16] Notably, neither of these two risk mitigation features is referred to as stop loss insurance, which CPS is not licensed by the state to sell.[17]

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plans that it administers ("ASO"), reporting 820,769 at the end of 2015 on its 2015 Annual Statement and the same number at the end of the previous year on its 2016 Annual Statement.

[12] Financial Form Reporting Instructions, Report #4: Enrollment and Utilization Table (Ex. A-8)

[13] San Francisco Health Service System Memo, August 10, 2017, p.2. (Ex. A-10) Also see Aon Hewitt, "Blue Shield of California (BSC) Rate Stabilization Reserve Presentation," March 9, 2017 p. 3. (Ex. A-11)

[14] Aon Hewitt, "Blue Shield Claims Experience Presentation," March 13, 2014, p. 8. (Ex. A-12)

[15] Aon Hewitt, "Blue Shield HMO 2015 Plan Renewal," May 8, 2014, p.5. (Ex. A-13)

[16] "Blue Shield Claims Experience Presentation," March 13, 2014, p. 9. (Ex. A-12)

[17] CPS subsidiary Blue Shield of California Life and Health Insurance Company is licensed to sell such insurance, but no mention of the entity is made in any HSS documents describing the plan.

The Plan also provides for capitation, whereby medical groups under contract to CPS ("the Blue Shield HMO") are paid a fixed fee per enrollee to provide all specified medical services needed by enrollees.[18]

Contract for insurance. The Evidence of Coverage document, which is a summary of the health plan contract, describes the plan not as a self-funded plan administered by CPS, but rather as follows: "Notice About This Group Health Plan: Blue Shield makes this health plan available to Employees through a contract with the Employer."[19] The document also makes clear that it is CPS, and not HSS, that has authority to determine the benefits that Plan members are entitled to receive: "Blue Shield shall have the power and discretionary authority to construe and interpret the provisions of this Plan, to determine the Benefits of this Plan and determine eligibility to receive Benefits under this Plan."[20] The fact that the language cited above is identical to that used by CPS in the 2018 Evidence of Coverage documents it issued for its fully insured group health plans is further indication that the HSS Flex Funded Plan is an insurance product.[21]

Regulation by the DMHC. The Evidence of Coverage document makes clear that the Plan is subject to regulation by the DMHC as a health care service plan. Under the heading "Department of Managed Health Care Review," the document informs Plan members that "The California Department of Managed Health Care is responsible for regulating health care service plans."[22] The document goes on to describe how members can avail themselves of certain consumer protections, such as Independent Medical Review, that are available by law only to enrollees of health care service plans and not to self-funded plan members.[23]

State taxation. CPS intends in 2018 to continue treating the Flex Funded Plan as not subject to the ACA tax, yet it expects to pay an assessment for the Plan in connection with a new state tax on health plan enrollment, according to the proposed renewal for 2018.[24] The renewal proposal reports that CPS's charges would include zero dollars for the ACA tax and $2.22 per member per month for the new state tax, the Managed Care Organization Tax.[25] Under the statute imposing the state tax, only enrollment in "health care service plans" is taxed.[26]

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[18] Ibid., p. 2

[19] CPS, "Combined Evidence of Coverage and Disclosure Form," January 1, 2015, p. 1. (Ex. A-14) Note that the document refers to the Plan as "Access+ HMO." See Exhibit A16, p. 2, which shows that the Blue Shield Flex Funded Plan is an Access+ HMO plan.

[20] Ibid., 58.

[21] See the Evidence of Coverage documents for CPS' fully insurance large group plans, which are posted on the company's website at:
https://www.blueshieldca.com/bsca/bsc/public/employer/ListingDocuments?page=lgp

[22] Ibid., p. 61.

[23] See California Health and Safety Code § 1374.30 re eligibility for Independent Medical Review.

[24] See Exhibits A-15 and A-16, which contain the renewal presentation and Evidence of Coverage document for the Plan for 2018 and show that CPS has continued to treat the Plan as not subject to the ACA tax and that the Plan retains the essential features discussed earlier that render it a health care service plan.

