The Metamorphosis: Conversion in Historical Context

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Among close observers of the health-care scene in New York City and State, the proposed conversion of Empire Blue Cross-Blue Shield**, a nonprofit entity for some six decades, to for-profit status is widely viewed as a "defining moment," so significant as to justify (for example) a day-long conference at the New York Academy of Medicine. Empire has redefined itself repeatedly over several tumultuous decades; what makes this latest transition so salient? The answer, surely, is that the change would seem to dramatize a loss of precious values—institutions, rooted in communities, that empower communities to run their health affairs; the service mission; health dollars spent "only for health care." Rather like the Dodgers' departure from Brooklyn, the conversion is a poignant symbol and symptom of a vanishing world. Moreover, those who are not enchanted with market forces in health care may find Empire's metamorphosis all the more chilling, because this plan is the largest member of the national Blue Cross-Blue Shield set, was one of the earliest to emerge, and has enjoyed since its launching the prominence duly accorded a national leader. The conversion issue, then, turns partly on economic interests served, but at least as much on values and their presumed surrender under remorseless competitive fire.

As one who works at a School of Public Health, perhaps I should display much anguished consternation. Public Health, after all, likes *public* health and distrusts private (and especially for-profit) models. The third sector—voluntary, nonprofit institutions—

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though inferior to the former, is far less objectionable than the latter. This paper departs from the party line by contending that a quick historical review of the values Empire has represented and the roles and missions it has occupied helps put the current conversion debate into a less Manichean context.

In this presentation I develop three arguments. First, the organizational identity that we may be tempted to mourn has always been chronically crisis-ridden and in the midst of redefinition. Second, pressure on the plan to adapt to a changing business environment is nothing new; rather it is an old, recurring tale that has set the evolutionary stage for this latest and most dramatic transition. Third, the significance of conversion (and of related shifts in the health insurance world) for the broader public interest and public health may prove to be counterintuitive and non-catastrophic after all. In what follows I trace the development of Empire through five "stages" (of which conversion is the latest) and seek to indicate "defining moments" over time.[1]

Experiment (1935–45)

In New York, as across the United States, Blue Cross-Blue Shield plans began as experiments—tests of the proposition that a certain distinctive approach to supplying health coverage for much of the population was workable. The Great Depression left many citizens unable to pay for medical care, generating fiscal distress for patients and providers alike. The nation faced a proverbial fork in the road. Down one path lay national health insurance (NHI)—a compulsory social insurance program established by the national government. The other path was a voluntary, cooperative, community-based strategy. The latter, supposedly more consonant with the "American way," won out.

The Blue Cross and Blue Shield plans that aimed to create a semblance of "national" health insurance outside the realm of public policy rested on three core values. The first was *voluntarism.* Health insurance was an extension of the mission of the

voluntary hospitals that took the lead in sponsoring it.[a] Like these hospitals, Blue Cross stood between and aloof from government and politics on one side and markets and profits on the other. It was a nonprofit, "third sector" institution that was invented solely to serve the needs of communities. Voluntarism also had an important secondary connotation: members joined voluntarily (assuming that they or their employers could afford it), not because government ordered them to do so.

The second core value that infused Blue Cross was *community*. In essence, plans were founded to meet the health insurance needs of the areas that local nonprofit hospitals served. Like the hospitals, the plans were community controlled, that is, run by local citizens who were chosen by and from prominent community organizations. These boards were accountable not to public authorities or private shareholders, but rather to the community. A significant secondary sense of "community" justified cross-subsidies—community rating—within the local subscriber pool.

Third, Blue Cross embodied a *cooperative* ethos. The plan let purchasers (business firms and unions) and providers (hospitals) manage their health-care transactions harmoniously and efficiently. In effect a treasurer or exchequer for the hospitals, it managed money, not medical care.

These three values and the assumptions built on them gave Blue Cross its core identity and mission at the outset, and the decision to test whether health insurance institutions thus grounded could work on a large scale was the plans' first defining moment. The unfolding of the world view that Blue Cross represented would subsequently lead to copious critiques, challenges, and changes. Because much of the discontent with the plans centered on their alleged "capture" by providers, it is worth noting here that Blue Cross was born in captivity. To reconstruct the original rationales for the plans is to see that capture was not then perceived as a problem or even an issue. Quite the contrary, the

[a] Blue Cross and Blue Shield are two different (though often intersecting) historical tales. For brevity, the focus here is on Blue Cross, purveyor of hospital coverage.

nexus of voluntarism, community, and cooperation that eased transactions among payers, providers, and purchasers was then viewed as the central virtue of this innovative American institution.

