CHAPTER 3

Blue Plans: Playing the Blues No More

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Introduction

The "Blues" are not just any health plan. Taken together, local member companies of the Blue Cross and Blue Shield Association (BCBSA) have insured millions of Americans for nearly three quarters of a century. Throughout their history, they have been witness to and played a role in countless changes in the healthcare system. Today, 46 Plans provide healthcare coverage to 79 million people or one in four Americans, making them the largest private payer in the U.S. (BCBSA 2001). Their collective enrollment in government insurance programs and their share of Medicare claims processing far surpasses any other plan (BCBSA 2001). Their combined enrollment in HMO products makes them the largest provider of such products in the United States (InterStudy 2000). As Rosemary Stevens wrote in her foreword to *The Blues: A History of the Blue Cross and Blue Shield System* (Cunningham and Cunningham 1997): "One cannot understand the peculiar, constantly evolving, even Byzantine challenges of health care organization and financing in the United States in the twentieth century without also understanding the role, the changes, and the

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continuing dilemmas of the Blue Cross and Blue Shield Plans, past and present."

These Plans have played a unique and central role in local communities. Amid an environment of rapidly rising costs and little insurance coverage, the Blues entered an arena where commercial insurance companies had been reluctant to go, establishing themselves as the first prepaid health insurance plans over 70 years ago. Each individual Plan developed locally and independently, with local representation on its board of directors. A defining characteristic of these early Plans and their leaders was their commitment to community service and the provision of public benefit. As a consequence, the Plans operated on a not-for-profit basis, accepted all persons who desired insurance coverage, and used community rating to set uniform premiums without regard for individual enrollee health status or risk factors. Local accountability and community mission were indeed a hallmark of the early Plans.

The early Blues also enjoyed advantages from a number of other defining characteristics. In return for the public benefit they provided, they were subject to special regulatory treatment, which provided tax benefits and other advantages. Also, they had close ties to providers, rooted in their origins as provider-sponsored organizations, which yielded broad networks and provider discounts. Finally, each Plan benefited from the exclusive use of the Blue Cross and Blue Shield trademarks in their designated service area, eliminating competition from other Blue Plans. The Blues were able to leverage their early presence along with these unique conditions to develop the value of their brand name and to gain and maintain a dominant position in local markets (Frech 1996).

Despite the dominance they achieved, the Blues have never been immune to the pressures of a changing operating environment. While they have struggled with and responded successfully to pressures from regulators, purchasers, and competitors over their long history, the process of change and adaptation has made them less distinct from their competitors over time (Cunningham and Cunningham 1997; Brown 1997). In particular, adaptation has led to a diminishing of their community mission and public-benefit role. For example, in the 1950s, under competitive pressure from commercial insurers, many Plans abandoned community rating—a hallmark of their community focus—and switched to experience rating when setting premiums for group business.

The developments in healthcare organization and financing of the past 15-20 years have posed new challenges for the Blues and have diminished their dominance in many markets. There has been rapid growth in employers' dependence on managed care and the rise of national for-profit managed care companies, increasing reliance on self-insurance among

employers, and greater demand by national employers for multistate accounts. At times, the Blues have been slow to respond to these pressures or have made serious missteps, with many Plans losing significant local market share (Cunningham and Cunningham 1997). For example, during the late 1980s and early 1990s, some Plans suffered serious financial problems and several high-profile management mishaps occurred (U.S. GAO 1994). Critics continue to question the Blues' ability to compete effectively in a managed care environment despite the benefits of still substantial market share, a strong brand name, and longstanding relationships with providers (Friedman 1998).

While much has been written about the Blues throughout this period, few systematic studies about them in the era of managed care exist (Cunningham and Cunningham 1997; Friedman 1998; Cain Brothers 1997). This chapter presents our analysis, which seeks to fill this gap in the literature. It uses data from HSC's 1998-1999 CTS site visits to explore how the Blues are positioned to compete in today's healthcare market and their strategic responses to current pressures. Given the importance of their role in the market, we also examine the implications of their market position and strategies for consumers and policymakers. In particular, we consider the extent to which the current strategies of the Blues could lead to erosion of the benefits they provide to consumers at the local level, and whether or not policymakers should be concerned.

This chapter describes the study design and the 14 Blue Cross and Blue Shield Plans included in the study sample; reports on the market pressures facing Blue Plans as they compete in today's market; explores the ways in which the Blues continue to be uniquely positioned in the market relative to their competitors—large market share, broad networks and product array, longevity in local markets, membership in the BCBSA, and regulatory treatment; and assesses how these characteristics affect their relationships with providers and purchasers. In addition, it discusses the strategies being pursued by the Blues. Two strategic responses to market pressures have potential implications for consumers: (1) decisions about whether to cover hard-to-insure populations and (2) mergers and related for-profit conversions. It concludes with a discussion of the potential costs and benefits of the Blues' strategies for consumers in local communities and implications for public policy.

Study Design

This chapter is based on interviews completed during the second round of CTS site visits to 12 communities or study sites, which were conducted between June 1998 and February 1999.

Sample of Blue Plans

This analysis focuses on all 14 of the Blue Cross and Blue Shield Plans operating in the 12 CTS study sites (see Table 3.1 for a complete listing). In two sites, Orange County and Seattle, the Blue Cross Plan and the Blue Shield Plan remain separate organizations and actively compete against each other.