[25] Aon Hewitt, "Blue Shield of California 2018 Flex Funded HMO Rates and Premium Contributions Presentation—Active Employees and Early Retirees," May 11, 2017, p. 23-24 (Ex. A-16).

[26] California Welfare and Institutions Code §14199.50 et seq.

While it is clear from the documents cited above that the Flex Funded Plan is a health care service plan, and thus subject to the ACA tax, it is important to note even if CPS had obtained an opinion from the DMHC about the nature of the Plan that somehow trumps the state's actual treatment of it, that determination was obtained in 2016 and the ACA taxes currently at issue relate to the Plan as it existed in 2015.[27]

It is also worth noting that others are treating this type of plan, which is typically called a "minimum premium plan" or "minimum premium funding arrangement," as subject to the ACA tax. For example, Warren County, New York, considered in 2017 that one advantage of a self-funded plan over a minimum premium plan was that the former would not be subject to the ACA tax while the latter would be.[28] Another New York governmental entity, the Webster Central School District, decided in 2017 to switch from a minimum premium funding arrangement to a self-funded plan primarily to "avoid the annual HIT (Health Insurer Tax-ACA driven)."[29]

No other major health insurer has reported to the IRS similar reductions in premiums.

A comparison of premiums reported to the IRS and CMS by each of the ten largest health insurers provides further indication that CPS has failed to full report premiums to the IRS. Among these insurers, CPS is the only one that has significantly decreased the premiums it has reported to the IRS relative to the total it has reported to CMS on its MLR statements. (Fig. 3)

Fig. 3: Premiums Reported to the IRS as a Percentage of Premiums Reported on MLR Statement – Ten Largest Insurers

	Premium/Data Year 2013	Premium/Data Year 2014	Premium/Data Year 2015	Pct. Point Change
UnitedHealthcare Insurance Co.*	79%	77%	73%	-6
Health Care Service Corp.	90%	88%	94%	+4
Humana Insurance Co.	98%	99%	98%	0
Aetna Life Insurance Co.	90%	89%	90%	0
Blue Cross of California	94%	93%	93%	-1
California Physicians Service	**97%**	**94%**	***71%***	***-28***
Blue Cross Blue Shield of FL	94%	93%	94%	0
UHC of California	100%	100%	100%	0
Excellus Health Plan, Inc.	99%	98%	99%	0
Blue Cross Blue Shield of MI	91%	89%	92%	+1
Methodology: IRS premium (CGM net premiums written, as reported on IRS website) divided by MLR premium (total of amounts on MLR report in Part 1 on line 1.1 in the "as of 12/31" columns).				
* UnitedHealthcare is a major provider of Medicare Supplement insurance, which is excluded from premiums reportable to the IRS for purposes of the ACA tax.				

[27] Since the ACA tax was suspended for fee year 2017/data year 2016, the amount CPS was reported to have charged, and then rebated, to HHS "for 2016" must have related to ACA fee year 2016/data year 2015.

[28] Jaeger & Flynn Associates presentation to Warren County, June 14, 2017, p. 4. (Ex. A-17)

[29] Webster Central School District, Memo from Brian Freeman to Carmen Gumina, September 9, 2017. (Ex. A-18)

CPS is also the only insurer among the top ten to report to CMS on its MLR statements a major increase in the proportion of its premiums coming from Other Health Business. (Fig. 4)

Fig. 4: Other Health Business as a Percentage of Total MLR Premiums

	2013	2014	2015
UnitedHealthcare Insurance Co.	23%	24%	28%
Health Care Service Corp.	9%	8%	8%
Humana Insurance Co.	2%	2%	3%
Aetna Life Insurance Co.	17%	15%	15%
Blue Cross of California	7%	7%	7%
California Physicians Service	**6%**	**4%**	***27%***
Blue Cross Blue Shield of FL	7%	7%	5%
UHC of California	0%	0%	0%
Excellus Health Plan, Inc.	2%	2%	2%
Blue Cross Blue Shield of MI	11%	10%	10%
Methodology: Other Health Business premium (amount in MLR reports in Part 1 on line 1.1 in the "Other Health Business" column) divided by MLR premium total (as calculated for Fig. 3).			