Movement (1945–60)

A decade of energetic plan building proved that the Blue Cross experiment worked. People signed up in droves; by the end of World War II, New York's plan had two million members. Secure and confident, the New York plan and its smaller peers did not hesitate to declare that the Blues' approach was "the answer," at least for employed paying customers and their dependents. The discarded alternative strategy, however, refused to lay down and die. President Harry S Truman and the Democratic remnants of the New Deal coalition in Congress were pushing national health insurance. For Blue Cross, the countermeasures were clear: broaden benefits, add members, and insist that NHI was undesirable and unnecessary.

These self-protective measures drove the plan rightward into a deepening anti-governmental animus. The annual report of the New York plan for 1951 warned that the new British National Health Service—which emphasized "quantity rather than quality," restricted medical care to the few, and consigned the British to "chew with their dentures upon bitter bread and.... look through their spectacles upon a barren scene"—showed what horrors could happen here.[2] In times like these, commercial health insurance competitors, of suspicious moral pedigree because they operated on the profit principle, became *de facto* allies. Summing up the growing enrollments of the two camps, even the dullest politician would see that the private sector was getting the job done. Lobbying against NHI brought Blue Cross to a second defining moment: if the price of keeping government out of the health insurance business was an intermittent political alliance with for-profit competitors, so be it.

As the plans' attitudes toward government hardened, their judg-

ments of the private sector and market forces softened. Community service and social mission notwithstanding, Blue Cross found it hard to maintain community rating in the face of commercial competition and demands from insured groups that lower use of services be rewarded by lower rates. The plan concluded that a firm stand on principle would drive "the better groups" into experience-rated plans, and thus deplete the funds for cross-subsidies for less well-off subscribers. The plan could no longer "reject experience rating altogether and run the risk of losing groups which contribute much" to its financial health.[3]

The proposition that Blue Cross must adapt to the realities of the marketplace is not new. Nearly 50 years ago, the plan's leaders made a virtue of necessity by averring that "competition is good for the public." Rivalry with commercial companies for market share obliged the Blues to offer wider benefits and better service. What mattered was that "people secure adequate protection, regardless of which agency provides it"—so long, of course, as the agencies were not public.[4] The voluntarist way did not disdain to accommodate competitive means.

Business (1960–74)

The plan's third defining moment capped its intensifying struggles to balance its emerging sense of itself as a health insurance business with its traditional social mission. This identity crisis produced internal strains, an unraveling of the old cooperative ethos, and a fresh look at relations with government and public regulators. Throughout the 1960s, purchasers—corporate and union—pressed more insistently their familiar complaint that the cost of health insurance was too high and rising too fast. Initially, the plan's leaders, defensive and indignant, rebuffed critics who failed to acknowledge its cost containment efforts, the "rising value of that coverage," and the degree to which increases in the "quality of the product" exceeded higher costs.[5] Such reasoning evidently eluded the skeptics, however, and the annual outcry over premiums grew louder, persuading Blue Cross to seek pro-

tection against its cooperative partners, the hospitals, from the state.

In the 1960s Blue Cross took the interventionist side in the politics that would make New York State the earliest and toughest regulator in the federal system. Such regulatory innovations as certificate-of-need, rate setting, and state-set discounts on Blue Cross payments to hospitals (adopted in explicit recognition of its social mission) helped to placate purchasers and assure the public that the plan was not captured by providers. They also gave Blue Cross a new business partner, state government, whose agenda further splintered the plan's increasingly fragmented organizational character. Having made common cause with private profit makers and in the fight to keep government at bay, Blue Cross was now concluding a new and separate peace with public policy makers in hopes of gaining insulation from community business partners—purchasers and providers—who were aggrieved and increasingly antagonistic to each other and to the plan.

Agglomerate (1974–96)

Purchasers' demands for rate relief drew Blue Cross closer to state government in hopes of gaining leverage over providers, but the results—an organization that anomolously conjoined the shelter of a private enterprise with the visibility of a public utility—were no more satisfactory or stable than the plan's earlier adaptations. As the plan floated doggedly on the rough waters of the health insurance marketplace, its traditional social mission grew befogged. Time passed, generations changed, and fewer people in and around the plan remembered what the powerful purposive commitments of the movement days had meant. To be sure, the plan played insurer of last resort, offering coverage to all comers who could pay the premium—no small social contribution. But the public increasingly viewed Blue Cross as a large insurance bureaucracy. Meanwhile, as outsiders decried the plan's alleged capture by providers, insiders worried over its capture by government, exemplified by annual rate hearings before the State Superinten-

dent of Insurance. These yearly epics created bad press that damaged morale and marketing.