A strength of this study is that the sample of nationally representative health insurance markets allows for a systematic examination of Blue Plans located across the country. The 14 Plans represent a quarter of the 53 Plans that were members of the BCBSA at the end of 1998. The study Plans are in states that are equally divided among the four Census regions: Northeast, South, Midwest, and West. At the time of the site visits, there were 13 Plans that acted on a not-for-profit basis, eight of which were organized as non-profit entities under special enabling statutes and the other five as mutual companies. (Throughout the rest of this chapter, the term "not-for-profit" will be used to refer to both nonprofit and mutual companies) . One Plan, Blue Cross of California, operated as a for-profit company and was owned by the publicly traded WellPoint Health Networks, Inc. Three Plans had wholly owned for-profit HMO subsidiaries. Six of the 14 Plans were subsidiaries of parent companies that also operate subsidiaries in other service areas. The most well known of these parent companies are Anthem, Inc., which is the parent to two plans in this sample (Anthem BCBS of Indiana and Anthem BCBS of Ohio) and the aforementioned WellPoint. The Plans are also differentiated by number of enrollees, which ranged from around 670,000 in Blue Cross and Blue Shield of Central New York to 4.7 million in Blue Cross of California at the time of the site visits.

Data Collection

Information on the 14 Plans was gathered through interviews with 33 Blue Plan respondents. In eight of the 12 study sites, a minimum of three Blue Plan respondents were interviewed in each site; in the remaining four sites, either one or two respondents were interviewed. Respondents usually included a senior executive such as the CEO; a marketing executive; and, when possible, a medical director and/or network executive. In each market, other key players were interviewed to provide triangulation on the responses of Blue Plan respondents. A total of 95 "vantage" interviews were conducted, with an average of eight interviews per site. Vantage respondents included competing plans, hospitals, physician organizations, employers, and in five sites, state insurance regulators. Several interviews with

Table 3.1: Corporate Organization of Blue Cross and Blue Shield Plans in 12 Study Sites

Study Site	*Blue Cross and Blue Shield Plan*	*Corporate Parent*	*Profit Status of Parent*	*Service Area of Corporate Parent**
Boston	Blue Cross and Blue Shield of Massachusetts		Nonprofit	State
Cleveland	Anthem Blue Cross and Blue Shield of Ohio	Anthem, Inc.	Mutual	Multiple regions
Greenville	Blue Cross and Blue Shield of South Carolina		Mutual	State
Indianapolis	Anthem Blue Cross and Blue Shield of Indiana	Anthem, Inc.	Mutual	Multiple regions
Lansing	Blue Cross and Blue Shield of Michigan		Nonprofit	State
Little Rock	Arkansas Blue Cross Blue Shield		Mutual (For-profit HMO subsidiary)	State
Miami	Blue Cross and Blue Shield of Florida		Mutual	State
Northern New Jersey	Horizon Blue Cross and Blue Shield of New Jersey		Nonprofit (For-profit HMO subsidiary)	State
Orange County	Blue Cross of California	WellPoint Health Networks, Inc.	Publicly offered for-profit	Multiple regions
	Blue Shield of California		Nonprofit	State
Phoenix	Blue Cross and Blue Shield of Arizona		Nonprofit	State
Seattle	Premera Blue Cross	Premera Blue Cross	Nonprofit	Single region
	Regence Blue Shield	The Regence Group	Nonprofit	Single region
Syracuse	Blue Cross and Blue Shield of Central New York	Excellus, Inc.	Nonprofit (For-profit HMO subsidiary)	Within state

* Represents the corporate parent's service area for health insurance products sold under the BCBS trademark.

recognized experts also were done, including individuals affiliated with the BCBSA who provided a national perspective on Blue Plans.

To assess the role of Blue Plans in local markets, respondents were asked to comment on:

1. the current market position of the Blue Plan(s);
2. the pressures that were driving change among the Plans;
3. the advantages and disadvantages the Plans had in responding to these pressures; and
4. the competitive strategies being pursued by the Plans.

Although all of the Plans had service areas that were larger than the local CTS study site, respondents were asked to frame their answers in the context of the local market.

Several additional sources of data helped in this study. Findings from the first and second rounds of the CTS site visits provide an understanding of the competitive environments in each of the 12 study sites (Grossman 2000; Kohn 2000; Lesser and Ginsburg 2000; Kohn et al. 1997; Center for Studying Health System Change 1999). Background information on the Plans, such as corporate structure and product characteristics, was obtained from each Plan directly and/or through secondary sources. Baseline information was also available from the first round of interviews with the study plans. To allow for additional triangulation on the findings, trade publications were monitored throughout the study period for news about Blue Plans across the country.

Pressures Facing the Blues

The Blues' competitive strategies—including decisions about which products to offer, provider contracting strategies, and whether to merge with other plans—are affected by a number of important market and firm-specific factors (Grossman 2000). Market factors include purchaser demands, regulatory pressures, and the structure of the local health insurance market. Factors internal to Blue Plans include BCBSA rules, organizational culture, financial position, and access to capital. This section explores the most acute pressures facing the Blues in today's market.

General Market Pressures Facing Health Plans

In today's healthcare market, health plans, including the Blues, are facing a number of significant external pressures (Grossman 2000; Lesser and Ginsburg 2000). Over the past five years or so, there has been increasing

purchaser demand for broad networks and less-restrictive managed care products, part of a broader documented managed care backlash, as well as more demand by multisite employers for broad geographic coverage. Greater competition has also surfaced from other health plans—particularly national managed care companies—that threaten to enter markets and take away market share from the Blues and other local plans. Finally, more recently, because underlying health care costs were increasing more rapidly than premiums over the past several years, all health plans have been feeling a squeeze on margins, and the Blues are no exception. This has meant more disciplined pricing and more targeted entry and exit of business lines than during the prior several years, when plans were focused on expanding market share rather than protecting margins. Blue Plan respondents confirmed that these pressures were affecting the Blues' strategic decision making at the time of the study.