In addition, CPS is the only insurer among the ten largest that has reported on its MLR statements a major decrease in Large Group premiums compared to its total premiums. (Fig. 5)

Fig. 5: Large Group as a Percentage of Total MLR Premiums

	2013	2014	2015
UnitedHealthcare Insurance Co.	25%	25%	30%
Health Care Service Corp.	55%	49%	46%
Humana Insurance Co.	3%	2%	2%
Aetna Life Insurance Co.	33%	35%	38%
Blue Cross of California	63%	53%	51%
California Physicians Service	**75%**	**60%**	***33%***
Blue Cross Blue Shield of FL	53%	47%	45%
UHC of California	34%	34%	35%
Excellus Health Plan, Inc.	49%	46%	45%
Blue Cross Blue Shield of MI	45%	42%	42%
Methodology: Large Group premium (amount in MLR report in Part 1 on line 1.1 in the "Large Group Total as of 12/31" column) divided by MLR premium total (as calculated for Fig. 3).			

CPS underpaid the ACA tax in 2016 by $55.4 million by not fully reporting 2015 premiums on Form 8963.

As the evidence described above makes clear, the $3,092,632,841 in premiums CPS removed from its final 2016 Form 8963 should have been reported to the IRS because it was generated by coverage that was reported to and regulated by—and is currently taxed by—the state as health

care service plan business. The tax rate on CPS' 2015 premiums was 1.79%.[30] Hence, CPS underpaid the tax by $55,358,128 by not reporting these premiums on Form 8963.

II. Improper exclusion of Care 1st premiums

CPS also underpaid its ACA tax by failing to report premiums collected by its subsidiary, Care 1st Health Plan, resulting in a tax underpayment of $33.7 million. On Form 8963 filed in July 2016, CPS reported zero premiums for Care 1st. In its 2016 audited financial statement, CPS noted with respect to the ACA tax regulations:

> The regulation excludes certain non-profit insurers that derive 80% of their gross revenues from government programs targeted at low-income, elderly, or disabled populations. This exclusion is included in Section 9010(c)(2) of the Affordable Care Act. Our newly acquired subsidiary, Care 1st qualifies for exclusion for the entire 2016 fee year, for the portion of their business that falls under the California regulated entity.[31]

Care 1st, however, does not qualify for exclusion because CPS established Care 1st as a separate nonprofit corporation for a non-business purpose: to avoid paying the ACA tax on its revenues. As such, the corporate arrangement violates the economic substance/business purpose doctrine, and thus CPS is not entitled to any tax benefits that the arrangement would otherwise provide.

Care 1st also fails to qualify for exclusion because its corporate relationship with CPS provides for Care 1st's earnings to inure to the benefit of individuals in violation of CFR §57.2(b)(2)(iii)(B) and to be used for political campaigning in violation of CFR §57.2(b)(2)(iii)(D).

CPS structured Care 1st as it did for the purpose of tax avoidance.

CPS acquired Care 1st in October of 2015. CPS is a California mutual benefit nonprofit corporation, whose state tax exemption as a social welfare organization was revoked in 2014.[32] Care 1st, prior to the acquisition, was a private, for-profit California corporation. Its business consisted almost entirely of providing Medicare and Medicaid coverage in California and Arizona, with its business in Arizona transacted by its subsidiary, Care 1st AZ.

