

Calif. Blue Cross And Blue Shield May Pay Insurance Taxes

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Since their inception, California health care service plans have been considered not to be insurers for purposes of the state's 2.35 percent gross premium tax. Under a controversial ruling issued by the court of appeal, this could change.

On Sept. 25, the court of appeal held that a suit alleging that California's Blue Shield and Blue Cross plans — which are otherwise regulated as health care service plans — are insurers for purposes of the state's 2.35 percent gross premium tax, stated a claim for trial.[1] The court held that the test for whether a health care service plan is an insurer for purposes of the tax is whether “indemnifying” against future contingent medical expenses is a “significant financial proportion” of its business. The court said that allegations that California Physicians' Service, d/b/a Blue Shield of California (Blue Shield) and Blue Cross of California, d/b/a Anthem Blue Cross (Blue Cross) paid between 75 to 80 percent of member expenses under their preferred provider organization and health maintenance organization plans on a fee-for-service basis, rather than on a capitated basis, would be sufficient to find that they were predominantly providing “indemnity.”



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This dispute is far from over. The court of appeal's analysis can be criticized as failing to come to terms with the extent of California's dual health plan regulatory system, which has long treated health care service plans differently and not considered them to be insurers, even when they provide so-called indemnity coverage. It can be criticized for failing to understand that plans today frequently contract with providers under other financial models, such as shared risk contracts, that do not fit neatly into the capitation versus fee-for-service dichotomy. It also potentially fails to understand the impact of its decision on the health care industry in California. For nonself-insured commercial health benefit plans, the vast majority of California health plan enrollees are covered by plans regulated by the Department of Managed Health Care ("DMHC"), which do not currently pay the insurance premium tax.[2]

The Central Dispute: Are Fee-for-Service Products Subject to the Insurance Premium Tax?

The complaint in *Myers* seeks a writ of mandamus that the state collect premium tax from the defendant Blue plans. The premium tax is imposed by Article 13 Section 28 of the California Constitution on “each insurer doing business in this state.”[3] Both Blue Shield and Blue Cross are licensed as health care service plans, rather than insurers, and are regulated by the DMHC, rather than the Department of Insurance ("CDI").[4] Because they are not considered insurers under state law and do not operate under insurance

licenses, they do not pay premium taxes.

The plaintiff alleged that in its early years, Blue Shield contracted directly with providers to deliver services to members at set “capitated” rates, that is, a set per member per month payment. Blue Shield had no obligation to “indemnify” members for medical expenses; rather the risk fell entirely on the providers. According to the plaintiff, this changed when the Blue plans began selling PPO products that used an “indemnity structure” under which they contracted with providers to pay reduced fee-for-service rates, but retained the financial risk to pay for the members’ services. The plaintiff claimed that any policies, whether PPO or HMO products, where the Blues were on financial risk for subscribers’ medical costs, were “insurance indemnity policies” and subject to the premium tax.[5]

The trial court dismissed the suit on demurrer, primarily on the grounds that the Blues could not be regarded as insurers because they are health care service plans under the Knox-Keene Act and subject to a different regulatory scheme.[6]

The Parties' Positions

The plaintiff claimed that the California Constitution does not define the term “insurer,” but contended that the California Supreme Court had provided a definition. The plaintiff pointed to the 1968 case *Roddis v. California Mutual Assn.* in which the court had relied on a definition in Insurance Code Section 22, which provides that insurance is “a contract whereby one undertakes to indemnify another against a loss, damage or liability from a contingent or unknown event.” The *Roddis* court concluded that “where indemnity is a significant financial proportion of the business, the organization must be classified as an insurer.”[7]

The Blues responded that the term “insurer” actually is defined in the California Constitution to refer to “insurance companies” and is indicated in case law to refer to “insurers examined and regulated” by the CDI.[8] The Blues are not insurance companies, but “health care service plans” — a different category of entity specifically defined by the Legislature.[9] Health care service plans are subject to a host of regulations not required of insurers under the Insurance Code, such as to provide a minimum benefit package, establish provider networks and myriad other closely regulated operational requirements. They are also regulated by a different agency — the DMHC — and excluded by statute from regulation by the CDI.[10] The Blues contended that *Roddis* is not relevant because it was based on a regulatory scheme that was superseded 40 years ago by the enactment of the Knox-Keene Act.[11]

The Regulators Weigh In

The court of appeal received competing briefs from the regulators. The DMHC contended that the Legislature created two systems of regulation for health care coverage and that the DMHC has exclusive jurisdiction over health care service plans. Once an entity is licensed by the DMHC, it is not subject to the Insurance Code. Indemnity cannot be the dividing line between insurers and plans because the Knox-Keene Act provides that plans can offer indemnity products. The DMHC also argued that if the court of appeal found that health care service plans were subject to the premium tax, this might cause plans to seek licensure from the CDI instead of the DMHC. This would cause plan members to lose consumer protections imposed on health care service plans that are not required of insurers. The DMHC also pointed out that instead of paying the gross premiums tax, health plans can pay income tax as well as a state-imposed per member assessment that insurance companies do not pay.[12]