Changes in the Regulation of the Blues and BCBSA Operating Rules

Traditionally, the Blues enjoyed favorable regulatory treatment in return for providing public benefit, although the degree of both regulation and public benefit varied significantly by state. To some extent, this variation was related to whether Plans were structured as nonprofits under special enabling statutes or as mutual companies, which tend to be regulated more like commercial insurance companies and have fewer benefits or obligations. All Blue Plans benefited from special federal and state tax treatment, and some received mandated provider discounts in states with hospital-rate regulation. In return, the Blue Plans frequently served as "insurer-of-last-resort" (i.e., covering all applicants regardless of health status) or sometimes applied community rating to the full population (i.e., basing premiums on the average expected costs of the entire risk pool). Other related regulations existed to ensure access and affordability, such as requirements for open enrollment, premium regulation for some or all products, and restrictions on the level of plan reserves.

The regulatory playing field, however, has been evolving toward a more level one for quite some time. In 1986, the Blues lost the right to a full exemption from federal income taxes; however, they can still receive a partial deduction under certain conditions (Forgione 1999). In addition, a number of Blue Plan respondents indicated that the insurer-of-last-resort requirements for their Plan—a fundamental way in which many of the Blues fulfilled their community service—were removed in the 1980s or earlier. As of 1991, only four study Plans were still subject to differential regulation in the individual and/or small group markets (U.S. GAO 1994). These regulations included open enrollment and partial or pure community

rating. All of these Plans, with the exception of BCBS of Michigan, noted that the requirements specific to the Blues were replaced by state individual and small-group market insurance reforms in the early 1990s, which required all health plans to participate in ensuring access to coverage.

Some fundamental changes at the BCBSA have also occurred, which dramatically affect the way the Blues operate. In 1991, the BCBSA tightened its financial oversight of member Plans and revised its minimum surplus requirements, partially in response to the insolvency of the West Virginia Blue Plan (U.S. GAO 1994). Then, in 1994, the BCBSA took the unprecedented step of allowing investor ownership of Blue Plans, ending its longstanding requirement that each plan must act on a not-for-profit basis (Cunningham and Cunningham 1997). Prior to 1994, the BCBSA had stipulated that the corporate parents of member Plans operate on a not-for-profit basis, whether structured as a nonprofit or a mutual company (U.S. GAO 1994). For-profit subsidiaries, however, were allowed.

What It Means To Be "Blue" Today

Data from this study indicate that Blue Plans in the United States are well positioned, in terms of market share and product mix, to confront the pressures of today's market and a changing operating environment. These and other characteristics that have traditionally differentiated the Blues from their competitors continue to benefit them today, although certain characteristics, in some respects, are also weaknesses that continue to challenge each Plan.

Characteristics of the Blues

Large market share. Most Plans continue to maintain a strong position in local markets. Looking across all products, market respondents consider the Blues to be the dominant health plan with the largest market share in seven of our 12 study sites (see Table 3.2). Of these seven Plans, those that operate in Lansing, Little Rock, Syracuse, and Greenville stand out as having almost complete dominance in their markets with few competitors close in size; the first two Plans each have market shares of at least 50 percent in the states they cover. The Plans in Indianapolis, Northern New Jersey, and Seattle have the largest overall share in their markets, but they face more substantial competition from other health plans.

In the remaining five sites, the Blues are not the largest health plan but are still major competitors with significant market share. In most cases, in these sites, a number of health plans, including the Blues, have near-equal market share and jockey for the top slot. Only two study Plans are

Table 3.2: Market Position of Blue Cross and Blue Shield Plans in 12 Study Sites

Overall Market Position of Blue Plans	*Local versus National Competitors*	*Overall Market Concentration (all health insurance products)*	*HMO Penetration**	*Blues' HMO Market Position*
Markets where the Blues are dominant *in terms of overall market position*				
Greenville	Mixed	Concentrated	Low	Leader
Indianapolis	Local	Concentrated	Low	Distant competitor
Lansing	Local	Concentrated	High	Close competitor
Little Rock	Mixed	Concentrated	Low	Leader
Northern New Jersey	National	Fragmented	Low	Close competitor
Seattle	Local	Concentrated	Low	Close competitor
Syracuse	Local	Concentrated	Low	Close competitor
Markets where the Blues are major competitors *in terms of overall market position*				
Boston	Local	Concentrated	High	Close competitor
Cleveland	Mixed	Concentrated	Low	Distant competitor
Miami	National	Fragmented	High	Close competitor
Orange County	National	Fragmented	High	Distant competitor
Phoenix	National	Fragmented	High	Distant competitor

Note: Blues' overall market position, HMO market position, and local versus national competitors based on CTS site visit interviews. Overall concentration determined using CTS Health Insurance Followback Survey and site visit data. HMO penetration based on estimates as of January 1, 1999 from The InterStudy County Surveyor.

* Above or below the mean for U.S. metropolitan areas with populations over 200,000.

significantly smaller than the other major competitors in the market. Blue Shield of California lags behind other plans in Orange County, including Blue Cross of California. Anthem BCBS of Ohio is unique because only in 1997 did it acquire the license to cover Cleveland as a Blue Plan. The BCBSA took the license away from the plan that still dominates that market—Medical Mutual of Ohio.

While the Blues typically offer a wide range of products, their strong overall market position in all sites can be attributed to their dominance in the PPO and indemnity product markets. They are much less likely to be the leading provider of HMO products. This means that the Blues are more likely to be dominant in those sites with lower-than-average HMO penetration than in those sites with higher-than-average HMO penetration.

Broad networks, wide product array, and longevity in the market. In almost every site, respondents indicated that the Blues have the broadest networks among all competing health plans. These broad networks serve as platforms that allow the Blues to offer a broad range of products including indemnity, PPO, HMO, and POS products. Respondents viewed this in contrast to many managed care companies that specialize in a single product line and then fill out their product array to satisfy large purchasers. Also, in all markets studied, the Blues have typically been in operation much longer than most other health plans. Therefore, the history of each local market is inextricably intertwined with the history of the Blue Plan or Plans that currently operate there.