In carrying out the acquisition, CPS did not directly absorb Care 1st. Instead, it established a subsidiary holding company, which was incorporated as a California nonprofit mutual benefit corporation, and made Care 1st a subsidiary of that entity. It also converted Care 1st into a

[30] CPS reported on its 2016 Form 8963 net premiums of $10,965,613,011 for itself and all of its controlled group members. In its 2016 Audited Financial Statement, it reported paying $195,953,000 in ACA taxes 2016. Dividing the premium amount, less $37,500,000, by the fee amount equals $0.0179. See CPS' 2016 Audited Financial Statement, p. 41. (Ex. B-1)

[31] 2016 Audited Financial Statement for 2016, p. 15. (B-1)

[32] Los Angeles Times, "With billions in the bank, Blue Shield of California loses its state tax-exempt status," March 18, 2015.

nonprofit California mutual benefit corporation.[33]

According to information I learned while serving as Director of Public Policy for CPS, the [redacted].[34]

In May of 2015, following my resignation from CPS in March, I wrote a blog article alleging that CPS had structured the acquisition as it had in order to avoid the ACA tax and income taxes on Care 1st's business.[35] CPS acknowledged the truth of the allegation the following year in a court filing in support of its lawsuit against me alleging disclosures of company confidential information, including information in this blog article. In that filing, CPS stated that by publishing the article I had "disclosed privileged details regarding the company's strategy in the Care 1st acquisition."[36] More specifically, CPS declared, "Mr. Johnson disclosed information regarding the tax implications and strategy of how BSC legally structured the Care 1st acquisition..."[37]

The tax avoidance purpose behind the structuring of Care 1st as a separate nonprofit corporation is also evident in the fact that CPS does not operate its other subsidiaries as nonprofits. In addition to Care 1st, CPS has two active subsidiary companies, Blue Shield Life and Health Insurance Company and CareAmerica Life Insurance Company, neither of which is a nonprofit corporation.[38] Moreover, despite Care 1st's reincorporation as a nonprofit corporation, it has earned significantly higher profits since its conversion than it did before.[39]

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[33] However, CPS maintained the for-profit status of Care 1st's subsidiary, Care 1st of AZ, and in December 2016, sold the company. See 2016 Audited Financial Statement, pp. 9-10. (Ex. B-1)

[34] See Exhibit B-2.

[35] Michael Johnson, "Blue Shield structures acquisition to avoid taxes," May 25, 2015. (Ex. B-3) The article refers to publicly filed proposed bylaws for Care 1st that contained a provision limiting Care 1st's activities to those consistent with exemption as a 501(c)4 organization. (Ex. B-4) In subsequently filed proposed bylaws for Care 1st, CPS replaced that provision with one limiting Care 1st's activities to those consistent with exclusion under CFR §57.2(b)(2)(iii), relating to the ACA tax. (Ex. B-5)

[36] Blue Shield's Opposition to Defendant Michael Johnson's Special Motion to Strike, p. 3 (Ex. B-6)

[37] Declaration of Sarah E. Gettings, p. 2 (Ex. B-7) Note that "BSC" refers to Blue Shield of California.

[38] See the most recent status information for each company on file with the California Secretary of State, indicating its status as a domestic stock company. (Ex. B-8) An additional subsidiary company, GemCare Health Plan, whose business was recently folded into that of CPS, is also a domestic stock company. (Ex. B-8)

[39] Care 1st made net profits of 1.1% of revenues in 2014, the last full year prior to its conversion. See revenues and net income on Care1st Income Statement for 2014. (Ex. B-9) It made a profit of 7.1% in 2016, the first full year following the conversion. See revenues and net income on Blue Shield of California Income Statement for 2016. (Ex. B-10)

The establishment of Care 1st as a separate nonprofit corporation in order to avoid taxation violates the economic substance doctrine.

Under the economic substance doctrine, as clarified in 26 USC §7701(o), a transaction will be treated as having economic substance, and thus entitling the taxpayer to the tax benefits derived from the transaction, only if "the taxpayer has a substantial purpose (apart from Federal income tax effects) for entering into such transaction." Because CPS established Care 1st as a separate nonprofit corporation in order to avoid certain taxes rather than to achieve a business purpose, the transaction fails this test.

Care 1st also fails to qualify for exclusion because it violates the prohibition in CFR §57.2(b)(2)(iii)(B) against private inurement.

CPS has asserted to the DMHC that its legal duty as a nonprofit mutual benefit corporation is to operate for the benefit of its members rather than the public.[40] While CPS does not pay regular dividends to its members, it has established at least two ways that earnings, including those of Care 1st, could be distributed to CPS members.