The CDI argued that the test for whether an entity must pay the premium tax is not who regulates it, but

whether it is engaged in the business of insurance. The term “insurance” is defined in the Insurance Code as a contract to provide indemnity. The Blue’s indemnity products are therefore subject to the premium tax, and “DMHC jurisdiction did not change their character from ‘insurance’ to something else.”[13] Responding to the DMHC, the CDI argued that its regulations ensure that insurance companies are solvent — “the backbone of consumer protection” and that “[o]f the two regulators, CDI is widely acknowledged to be stricter. ...” The CDI also contended that it “has been the pioneer in regulating specific aspects of health coverage.”[14]

The Court of Appeal’s Decision

For its decision, the court relied on Insurance Code Section 22, which defines insurance as an indemnity contract.[15] The court also relied heavily on *Roddis*. *Roddis* did not involve a premium tax issue. It concerned whether an unlicensed entity should have been licensed as an insurer or as a health plan under the former Knox-Mills Act. At the time of the *Roddis* decision, the Knox-Keene Act, which has regulated health plans since 1975, had not been enacted.

According to the *Myers* court, the *Roddis* court observed that the Knox-Mills Act (the law at the time) defined a health care service plan as an entity that “undertakes responsibility to provide, arrange for, pay for or *reimburse* any part of any health care service ... but the provision shall not apply to such a plan operated by an *insurer*...”[16] While the Knox-Mills Act did not define insurer or insurance, the *Roddis* court noted that “insurance necessarily involves the element of indemnity.” The Knox-Mills Act permitted a health care service plan to “reimburse” a member, which meant service plans could include some indemnity features. But it excluded “insurers,” which meant that there was some undefined limit on the extent of indemnity permissible.[17]

To determine the limit, the *Roddis* court focused on capital requirements. The court noted that while insurers were subject to capital requirements, the Knox-Mills Act did not impose them on health care service plans. It reasoned that when an entity issues indemnity contracts, its liability for future expenses is unknown, creating a need for capital reserves. It added, “[w]here indemnity features are present, the member bears the risk of personal liability for medical services. This is the insurance risk which can be protected against by financial reserves to assure that the member will receive the benefits for which he has paid.” Balancing the policy concerns of encouraging the development of service plans with the need to provide for member financial security, the *Roddis* court concluded that “where indemnity is a significant financial proportion of the business, the organization must be classified as an insurer.”[18]

The *Myers* court concluded that *Roddis* provided the right approach to determine when a plan is an insurer for purposes of the premium tax as well. While solvency concerns were technically the issue in *Roddis*, a similar rationale underlay the premium tax. Insurers were charged a premium tax rather than an income tax, because the contingent nature of their liabilities made it difficult to determine their net income. The court reasoned that under indemnity policies, the Blues collect premiums up front but do not make payments until a contingent medical event occurs, “so the underlying rationale for applying the gross premium tax to insurance companies applies equally” to them.[19]

The court noted that the complaint alleged that in 2012 Blue Shield paid \$1.7 billion in claims on a capitated basis and \$5.2 billion on a noncapitated basis; and that Blue Cross made \$7.2 billion in fee-for-service and \$1.8 billion in fixed fee payments on claims. Notably, these figures appear to include the Blues’ HMO and PPO business.[20] The court concluded that the alleged predominance of fee-for-service business was sufficient to state a claim that the Blues should be treated as “insurers” for the purpose of assessing the gross premium tax, and it remanded the case for further proceedings in the trial court.

Concerns Raised by *Myers* Decision

The *Myers* decision is based on debatable assumptions. California law exempts health care service plans from Insurance Code requirements, calling into question the relevance of Insurance Code definitions of insurance. The court assumes that PPO plans are “customarily characterized as health insurance plans and, as such, are subject to the oversight of the Department of Insurance.” But the Knox-Keene Act permits health care service plans to offer PPO-style products when approved by the DMHC and the Insurance Code expressly exempts products offered by DMHC-licensed health care service plans from regulation as insurance.[21] The test for “insurer” in *Roddis* is dated, because it was based on that court’s concern about the lack of reserve requirements for health care service plans in 1968. In 1975, California replaced the Knox-Mills Act with the Knox-Keene Act, which imposed reserve requirements on health plans as well as a host of other requirements.[22] The notion that fee-for-service provider contracts make it “very difficult” for plans to determine taxable income is also questionable. Health care service plans cover *services* provided during a plan year, not *events* where costs may not be determined for many years as in a general liability policy. Bills for fee-for-service claims should arrive shortly after services are provided — like other industries subject to income taxes.