BCBSA membership. Members are independent plans that are affiliated through the BCBSA. BCBSA provides services to those member Plans but does not act as a corporate parent; Plan interests are represented on the BCBSA board of directors and decisions are made by member vote. The association itself does not sell insurance. Through licensing agreements administered by the BCBSA, each Plan enjoys the right to use the Blue Cross and Blue Shield brand names and trademarks to distinguish themselves from their competitors. The licensing agreements offer each Plan an exclusive service area to sell branded products, ruling out competition among Blue Plans for branded products. BCBSA provides a number of services that help coordinate member Plans' coverage of enrollees across the country. For example, it administers the Federal Employees Health Benefits Program and the popular Blue Card program, which provides traveling enrollees with access to a nationwide network, and it helps service multistate employers who want a single contract across geographic areas (U.S. GAO 1994).

Minor regulatory differences. Because of the changes in the regulatory environment facing the Blues, respondents in this study perceived that differential regulation is no longer a distinguishing characteristic of most Blue Plans. Some Plans reported that they continue to be subject to differential regulation, including favorable tax treatment and regulatory burdens such as rate review, but most did not view these regulations as having a substantial impact, either positive or negative, on their ability to compete. Generally, regulations that are unique to the Blues are much less extensive today than the kind of regulation they have faced in the past. Often, Plans are

subject to them because they are nonprofits, mutual companies, or are domiciled in state, rather than because they are Blue.

In the 12 study sites, only one Plan, BCBS of Michigan, is still being regulated as a "quasi-public utility." It is the only Plan in the study that is still required to be the insurer-of-last-resort. The state of Michigan also remains quite active in regulating many other aspects of its operations, including control of the membership of the Plan's board of directors: State law specifies all the interests that must be represented and who has a say in selecting the members.

The Advantages and Disadvantages of Being "Blue"

Relationships with providers. Respondents in all but two sites noted that the Blues' large market share gives them considerable market clout with providers. Even the Blues that are not dominant have significant leverage in setting payment rates. Perhaps the phrase used most often by respondents to describe the Blues was the "800-pound gorilla" in the market. Most providers—hospitals and physicians—participate in the Blues networks, and many get significant volume from Blues contracts. One national observer pointed out that the Blues benefit from contracts that give them discounts across all of their products. Historically, many Blue Plans had explicit "most-favored-nation" clauses in their provider contracts, which guaranteed them the lowest payment rates in the market. At least four study Plans still have such clauses, but the terms may be enforced only periodically. For example, BCBS of Central New York exercised the clause when a local HMO negotiated lower rates with physicians. Similarly, BCBS of South Carolina exercised the clause when a national for-profit HMO got lower rates.

Respondents did not report uniformly that all Blue Plans pay the lowest price in the market. Respondents in some markets indicated that, despite their clout, the Blues appear willing to pay more than other health plans that are demanding what providers perceive to be unreasonably low rates. Alternatively, Blue Plans may find that responding regularly to situations where lower rates are offered to other plans is not worth the effort, particularly if those plans have small market share and are not perceived as a threat, as suggested with the only periodic enforcement of the most-favored-nation clauses.

Suggestions were made that the Blues' relative advantages with providers are eroding. A few respondents at competing health plans, as well as national observers, noted that other managed care plans are increasingly successful at cutting into the leverage the Blues have over providers. In Northern New Jersey, for example, the increase in Aetna U.S. Healthcare's

market share as a result of mergers with Prudential and NYLCare is seen as giving that plan the type of clout with providers that Horizon BCBS of New Jersey has enjoyed.

One downside of large market share, particularly in combination with broad networks, is that it makes the Blues a visible target for those unhappy with them, including providers. Given the large number of providers in the Blues' networks, they are more likely to resist or publicly complain about the Blues' efforts to impose rate cuts, even in markets where relationships with providers are relatively friendly. Across a number of markets, when periodic adjustments in the physician fee schedule result in rate cuts, they are regularly met with well-publicized outcry. However, because of the importance of the Blues products, physicians generally do not leave the network, although in some of the 12 study sites, stories have been circulating more recently about hospitals and physician groups threatening to terminate contracts with the Blues as well as with other plans. On some occasions, the Blues are responsive to provider concerns. For example, in Little Rock, complaints from doctors several years ago about the inadequacy of clinical data and payment delays caused Arkansas BCBS to quickly abandon a new payment initiative based on quality measures.

National observers noted that providers are also more likely to resist attempts by the Blues to pursue managed care initiatives that result in restricted networks of providers—for example, those that feature low-cost or high-quality providers. Unlike new entrants that can form narrow managed care networks from the start, the Blues have to *deselect* providers in order to create such networks. As in the case of the Blues' market share, this raises the potential for provider resistance and a general souring of relationships. Even trimming the network at the margin can elicit bad press, as was the case with one Blue Plan that canceled contracts with a small number of physicians who had high utilization.

Relationships with purchasers and consumers. The characteristics associated with being "Blue" work to the Plans' advantage in their relationships with purchasers and consumers. The Blues offer purchasers and consumers attractive features, including provider and product choice, access to a valued brand name and national network, and stability. But, as with provider relationships, some of the characteristics that give the Blues their identity work against them, particularly with respect to their ability to change and to innovate.

On balance, the Blues appear to be well positioned, with their broad networks and related availability of PPO and POS products, to offer choice to purchasers and consumers in response to the managed care backlash. While some critics have suggested that the Blues were slow to respond to

managed care, the national observers interviewed for this study argued that this has worked to the advantage of the Blues, relative to other managed care companies, as consumer demand has shifted toward less-restrictive managed care products.

