
C. Rufus Rorem Award Lecture

Big Question for the Blues: Where to from Here?

Editor's Note: *The following paper was delivered by Walter McNerney on the occasion of his being presented the C. Rufus Rorem Award from the Blue Cross and Blue Shield Association on November 15, 1995. By publishing Mr. McNerney's paper, we hope to start a tradition of publishing the lectures of Rorem Award recipients.*

The Rorem Award was established to honor the memory of C. Rufus Rorem (1894–1988), who is credited with being one of the original proponents of prepaid hospital insurance and a moving force behind the creation of Blue Cross. The Rorem Award recognizes a person whose activities and ideas regarding the organization and delivery of health care represented Mr. Rorem's approach toward prepaid hospital insurance and community needs.

Walter McNerney is the tenth recipient of the Rorem Award. Mr. McNerney was president of the Blue Cross Association between 1961 and 1977, and was president and chief executive officer of the Blue Cross and Blue Shield Association from 1977 to 1981. He currently is the Herman Smith Professor of Health Policy at the J.L. Kellogg Graduate School of Management of Northwestern University where he has taught since 1982. Mr. McNerney was elected a charter member of the Institute of Medicine, and has served on the Physician Payment Review Commission and numerous other committees involving such issues as health care reform, the structure of veterans' health care, and medical technology. Mr. McNerney is the recipient of numerous awards for his public service. Of no small importance to our readers, he is also the founder of Inquiry.—K. Swartz

Like all major institutions, Blue Cross and Blue Shield Plans periodically evaluate their mission and strategies in the light of a changing environment.

Some institutions get in trouble when they fail to read or evaluate change in the market, while others become too reactive and fail to appreciate the reasons they succeeded in the first place.

In this context, I should like to trace some milestone events for the Blue Cross and Blue Shield organization, then offer a few prejudiced comments about the future.

Milestones

Blue Cross and Blue Shield Plans, although differing among themselves in some notable respects, share a common root—the Great Depression (the first milestone), which started in 1929 and extended well into the 1930s. During this period, people lacked means to purchase health care insurance and both providers and professionals lacked revenues. Illness was largely unpredictable and occurred unevenly among groups and communities, often inversely related to income. The means did not exist to mutualize risk in pools that contained

both high-risk and low-risk individuals in the absence of supportive government programs. A service contract was needed through which special rates with hospitals could be negotiated, such rates likely being less than hospitals wanted, but ample enough to keep beds open and, in turn, to make typical hospital admission rates affordable; physician contracts followed. People sought service and security; out-of-pocket payments were minimal.

With few exceptions, in response to these pressures the Plans were organized as non-profit entities, reflecting a social as well as an economic mission. Those that chose to live by standards promulgated with the cooperation of provider and professional associations ultimately adopted a name and mark familiar to people throughout the United States.

World War II constituted the second milestone. During the war, the federal tax code was revised to exempt fringe benefits from a wage freeze and allow employers to write the benefits off as a cost of doing business. Plans began to face competition from commercial insurance companies, which up to this point claimed that health was not an insurable risk. Many of these companies wrote health indemnity coverage as an adjunct to life and other lines of insurance, avoiding serious financial risk through clever underwriting as well as through experience rating.

As it turned out, the federal government's tax exemption of fringe benefits had profound implications. Not only did competition among carriers accelerate, but employer-based financing of the benefits was affirmed and regulation of carriers was left mainly to the states. Lacking federal guidelines, states regulated carriers unevenly, but mostly poorly. As a result, the market became cluttered with a variety of marginal carriers that lacked adequate skills or reserves, and that selected their risk pools aggressively against more responsible carriers.

In this frenzy, Plans that used community rating and did minimum underwriting (neither of which has ever been consistent among Blue Plans) migrated to class rating, and, ulti-

mately, to experience rating and to health status restrictions—often forcing Plans with the lowest market share to yield first in taking subscribers with high health risks. Distinctions among nonprofit and commercial competitors thus began to blur.