One would be if Care 1st and CPS dissolved. The governing documents for the two corporate entries, and the holding company that sits between them, provide that upon dissolution of all three, any remaining assets would be kicked up to CPS and then distributed to CPS' members.[41] Moreover, CPS General Counsel Seth Jacobs has asserted to the DMHC that CPS, as a California nonprofit mutual benefit corporation, "may make distributions of gains, profits or dividends to any member (Cal. Corp. Code §7141), while such distributions are barred as 'private gain' and expressly prohibited under the Nonprofit Public Benefit Corporation Law (Cal. Corp. Code §5410)."[42]

Another way CPS has provided for Care 1st earnings to go to its members is through its corporate policy of distributing to its members earnings of its combined entities that exceed two percent of revenue.[43] CPS has not had earnings high enough to trigger a distribution since the acquisition, but it has promised the DMHC that when it does, Care 1st earnings will be included in the distribution. In testimony before the DMHC during the review of the Care 1st acquisition, CPS CEO Paul Markovich stated:

> … in the process of acquiring Care1st we will convert the company from for-profit to not-for-profit. Since we made the pledge to voluntarily cap our net income at 2% in 2011, we have given back $560 million to customers and the community. When we

[40] See letter of CPS General Counsel Seth Jacobs to California Department of Managed Health Care General Counsel Gabriel Revel, April 20, 2015, pp. 1-3. (Ex. B-11)
[41] See Articles of Incorporation of Care 1st, Article VII; Articles of Incorporation of Cumulus Holding Company Inc., Article IV; and CPS Bylaws, Ch. 12, Section 3. (Ex. B-12, B-13 & B-14)
[42] See letter of CPS General Counsel Seth Jacobs to California Department of Managed Health Care General Counsel Gabriel Revel, April 20, 2015, p. 2. (Ex. B-11)
[43] The earnings are distributed in the form of premium credits to CPS' members, who are also its customers. See CPS' description of the policy. (Ex. B-15)

convert Care1st to not-for-profit, their results will be included in the company-wide 2% pledge.[44]

Care 1st also fails to qualify for exclusion because it violates the prohibition in CFR §57.2(b)(2)(iii)(D) against participation in political campaigns.

CPS is a major contributor to California election campaigns and has continued to be one since its acquisition of Care 1st. In the 2015-2016 election cycle it contributed over $1 million to dozens of election campaigns.[45] Any distribution of Care 1st earnings to CPS would therefore constitute participation by Care 1st in political campaigning.

Since CPS reports on a consolidated basis, its financial statements do not reveal whether any Care 1st earnings have yet been transferred to CPS. However, the fact that Care 1st does not separately report its financial results, as well as CPS' promise to include Care 1st in its "company-wide 2% pledge," indicates that CPS intends to subsume Care 1st's earnings.

By improperly excluding Care1st premiums on Form 8963, CPS failed to report $1.9 billion in premium revenue, resulting in underpayment of the ACA tax by $33.7 million.

Care1st reported to the DMHC that in 2015 it collected $1,880,458,302 in premiums, excluding the premiums of its for-profit subsidiary, Care1st AZ.[46] Given CPS's ACA tax rate of 1.79% in 2016, the company underpaid the tax by $33,660,204 by not reporting these Care1st premiums.

[44] DMHC, In the Matter of Public Meeting on the Acquisition of Care1st Health Plan by Blue Shield of California, p. 23. (Ex. B-16)

[45] These are not PAC contributions, but rather direct contributions from the corporation. Political campaign expenditure data is available on the California Secretary of State website: http://cal-access.sos.ca.gov/Campaign/Committees/. Search using "Blue Shield of California."

[46] See Care1st Consolidated Income Statement for 2015, YTD tab, lines 4 & 5, California column. (Ex. B-17) Note that premium amounts reported on these lines, for both California and Arizona, are the same amounts used by the DMHC in calculating minimum reserve requirements. See Required Tangible Net Equity Calculation in Care1st Annual Financial Statement for 2015. (Ex. B-18)