As independent local plans, Blue Plan respondents particularly value the BCBSA services that enable them to provide multisite employers and traveling enrollees with access to a nationwide network. While respondents report that the network is not seamless, the Plans and their customers get the benefit of substantial provider discounts in other Plans' markets and central claims processing for national accounts. However, BCBSA does not offer the benefits of standardized national products as do some national managed care companies, with the exception of the Federal Employees Health Benefit product. Regardless of the shortcomings, the respondents thought they have a competitive edge over many national plans because the Blues have coverage in most markets across the United States with sufficient market share to get good discounts.

While these services are important, Plans' number one benefit from BCBSA membership is the local monopoly on use of the trademarks, which was viewed by a number of Plans as their most important asset. Blues respondents widely quoted a marketing study done by the BCBSA that stated that the cross and shield symbols are two of the most widely recognized trademarks in the United States. The Blues believe the trademarks are generally perceived to be associated with good coverage, security, and stability. Several Plans in the study that had stripped "Blue" from their product names have reclaimed it, citing the wide recognition and positive association the name has.

In contrast to the perspectives of most Blue Plan respondents that the trademarks are valuable assets today, vantage respondents across and within each market were more mixed in their assessment of the trademarks' value. In particular, many vantage respondents felt the value of the trademarks across all market segments has been diminishing over time. They did agree with the Blue Plan respondents that the brand names continue to help business in certain traditional segments such as the markets for seniors, individuals, travelers, and unions, but they contended that those lines of business are not profitable in all states. In general, contrary to the claim of respondents at three Blue Plans that purchasers are willing to pay a premium for the trademarks, vantage respondents and national observers suggested that only when the Blues price at market do the trademarks give them an advantage over their competitors.

Respondents reported that the reputation of the brands, along with longevity in local markets, makes the Blues stand out as "stable" and "secure" amid much organizational turnover. Respondents did not expect

local Blue Plans to exit the market or be acquired. This stability is an attractive quality to many purchasers who want to ensure the financial viability of their carrier and minimize fallout from administrative and network upheavals. In quite a few sites, the Blues also benefit from the strong preferences of providers and purchasers for local ownership of healthcare organizations, which has restricted the ability of other plans to gain a foothold in the market (Grossman 2000).

While the Blues appear well positioned with respect to purchaser demands, the evidence from this study suggests that this is more a reflection of their legacy—particularly their close relationships with providers and their reluctance to fully embrace restrictive managed care products—than of innovative behavior. In fact, few vantage respondents in any market considered the Blues to be innovative. This is largely tied to their longevity in the market and not-for-profit culture, together with the strong market position they continue to enjoy. The Blues were frequently criticized for being "slow to move," "complacent," and "bureaucratic." In addition, vantage respondents considered them to be "old fashioned" and "behind the times" compared to for-profit managed care companies. One Blue Plan respondent joked that his Plan still worked hard to make sure they never refused a claim, highlighting the tension between indemnity and managed care cultures. Therefore, the common perception that the Blues are an "800-pound gorilla" was not only a reflection of their clout with providers but also a reflection of their unresponsiveness to purchaser demands—for example, to customize products or improve customer service. In a few markets, however, the Blues were praised for being timelier in processing claims and provider payments than were other plans.

Despite the general picture of the Blues as non-innovators, respondents in four markets volunteered specific examples of new products, showing that the Blues can sometimes be innovative. In each case, the Blue Plan was the first to introduce a less-restrictive managed care product in the market, ranging from an open access HMO to a PPO with preventive care benefits. From a national perspective, these products were not new; however, from the perspective of local respondents, the Blues were clearly doing something that had not been done previously in the market, and the Plans and consumers benefited from these introductions.

Strategic Responses of the Blues

Although the Blues continue to be differentiated from their competitors in ways that are beneficial to them and appealing to consumers, they are implementing strategies in response to current market pressures that are

diminishing some of the unique benefits they have traditionally provided to consumers. With most Blue Plans no longer subject to regulatory requirements that require them to take hard-to-insure enrollees, their large market share means that they find themselves balancing the demands of being a good corporate citizen against the pressures to enhance margins. Likewise, in the face of increased competition, the Blues are engaging in a significant amount of consolidation and conversion activity that could diminish their local focus and not-for-profit status.

Balancing Profit Margins with Corporate Citizenry

Although most Blue Plans are no longer subject to unique regulatory requirements, Plan respondents felt that the public and regulators still have an *expectation* that the Blues serve the community in ways other plans are not expected to, albeit in more informal and ad hoc ways than in the past. For many Blue Plan respondents, this regulatory legacy is closely linked to the obligation they feel to serve as a good corporate citizen, given their large market share and significant role in the local economy. For those Blue Plans that serve less densely populated areas, the local representation on the Plan's board of directors heightens this pressure. Many Plans were acting to fulfill these expectations by funding local public-health efforts, community events, and civic organizations.

While Blue Plan respondents generally felt it is important to respond to the community's expectations, and, in some cases, it is in fact "good for business" to do so, some respondents suggested that current market conditions require them to carefully balance such demands against the need to maintain margins. For example, several plans noted regulators' expectations that the Blues accept the enrollees from plans that have gone bankrupt. While these Plans have generally complied, one of them said that they now only do so when it is in their financial interest.