The third milestone occurred when the landmark Medicare and Medicaid laws were passed in 1965. These federal laws provided some, albeit not totally comprehensive, relief to the disadvantaged. However, the reimbursements under these laws were enough to discourage free care by hospitals and physicians. Perhaps the most far-reaching effect Medicare and Medicaid had was the pumping of billions of dollars into a health system already getting fat on generous service and indemnity contracts—many involving open-ended cost reimbursement and professional fee schedules—thus starting a cycle of serious and long-lasting inflation.

The two trade associations that represented Blue Cross and Blue Shield Plans, respectively, already were armed with a variety of programs that dovetailed quite well with many of the rules and regulations under the Medicare law. What seemed to be lacking, however, was a stronger single network representing both types of Plans.

Meanwhile, Medicare's pump-priming effect of cost reimbursement and fee schedules was useful in overcoming the shortages of beds and physicians, as well as the deficits in medical education and research that were triggered by the Depression and which worsened because of World War II. But, in the 1960s and 1970s, surpluses in beds and physicians began to build and markets began to mature—a fourth major milestone.

The results were characteristic of all maturing markets, namely, increased competition, rising costs, more sophisticated buyers focused on costs, aggressive shopping among the growing number of options produced by competition, greater price and service sensitivity, market segmentation, and consolidation. And we tend to forget that in the '70s and '80s there was active discussion about the merits of man-

aged care, use of alternate sites, utilization management, and the need for continuity of care. Indeed, these are not new terms coined during the health care reform debates of the '90s.

Disillusioned with Great Society programs, put in place under President Lyndon B. Johnson's administration, the public turned toward these new market forces to spark innovation and control costs. Employers became more aggressive buyers, both through carriers and as self-insurers. Blue Plans had to learn to live in the worlds of assuming the risk and providing administrative services only. The poor and disabled were given incremental attention. Quality often was taken for granted.

Under the lash of market forces, consolidation among providers, physicians, buyers, and suppliers started a process still under way. We began to see vertically integrated and horizontally linked health systems; more group activity among physicians, such as formation of independent practice associations (IPAs); aggregation among carriers, health maintenance organizations (HMOs), pharmaceutical and medical device manufacturers, and biotech companies.

Much of the consolidation did not work at first. Providers are a case in point. As hospitals evolved into health systems, few achieved economies of scale. There was little gain in either efficiency or access. Health systems are getting better, but they still are struggling with governance issues. Examples include centralization vs. decentralization and strategic issues, like the relative emphasis to be put on efficiency vs. market share.

In the 1980s, initial responses of carriers and the self-insured were to stick with basic service contracts and indemnity and to control costs through increased cost sharing (copays and deductibles), more refined selection, and underwriting. These responses were pushed to the limits until the consumer backlash started. The backlash had relatively little overall impact on costs, although it did succeed in accelerating access problems. During this period, many Blue Plans lost their way because

they chose to imitate their insurance company competitors instead of their HMO competitors—and managed to lose market share to both.

Gradually, carriers concluded that costs could be controlled more effectively by impacting the way medicine was practiced, that is, by dealing more directly with providers and professionals to produce a value-added service vs. exchanging money with subscribers. A few years ago, Blue Plans announced at their annual meeting that 90% of benefits would be delivered through managed care contracts by the year 2000. It was quite an announcement to make, because the majority of Plans had let their provider and professional relations skills wither, or had failed to replace persons who were superannuated despite the fact that managed care—involving provider and professional selection, utilization management, case management, protocols, and other evolving programs—demanded much more sophistication than actuarial projections and fiscal manipulations. Early efforts at instituting managed care initiatives among many Plans were limited. It's true that even today, not all Plans are highly skilled at managing care.

Similarly, employers discovered managed care and many (particularly the larger ones) started to offer managed care options. A little later, hospitals and health systems woke up to the fact that their future lay in bonding the essential elements of primary care, acute care, post-acute care, and home care, capitalizing on the power of new information systems, aggressively pursuing case management, and, where successful, going directly to market with selected physicians at risk.

