A Perspective from the National Blue Cross and Blue Shield Organization

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As the symposium progressed, it was interesting that most participants mentioned the National Blue Cross/Blue Shield (BC/BS) Association's rules regarding matters of conversion. The Empire Plan seemed no happier about those rules than the state regulators were; in that context, therefore, the National Association takes some comfort in the knowledge that it is applying the rules evenly.

This presentation addresses lessons learned from other states, what the National Association rules are, and, perhaps more important, why they are in place.

Lessons Learned from Other States

In the presentation by Silas *et al.*, it was noted that some of the problems experienced in other states seem not to be present in New York. Empire is avoiding several of the pitfalls that we have seen in other states. This paper will not, however, engage in a discussion of the merits of the issues in those other states.

There were 14 BC/BS transactions in the 2 years before the symposium. When I use the term, "transaction," I distinguish it semantically from the term, "conversion," which is a subset of transaction. A conversion is a transaction that results in a nonprofit entity becoming a for-profit entity, such as the conversions at Wellpoint in California and Trigon in Virginia and Georgia. These

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are distinct from "affiliations," which are agreements in which two or more plans combine in some measure, and from "internal reorganizations," in which a single plan reorganizes (most frequently to the form of a holding company).

The number of pending transactions is also numerous, and these transactions are as varied as the ones that have been completed in the previous 2 years. There are two outstanding conversions, one in Colorado and the other in New York. There are also a few other transactions, including an affiliation in New Jersey (the Anthem plans) and an affiliation that will commence through the creation of a new holding company (the Maryland and the District of Columbia BC/BS plans).

With dramatic pace, there is a great amount of activity afoot in the form of consolidations and capitalizations among BC/BS plans. The reasons for this, from our perspective at the National Association, come down to one: competition in the marketplace. Much to the delight of consumers but to the challenge of people who run health-care companies, this competition has held the lid on costs in a rather dramatic way in the last 2 years.

The reasons for the ferocity of competition in the marketplace are beyond the scope of this paper. BC/BS plans, however, must deal with that competition; the pace and amount of activity amongst the plans help to reveal how the plans are reacting.

Responses of Plans to the Marketplace

At least one of two strategies is being pursued. One is to achieve the scale necessary to realize economies that drive down costs. Some have said that in the coming years $10 billion in revenue will be the minimum required to survive as a managed-care company. I do not know whether this is true. The recent combination between US Healthcare and Aetna certainly demonstrates that drive to scale is important. The Empire plan starts with a significant advantage: more than 4 million subscribers.

The other strategy—sometimes used in combination, sometimes pursued separately—is relying on access to capital. There is

a perceived need, in some areas at least, to acquire access to the capital markets enough to build scale. There is also a need to make the investments in systems and networks that are necessary to take full advantage of the scale that is achieved.

Within these two strategic objectives there are different tactics. In the Northwest, two holding companies, Premera and Benchmark, are combining several smaller BC/BS plans. They have chosen to proceed as nonprofits, affiliating their boards but maintaining the nonprofit setting both for the subsidiary corporations and for the parent holding companies. They are consolidating their approach to the marketplace and their operations to take advantage of scale and to gain efficiencies.

Some plans are pursuing internal corporate reorganizations that do not involve affiliations, but rather place the plan in a more modern insurance holding company form, allowing for certain tax benefits and other efficiencies. A third approach, central to the symposium's discussion, involves the conversion of a nonprofit organization to a for-profit enterprise that results in access to capital markets.

The Role of the National Association

The first Blue Cross plan was started in Dallas, Texas, at Baylor Medical Center, where a local school group was signed up by the hospital at very low cost, perhaps five cents per day. The history of Blue Cross goes back to the Great Depression. Blue Shield's origins go back to the mining camps in the Northwest immediately after World War I. Their combined history is long.

Blue Cross and Blue Shield Plans, in my view, have developed like siblings. Often in infancy siblings can look and act very much alike. But over time, nature and nurture take their course, and plans develop in different directions. There is still a strong family resemblance, but there are also definitely distinct features and personalities for each plan.

The lesson is that each plan addresses its marketplace according to its own distinct history and current environment. The National

Association has been cognizant that one size rarely fits all situations, in terms of key strategic questions for plans. Different market dynamics and different histories result in different solutions to the current problems of the marketplace. The National Association believes that it must accommodate this reality.

Nevertheless, there is a core of interests that the National Association serves to protect. The National Association owns the Blue Cross and Blue Shield trademarks. It licenses those trademarks to each local plan under the terms and conditions of a license agreement. Those license agreements, although they contain many technical details, embody at least five fundamental commitments that are shared among all BC/BS plans:

1. BC/BS is committed to the integrated national network of BC/BS plans. BC/BS members can go anywhere in the country, present their cards to providers, and take advantage of the networks and discounts that the BC/BS plans in that locality have negotiated. This is a great advantage, a selling tool in the marketplace, an important consumer benefit. Other national programs that knit all the plans together include a national network of HMOs called HMO Blue USA. We also serve 40% of the federal work force through a national program in which all BC/BS plans, including Empire, participate.
2. BC/BS is committed to excellence in service and financial stability that is enforced through minimum standards in the license agreements.
3. BC/BS is committed to independence. Through the license rules and requirements, all plans are committed to independent action that is free from the influence or domination of any single entity or group that might serve a special interest distinct from the interests of the plan, its members, or the BC/BS names and marks.
4. BC/BS is committed to local focus and a presence within exclusive service areas. A plan is licensed to use the names and marks only in its designated service area.
5. BC/BS is committed to promoting and enhancing the value of

its shared brands. That is achieved through a variety of service mark use regulations and other rules.

Formerly, there was another commitment: a commitment to the nonprofit structure. This was dropped in 1994. There were several reasons for this.

One reason was a recognition that some plans began with a "social service" model but evolved into what might be termed the "mutual company" model. They had become recognized by their local communities as existing principally to serve their subscribers. Therefore, in law, or at least in policy and practical terms, they were owned by their subscribers. Their chief duty with respect to ownership was to their subscribers. That model existed in several states. Indeed, in some states the "mutual company" model was in place at the company's founding.

There was also a recognition that with the increasing intensity of competition, some plans would not be able to survive in their current forms. The nonprofit structure was seen not to be viable as a business model. Access to capital markets that could be achieved through a for-profit conversion would be essential for some plans to survive.

Finally, and importantly, extensive research done at the time showed that the vast majority of consumers either did not know the difference between for-profit and nonprofit insurers, or did not care. The vast majority of business decision makers who bought health insurance had decidedly negative impressions of the nonprofit form.

In all this, the National Association sought to balance two goals: one, to allow plans for which it was either desirable or necessary to convert, to do so; and the other, to protect the classic five commitments—national network, excellent service and financial stability, local presence, independence, and a commitment to promoting and enhancing the value of the brand.

The conclusion in that balancing process was to allow plans to convert, but also to implement a set of rules that would apply to for-profit plans. These rules have many technical nuances, but in basic form they are designed to prevent a single entity or group of

entities acting in concert from gaining control of an individual plan while retaining the right to use the BC/BS mark. Why is that important? Take the prospect of a large national HMO with a large investment in, and commitment to, another brand acquiring a BC/BS plan and seeking to keep the BC/BS name. The problems with that plan's serving and remaining fully committed to those five goals seemed insurmountable to us. Protections were put in place to ensure that if a plan that had converted to for-profit status fell under the influence of a single group or entity, that it would no longer have the right to carry the BC/BS name.