The tension between profitability and public benefit is particularly evident in decisions about whether or not to offer products to the hard-to-insure market segments that the Blues have traditionally served, such as the markets for Medicare supplemental insurance (Medigap) and individual coverage. In many sites, Plans—whether nonprofit, mutual, or for-profit—report that they are giving more consideration to profitability when making decisions about offering these lines of business and less consideration to the public benefit role they've played in the past. Arkansas Blue Cross and Blue Shield, for example, continues to offer Medigap and individual products, not because they are required to do so but because they are profitable—so profitable that they are targeted for growth. The opposite

is true in Washington, where both Premera Blue Cross and Regence Blue Shield closed their doors to new enrollment in the market for individual coverage. Individual products were very unprofitable in Washington as a result of regulation that restricted premium increases.

Nonetheless, it is not always the case that profitability considerations alone are dictating the Blues' actions with respect to serving hard-to-insure populations. On the contrary, respondents at several Blue Plans report that this is one area in which residual public expectations sometimes affect strategic decisions. In both Michigan and Massachusetts, for example, the Blues continue to offer Medigap at regulated rates they say have caused tens of millions of dollars in losses each year. In Michigan, the Plan is required by law to provide this product. Blue Cross and Blue Shield of Massachusetts is not legally required to sell the product, but as the only in-state plan remaining in the Medigap market, it feels that it is under unique pressure to continue to do so. Although Premera Blue Cross and Regence Blue Shield were able to stop enrolling new individuals in Washington, both were faced with a large amount of public scrutiny and resistance to their actions. While they clearly attracted more scrutiny than other plans that exited because they were the largest providers of individual insurance in the market, the Blues felt they were also subject to lingering expectations of their public benefit role. As one respondent put it, "the Insurance Commissioner is more passionate about the Blues because she perceives them to be a public utility."

Mergers and Conversions Transforming the Blues

Up until 1994, most mergers among the Blues took place within state lines, with the number of Plans decreasing from 110 to 69 between 1982 and 1994. However, with the change in the BCBSA rules at that time allowing investor-owned, for-profit firms, several Plans, including WellPoint Health Networks and Anthem, Inc., saw opportunities to implement geographic-expansion strategies. These moves have set in motion a large number of mergers among Blue Plans across state lines and conversions to mutual or for-profit companies. For the first time, Blue Plans are becoming acquisition targets of out-of-state Plans. Prior to this time, Blue Plans had not merged across state lines and national managed care companies were restricted from acquiring Blue Plans because of BCBSA rules that restricted the ownership share of non-Blues entities in Blue Plans to no more than 5 percent. Together, the mergers and conversions are in the process of substantially altering two unique characteristics of the Blues—local focus and not-for-profit operation—and rendering at least some of the Plans relatively indistinguishable from their for-profit national competitors.

Mergers. Blue Plans that want to expand across state lines typically merge with or acquire other Blue Plans to be able to sell branded products in those new markets. Still the exception rather than the rule, an increasing number of Blue Plans, most notably WellPoint, are engaged in a strategy to acquire non-Blue Plans in multiple markets outside of their licensed service area(s) and to expand enrollment in unbranded products.

The Blues have a number of incentives to expand geographically (Corrigan et al. 1997; Robinson 1999):

1. to gain economies of scale in administration and information systems;
2. to expand products and services;
3. to serve multistate employers;
4. to diversify risk across different market and regulatory environments; and
5. to provide counter-leverage to the consolidation activities of other plans, both Blues and national for-profits.

Mergers also have the potential to enhance access to capital. Capital can be used for further expansions or to finance information systems, product development, or clinical management strategies (Corrigan et al. 1997). Interestingly, one of the most compelling reasons for national plans to merge with or acquire other plans—to increase local market share and improve leverage with providers—is not a driver for the Blues.

A few Blue Plan respondents and national observers expressed skepticism about some of the benefits accruing from merging with other Blue Plans. Some respondents claimed that few economies of scale exist across state lines because insurance products are regulated at the state level, and, in many markets, it is unclear how much business from regional employers has materialized (Grossman 2000). Also, while capital is needed if plans have aggressive acquisition strategies, capital needs to develop tightly managed networks and care management systems have abated because of the managed care backlash and technological advances that reduce the costs of information systems. Many plans already have adequate sources of capital to meet their needs, including reserves and borrowing capacity through for-profit subsidiaries (Cunningham and Cunningham 1997; Robinson 2000).

Despite arguments on the merits, the site visits and activity since then make clear that the Blues are very interested in merging with each other. While at the time of the site visits, regulatory scrutiny and legislation in a number of states had put a damper on merger activity among the Blues across the country, it was still the case that two-thirds of the plans in the study expressed interest in, or had been involved in, merger discussions

with other Blue Plans. In fact, two Plans were implementing mergers: (1) BCBS of Central New York joined two other nearby Plans in the state under a nonprofit parent corporation, Excellus, and (2) WellPoint began the process of acquiring BCBS of Georgia, which had already converted to a privately held for-profit company.

More importantly, however, there has been an increase in actual merger activity among the Blues nationally and in the CTS study sites since the site visits. Very soon after the study period ended, Anthem and WellPoint once again began vigorously pursuing Plans across the United States. Most recently, The Regence Group—a nonprofit affiliation of Blue Plans in Washington, other northwest states, and Utah—announced plans to affiliate with the mutual Health Care Service Corporation (HCSC), which operates the Blue Plans in Illinois and Texas as well as other recently acquired Plans.

As Blue Plans continue to consolidate, the national landscape appears to be developing into a tug of war between these three large players—Anthem, WellPoint, and HCSC. While Blue Plans have cited improved efficiency and access to capital as reasons for joining together, recent activity also appears quite rivalrous and reactionary in nature, with these powerful plans and others trying to be the first to pick off the most attractive independent Plans remaining in the market. When Anthem tried, unsuccessfully, to merge with BCBS of Rhode Island in mid-1999, BCBS of Massachusetts was quick to make a counteroffer to acquire or affiliate with the Plan, even though at the time of the site visits, they had no plans to entertain any mergers. Anthem and BCBS of Massachusetts jockeyed over other Plans in New England as well, with Anthem ultimately making three acquisitions. Similarly, when Anthem made an offer to BCBS of Colorado, a number of other Plans, including Wellpoint, HSCS, and Blue Shield of California, made offers as well.