Pharmaceutical manufacturers started to acquire drug distribution systems and case management expertise to maximize the effectiveness of their products. Drug, medical device, and biotech companies began to work measures of cost effectiveness into their field trials, and the U.S. Food and Drug Administration (FDA) started to talk about making cost effectiveness a criterion of approval, as well as of safety and clinical effectiveness.

Boutiques exploiting niche markets (characteristic of mature markets) also focused on managing care, an example being the time when Value Health, with its national database, piggybacked the Blues in such areas as mental health and drugs.

Physicians joined IPAs, physician-hospital organizations (PHOs), and HMOs, gradually integrating themselves into the culture of managed care. The vocabulary of that culture—including words such as salary and bonus—which used to cause apoplectic reactions within the ranks of medical practitioners now were more calmly weighed. Indeed, today it is not in the least unusual for a primary care doctor to negotiate over salary/bonus arrangements.

This was the setting in which the Clinton administration's health care reform proposal was introduced despite signs of deceleration, costs that appeared out of control, and access that was clearly a chronic problem as well as a national disgrace. Public frustration was high. One early indication of this was the theme of the proposal's national debate that included analysis of a single-payer system and the extension of a Medicare-like program to the entire population, as well as the strengthening of the employer-based financing system.

The Clinton proposal was a heavy blend of public and private ingredients. In looking forward, it is tempting to reflect on the operational reasons why it failed and to ignore the underlying reasons, where the essential lessons lie. Operationally, the proposal was poorly conceived and handled; it was too complex, it cost too much, it attracted the widespread opposition of special-interest groups, and it was backed by a president with a weak mandate. However, major lessons are found at the grassroots. This is the fifth milestone:

- In 1993 and 1994, public surveys revealed growing anti-government resentment across the country.
- Young people, expecting to fare better than their parents, found themselves struggling economically and in no mood for more

social commitments. Median household income declined 7% in constant dollars between 1989 and 1993, despite a large number of families with two, and sometimes three, breadwinners.

- Worried about the shrinkage of their income, middle-class and blue-collar workers were resentful that the government had gone too far in offering special programs to minorities.
- Although the economy looked fairly strong, the upper one-fifth of the population earned 45% of the income while the lowest one-fifth earned 4% to 5%—and the widening gulf between the two extremes made the middle three-fifths sullen about tax increases or additional out-of-pocket expenses.
- There was a deeper feeling that top-down command and control bureaucracies, such as the Clinton proposal envisioned, were obsolete. Instead the trend was toward the flattening of corporation(s) into decentralized networks where people take fewer orders from bosses and take more responsibility for the end results. This is rich philosophical soil for devolution to the states and the voucher method of distributing services and entitlements.
- Finally, there was a glimmering feeling here and abroad that a stronger economy was the answer to complex problems vs. a bigger government.

Looking Ahead

After two years of debate, reported daily on TV and in the newspapers, health care policy scarcely was mentioned as an issue during the 1994 off-year elections. As in the past—with the Great Society programs of the 1960s excepted—we are today on an incremental path. Comprehensive national health insurance (NHI) has been put back in the closet. The operative words these days are competition, option, consumer choice, value. Efforts to provide all Americans with equal access to health care services promise to be regrettably meager.

Instead of NHI, we now are debating whether to make Medicare a defined contribution program, restore its Part B premiums to 50% of cost, and open health plans to provider/professional plans—subject mainly to state regulations within federal guidelines. Regarding Medicaid, major proposals include block grants to the states, greater freedom of state action governing eligibility and benefits, and a controlled federal contribution.

For both programs, managed care is cited as an important element in reducing costs. Under Medicaid, it is envisioned that capitation, with managed care, will play an increasing, if not dominant, role.

We might see some liability reform, some insurance reform affecting rating, underwriting and portability, and perhaps some encouragement of purchasing coalitions. State reform, at first grandly predicted, now seems modest at best. Employer-based financing remains our centerpiece, despite serious problems with it, namely, lack of portability, lack of employer sophistication in offering and controlling benefits, and the economic struggles inherent in start-up and marginal industries.