By the mid-1970s Blue Cross managers saw that the plan's well-being demanded both internal modernization and diversification into new product lines and regional markets. The plan began boasting of bigger and better computers, quicker and more accurate processing of claims, closer audits of provider billing, and more. Having recently acquired a large book of government business—Medicare—it now also developed health maintenance organizations and expanded into eastern counties in upstate New York. Quick, large-scale innovation did not come easily to a traditional insurer, nor could the plan hope to be as fast on its feet as smaller, hungrier rivals. This fourth exercise in reinvention did not suceed. Rates rose, reserves dwindled, and membership declined, triggering the crises of the 1990s that raised the curtain on the plan's fifth and latest defining moment.

Conversion (1997—)

In historical context, the proposed conversion of Blue Cross-Blue Shield to for-profit status signals the collapse of a world view that began as principle and transmuted into myth. Conversion suggests that the "American way," based on voluntarism, community, and cooperation, and enshrined in the book of civic virtues by the Founding Fathers, de Tocqueville, and the government downsizers of today, does not work especially well in the health field. Voluntarism has proved to be the proverbial center that failed to hold as Blue Cross emulated private practices one day and ran to government for relief the next. Weak regulation of the US health insurance industry forces tragic choices on voluntary organizations with social missions: avoid bad risks and live, or accept them and die (or, perhaps, extract subsidies from government and die more slowly).

In practice, cooperation has compelled insurers to choose between dealing aggressively with costs and antagonizing provider partners, or avoiding the issue and alienating business purchasers.

Caught in the back-and-forth, Blue Cross advertised new internal efficiencies presumably acceptable to both "sides" and sought succor in Albany. Community, meanwhile, meant reciting the mantra that "health is a community affair," while watching commercial insurers and HMOs from elsewhere capture local markets, beseeching state government to confer discounts, subsidies, and regulatory relief, and pretending that communities are dynamic nodes of action rather than the receiving ends of private and public decisions made above and beyond them.

Capital markets largely disdain community lines. As HMOs go for-profit to find funds, Blue Cross will do likewise or risk expulsion from the competitive field. Community cannot be a dominant value in a health insurance firm striving to play in national capital markets; cooperation cannot hold center stage in a company that must learn to manage care and discipline providers to drive costs down; a voluntarism that sees singular virtue in plans run by nonprofit boards of local notables who lack clear accountability to the public and private sectors that increasingly call the health policy tune is anachronistic at best.

Conclusion

The contribution of historical context in this case is to clarify the significance and stakes of what is being lost. This organizational history discovers a troubled 60-year evolution yielding repeated identity crises brought on by dissonant defining moments. Put more pointedly, one sees here the gradual disintegration of a model of "national" health insurance that was not coherent in the first place.

Because this historical survey of Empire Blue Cross-Blue Shield is a commentary on evolutionary ironies, it may do well to close by sketching three ironies that may unfold in the future. First, the new obeisance to private market principles in the health-care system could prove to be a powerful vindication of the visions of the public health community. For decades public health proponents have advocated the merits of planned and cost-effective use

of scarce resources to care for defined populations according to careful needs assessments and with due attention to prevention and health education. This agenda essentially captures what it means to manage care. Market-minded systems competing in the art and science of population-based planning are an intriguing public prospect.

Second, market forces and competition may bring issues of public accountability to the fore with clarity and urgency largely lacking before. Until now, the Blues have stood between politics and profit, radiating an image of accountability (control by community-spirited, unpaid, volunteers) that rejected on principle both the efficiency demands of profit makers and democratic management by public officials. For-profit conversion calls these questions abruptly. If health coverage for many millions comes under performance criteria linked partly to profit, then it may seem intuitively obvious that public officials should protect the public interest by means stronger than such traditional interventions as monitoring the adequacy of plan reserves and other proximate indicators of fiscal stability.

Finally, market reforms could eventually create an insurance industry that won the battle (that is, defeated the Clinton health plan) but lost the war. As public and private purchasers gain skill and confidence in their pro-competitive roles (acquiring and managing information, shopping for good value, and such) they may conclude that too much of the premium dollar goes to superfluous insurance "middlemen." Providers, meanwhile, will continue to snipe at excessive rake-offs and profits by insurance-based care managers. As competition evolves, purchasers will want to pay less, providers will want to get more, and savings from straightforward squeezing of excess capacity will decline. As profits from managing care shrink, venture capital may migrate elsewhere, triggering corporate shakeouts that invite providers to contract directly with purchasers. Might the dynamics of profit and loss in time reduce the insurance industry to a vestigial organ gradually disappearing from the evolving body of managed care?

References

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