Conversions. The 1994 rule change in the BCBSA was also an important catalyst for conversion activity among the Blues, and they have a number of incentives to do so. As with mergers, access to capital is a key incentive to convert to for-profit status, particularly for plans looking to fund acquisitions. Some plans convert to a mutual or privately held for-profit company to have more operating flexibility than is possible as a nonprofit. For-profit conversions, particularly conversions to publicly offered companies, can provide strong incentives for management to improve operating efficiency. Arguments against conversion also exist. Some Blue Plan CEOs strongly expressed their commitment to maintaining the not-for-profit mission of their Plan. Respondents also noted the challenges of being responsive on a regular basis to public investors in such a low-margin business. Consumer

advocates have suggested that the management of plans going public may be driven, in large part, by the opportunities for personal financial benefit (Community Catalyst 1999).

Following the 1994 rule change, Blue Cross of California became the first to convert to for-profit, investor-owned status, setting off conversion activity by other Blue Plans around the country. Many of the early conversion attempts were pursued as a way to gain access to capital markets and to achieve increased flexibility to respond to changing market conditions. However, the frequency with which conversions have been attempted also is closely tied to the merger activity that has been occurring among the Blues. While mergers and conversions do not have to go hand in hand—for example, the formation of non-profit Excellus in New York—the profit status of the merging parties often is not the same. Therefore, amid the recent flurry of mergers, many of the acquired Plans have converted to facilitate the legal process of the merger and align the incentives of all of the parties. So far, only a handful of all Blue Plans have become publicly offered, although many market observers speculate other Plans currently structured as mutual companies or privately held for-profits are poised to go public at some point in the future.

With the prospect that newly formed companies might at some point go public, the recent mergers between Blue Plans, particularly those that involve conversions to mutuals and for-profits, have received a great deal of regulatory and public scrutiny. Given the variation of Plan bylaws and state statutes, every case has transpired differently. Typically, because of the Blues' history as charitable organizations, regulators and consumer advocates want to ensure that a Plan's assets that belong to the public are kept within the state in a nonprofit entity and are not transferred to private investors, Plan executives, policyholders, or out-of-state organizations. Regulators and Plans have wrangled over whether the Plan has ever been a charitable organization under state statutes and, if so, the fair value of the public assets (Consumers Union 2000a). Some states also have proactively proposed or passed legislation prohibiting conversions, requiring regulatory approval, or restricting the movement of assets from a nonprofit into a for-profit parent or subsidiary, as is the case in New Jersey and Washington (Consumers Union 2000a).

This regulatory scrutiny has aborted some merger and conversion attempts and resulted in changes in the terms of others. BCBS of New Jersey had plans to convert to a mutual company to merge with Anthem, but the merger was called off in 1997 when the Plans were ordered to contribute a substantial sum of money to a charitable foundation. More recently, acquiring Plans have begun to offer to donate the full value of the acquired Plan to a charitable foundation as part of the initial terms of the agreement,

although assessing the market value of the plan is complex and open to controversy (Consumers Union 2000a).

Mergers and conversions may be scrutinized even if they do not involve the direct transfer of assets to for-profit parents because a variety of other ways exists to transfer assets and structure the new corporate entity that diminish the ability of regulators to scrutinize future activities. For this reason, regulators and consumer advocates in Washington have raised a number of concerns about the recent proposed affiliation between the nonprofit Regence Group and mutual company HCSC. First, the affiliation facilitates the transfer of funds out of state. For example, although it is not a full-asset merger, money from the Regence Group's member Plans is to be transferred to a for-profit corporation in Oregon that will provide administrative services to those plans (Consumers Union 2000a). In the event of a conversion, Washington regulators will no longer have an opportunity on behalf of the public to lay claim to those or any other assets moved out of the state. Second, consumer advocates have concern because of the relative ease with which Illinois-based HCSC can convert from a mutual company to a for-profit. Under Illinois state law, HCSC can convert with only a vote of its board of directors. If it decides to do so at some point in the future, Washington regulators will be limited in their ability to scrutinize the conversion (Consumers Union 2000b).

Implications of Strategies for Consumers and Policymakers

As the Blues respond yet again to changing market and regulatory forces, they are making strategic choices that threaten the benefits that consumers have traditionally enjoyed from them. Blue Plans are likely to continue to evolve in ways that make them look more like their national, for-profit competitors, leaving them less accountable and responsive to the demands of local purchasers, consumers, providers, and regulators, particularly expectations about the public benefit role they've traditionally played. As Plans in this study indicated, they are already under pressure to carefully weigh the financial impact of providing community benefit, and, unlike in the past, most no longer have regulatory requirements that put bounds on what they must continue to do. With diminished regulatory requirements, local accountability must work through market and community forces, which are less direct and inconsistent. While some Blue Plans will remain independent, continued consolidation and growth into large regional and national Blues conglomerates is likely. Even informal local accountability is likely to erode somewhat, along with the stability Blue Plans currently offer, as local Blue Plans continue to be acquired by out-of-state Plans. This is

particularly true for those Plans that are subject to the demands of Wall Street investors for earnings and growth, which could potentially come at the expense of access and quality.