The definition of “indemnity” in the *Myers* opinion is unclear, creating uncertainty as to how the court’s test for insurer would be applied. At some places, the court suggests that whenever a plan is not providing services *via* capitation but is at risk for a member’s services, then it is providing indemnity. In other places, it states that indemnity requires that the member have “personal liability” for medical services and that an indemnity plan “reimburses” a member for the cost of his medical services.[23] But the Knox-Keene Act provides that plan members cannot have personal liability for contracted (in-network) services, regardless of whether the plan’s contract with a provider is on a capitated or fee-for-service basis.[24] And under the *Prospect Medical Group v. Northridge Emergency Medical Group* decision, a plan member also has no personal liability for non-contracted emergency services.[25]

The *Myers* decision only considers two structures for payer-provider contracts: capitation versus fee-for-service. But the modern world of payer-provider contracting is far more complex. Contracts frequently feature other models of risk sharing. For example, many plans and providers are part of accountable care organizations in which risks are shared *via* pooling arrangements. It is unclear how the *Myers* holding would be applied to these or other forms of shared risk contracts.

Conclusion

There is still a ways to go before the impact of the *Myers* decision becomes clear. But it bears watching because of the effect it could have on health care service plan tax obligations.

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[1] *Myers v. State Board of Equalization*, Court of Appeal, State of California, Second Appellate Dist., Div. 2, No. B255455 (Cal. Ct. App., Sept. 25, 2015) (hereafter, “Opinion”).

[2] Katherine Wilson, Enrollment in Individual Health Plans Up 47 percent in 2014, California Healthcare Foundation (May 20, 2015 (available at <http://www.chcf.org/articles/2015/05/enrollment-individual-up>) (visited Oct. 6, 2015) (“as of 2014, DMHC now regulates the largest portion of enrollment in all three commercial markets, with 82 percent of the individual market, 77 percent of the small-group market, and 91 percent of the large-group market”).

[3] The relevant portions of Cal. Const., Article 13 § 28 state as follows:

“(a) “Insurer,” as used in this section, includes insurance companies or associations and reciprocal or interinsurance exchanges together with their corporate or other attorneys in fact considered as a single unit, and the State Compensation Insurance Fund. As used in this paragraph, “companies” includes persons, partnerships, joint stock associations, companies and corporations.

(b) An annual tax is hereby imposed on each insurer doing business in this state on the base, at the rates, and subject to the deductions from the tax hereinafter specified.

...

(d) The rate of the tax to be applied to the basis of the annual tax in respect to each year is 2.35 percent.

(f) The tax imposed on insurers by this section is in lieu of all other taxes and licenses, state, county, and municipal, upon such insurers and their property, except: ... [listing exceptions].”

These provisions are largely repeated at Cal. Rev & Tax Code §§ 12201, 12202, 12204.

[4] Both Blue Cross and Blue Shield have separately licensed insurance company affiliates that are subject to the insurance premium tax.

[5] Appellant’s Opening Brief at 3.

[6] Opinion at 3. The trial court also based its dismissal on the grounds that the suit was barred by res judicata and that the plaintiff lacked standing. *Id.* While not examined in this article, these grounds could be critical for a future appeal.

[7] *Roddis v. California Mutual Assn*, 68 Cal.2d 677 (1968). See Appellant’s Opening Brief at 34-35.

[8] Brief of Respondent California Physician Service d/b/a Blue Shield of California (“Blue Shield Respondent’s Brief”) at 28 (citing Cal Const., art XIII, § 28a; Blue Cross of California doing business as Anthem Blue Cross Respondent’s Brief (“Blue Cross Respondent’s Brief”) at 19 (citing same and *Silvers v. State Board of Equalization* (2010) 188 Cal.App.4th 1215).

[9] Blue Shield Respondent’s Brief at 28-20 (citing Health & Safety Code § 1345(f)).

[10] Blue Cross Respondent’s Brief at 19 (citing Ins. Code §§ 740(g) and 742(g) and Health & Safety Code § 1346.5).

[11] *Id.* at 22; see California Health & Saf. Code § 1340 *et seq.*

[12] *Amicus Curiae* Brief of DMHC.

[13] Brief of Respondent/Defendant Dave Jones, Insurance Commissioner of the State of California (citing Ins. Code §§ 23, 23).

[14] *Amicus Curiae* Brief, California Department of Insurance.

[15] Opinion at 17.

[16] The current statute retains much of this language. See Health & Safety Code §§ 1345(f); 1349.

[17] Opinion at 19.

[18] *Id.* at 18-20. See *Roddis*, 68 Cal.2d at 680 (noting that under the Knox-Mills Act, “[n]o provisions exist to assure financial responsibility”).

[19] Opinion at 14, 21.

[20] See *id.* at 6, 8. This holding shows how out-of-step the *Myers* decision is with long-standing regulation of health plans in California.

[21] See, e.g., Health & Safe. Code § 1374.72(g); 1375.7(b)(1)(B); Ins. Code 742(b).

[22] Health & Safety Code §§ 1374.64; 1377; 28 CCR § 1300.76. Health care service plans must maintain loss reserves as well as “tangible net equity” (TNE), and are subject to financial oversight by the DMHC.

[23] Opinion at 17, 19.

[24] Health & Safety Code § 1379.

[25] *Prospect Medical Group Inc., v. Northridge Emergency Medical Group*, 45 Cal.4th 497 (2009).