Consumers could see a net gain from merger and conversion activity if the Blues engage in strategies that support continued local accountability and service, while successfully implementing the aspects of mergers and conversions that are most likely to directly benefit consumers. For example, merging Plans have the option of keeping some functions at the local level to leverage their market presence, such as provider contracting, sales, and customer service, while consolidating others, such as back office operations at the corporate level to leverage economies of scale. For example, BCBS of Central New York, after merging with two other contiguous Plans, continues to do marketing, claims processing, and provider contracting at the plan level, but its product development has been moved to the corporate level. BCBS of Central New York believed that it has benefited significantly from this strategy in being able to rapidly roll out a new POS product that purchasers wanted. In contrast, Anthem was moving toward centralizing many functions, including hospital contracting, in the corporate offices of the Midwest unit. However, in both Indianapolis and Cleveland, Anthem was viewed as an outside plan because its management was in Cincinatti, and purchasers and providers lamented the lack of local focus. At the same time, little evidence was shown in these local markets of the type of care management and quality initiatives for which Anthem had been gaining national attention. After the site visits, Anthem reportedly moved management of BCBS of Indiana back to Indianapolis from Ohio, where it had been moved when Anthem acquired the Plan.

The experience to date of national managed care companies, however, suggests that mergers are difficult and costly to implement, particularly in the short run, and can negatively affect consumers. Companies have benefited from increased access to capital markets to continue their expansion and sometimes, from increased leverage with providers in local markets. These strategies have sometimes generated plan and network instability that have harmed consumers. Slower to materialize have been anticipated outcomes that have the potential to benefit consumers, such as lower costs because of increased efficiencies, improved customer service, more innovative insurance products, and enhanced quality of healthcare (Robinson 1999; Grossman 2000).

State regulators may have options to permit mergers and conversions to move forward while helping to prevent potential adverse effects for consumers. As Blue Plans have pursued mergers and conversions, regulators and consumer advocates have focused on ensuring that public assets

remain in-state and are invested for the public good. However, they have also raised concerns about the potential for negative impacts on the affordability of healthcare and local accountability (Community Catalyst 1999). While the terms of mergers and conversions vary significantly, several conversions, including those of BCBS of Illinois and BCBS of Connecticut, require that some portion of the public assets be spent on providing coverage for the underinsured and uninsured (Consumers Union 2000a). In at least one case, state regulators have detailed specific ways in which the acquiring Plan must work to maintain the level of community benefits and local accountability provided by the local Plan. Anthem acquired BCBS of New Hampshire in 1999, agreeing to put the proceeds of the sale into a charitable foundation. In approving the sale, given the dominance of the Blue Plan in that market, the Department of Insurance also imposed 18 conditions on the Plan (Consumers Union 2000a), including a commitment for three years to:

- continue community benefits at the same level of funding to finance such projects as a vaccine program;
- offer a nongroup product;
- maintain a provider network comparable to what had been offered;
- report on complaints to the Department of Insurance;
- maintain employment levels equal to Anthem's employment rates in other states; and
- form a local advisory board to be consulted on any major changes related to the above activities.

This example, however, raises an important question about the appropriate degree of state regulatory scrutiny. Such an approach moves beyond making sure public assets are protected and requires fairly active regulation. It is unclear to what extent other states have the option to, or feel it is appropriate to, impose such requirements on the Blues.

States and the federal government have been moving toward a more level regulatory playing field for insurance regulation, and this principle should generally be applied in regulating the Blues and other sectors in the healthcare industry. This is a particularly critical issue, given the increasing consolidation in both the health plan and provider arenas. For example, recent state-level individual and small group market reforms and managed care regulations have been applied across the board to all firms that participate in the market. Such approaches have the potential to expand the number of individuals who can benefit, while more widely sharing the burden for any costs incurred. Similarly, it is within the regulators' authority to monitor large plans and healthcare providers to ensure that their

behavior is not anticompetitive and to oversee conversions of nonprofits to for-profit status. However, such action should be applied consistently to all organizations in the appropriate class (e.g., market share or corporate structure), and the Blues or other healthcare organizations should not be subject to differential treatment unless they also get special benefits from this regulatory treatment.

In general, regulators seem to support this view today. However, they have not always been clear and consistent in letting that decision drive public policy and expectations. In addition, the principle of a level playing field in regulation will not be practical in all instances. The reality is that in some markets, such as New Hampshire and some of our study sites, the Blues are by far the largest health plan, and health plan regulation, de facto, is regulation of the Blues. In addition, as much as the Blues continue to receive tax or other benefits that are of value, they should expect to play a commensurate public-benefit role.

Conclusion

The Blues find themselves at yet another turning point in the evolution of the healthcare market. As the pendulum swings back toward a fee-for-service PPO market, the Blues are well positioned to compete against other managed care companies, given the attractive features they can offer purchasers and their market clout with providers. In almost every market, purchasers and consumers are perceived to value the stability and choice that the Blues offer relative to other plans in an era of managed care backlash and market turmoil. The Blues offer a wide range of products with broad and stable networks. Until recently, in contrast to most other managed care organizations, Blue Plans have remained locally managed, and ownership has not changed hands. Balanced against these strengths are the traditional weaknesses of the "800-pound gorilla," which manifest themselves in a lack of responsiveness to purchasers and providers in some markets and a uniformly poor record on innovation.

However, as the Blues adapt themselves to a changing environment, their transformations may come at a cost. The Blues' strategies today suggest that many of the benefits enjoyed by consumers in the past could erode, leaving the Blues more like their national for-profit competitors. It is possible that changes among the Blues, most notably mergers and conversions, could be structured in such a way as to preserve local accountability. In this respect, regulators can have an important role in ensuring that consumers are appropriately protected. However, the changes occurring among the Blue Plans, as well as in the organization of the healthcare system generally, might also call for a more level playing field where all the

relevant entities are subject to the same regulations. As the Blues continue their transformation and as both health plans and providers continue to consolidate, it will be important for regulators to determine what consumer needs are not being met by the market and how to effectively regulate it to improve healthcare affordability, quality, and access.