In effect, we are in a period of modest federal government regulation and leadership. Both public and private buyers agree that health expenditures must rise closer to gross national product (GNP) growth and that the best way to accomplish this objective, having tried a modest amount of micromanagement, is to transfer more risk to carriers, HMOs, and providers, while armed with better information on cost, use patterns, and quality.

In the private sector, increases in health care spending already are slowing (between 1990 and 1993, we saw less than one-fifth of the annual growth of the 1980s). However, public sector spending continues at a rate exceeding the economy's ability to sustain it, an issue central to the tension between Congress and the White House.

Count on more dynamic change ahead. Ponder a few statistics. If the highest HMO standards were applied to our current acute bed capacity nationwide, average occupancy rates

would be approximately 18% in the year 2000. We need about one-half the medical specialists who currently are practicing. With technology making health care far safer in ambulatory settings and homes, and with relatively little regulation or government bureaucracy to protect weak performers, is there any doubt that more dynamic changes lie ahead?

The latest signals make this apparent. Some predictions:

- See health systems putting greater emphasis on product lines vs. departments; clinical pathways and outcomes; process improvement; physician/institution partnering (some selling directly to market); growth of physician acquisitions by health systems.
- See differences among staff, group, IPA, preferred provider organization (PPO) and other models narrowing as they get more substantively interested in price and quality.
- See the self-insured seeking more managed care options; starting to move toward defined contributions; and revisiting the concept of employer coalitions and redefining their role.
- See the Health Care Financing Administration giving capitated managed care a closer look; seeking new ways to fund graduate medical education (GME) and research; and looking at offering controlled options (Federal Employees Benefits Program).

These are simply signals, but they portend marked changes for the Blue Cross and Blue Shield organizations.

Initially, Plans filled a social as well as an economic void. Their history in this regard was nothing short of dynamic. They became a major force, almost alone at first, in the building of our modern health care system. Today, what has been built must be reengineered, and numerous competitors want to be part of that action. People want security, but they also want value, and the Blues must be able to address both.

Lessons for Plans

Going forward, most Blue Plans would agree that certain minimum changes are necessary. Here are a few examples:

- Every Plan needs a full range of products—indemnity, PHO, HMO, and point of service. Managed care products must include stipulations that are rigorous regarding provider and physician selection, utilization management, and incentive payments. Capitation must be in the arsenal soon, if not immediately. The market must offer choices; consumers are the best judge of what works, and local market preferences vary.
- Few markets should be considered out of bounds. Given sound managed care options—particularly on a capitated basis—Medicare, Medicaid, Workmen's Compensation, and small groups, for example, should be enrollment targets.
- In the next year or two, health care delivery systems and carriers will decide whether to compete or cooperate. Health systems and physician groups, either together or separately, are beginning to feel muscle and to deal more on their own terms directly with employers or with a series of HMOs and carriers. The situation is still fluid. It is critical that the Blues become risk partners with delivery systems, providing the marketing know-how and capital needed to produce value *and* to stem the growing temptation for employers, government, business coalitions, and providers to bypass carriers. Partnerships should be the central theme for Plans, but purchase of physician practices and other innovations should not be beyond the pale.
- It will be critically important for carriers to have first-rate information systems. Giant strides have been made recently in measuring quality of care, a critical element in marketing value. The medical necessity and technology assessment programs were a fine start for the Blues, but there is increasing information among buyers and

providers on cost and clinical, functional, and satisfaction outcomes—and the precision is growing. A growing number of employers and providers is using guidelines, and their validation are starting to be seen through outcome studies. The cost and outcome data are being joined by way of more sophisticated software. Plans must not only put better options in the market, they also must update those options, such as refining provider selection based on results. If they don't, the consumer will.

Hurdles

In this scenario, what are some of the hurdles that Plans face? Here are three.

1. The biggest and first hurdle to get over is the grip of bureaucracy. As a representative of Robertson, Stephens and Co., an investment banking firm, put it two years ago, Blue Plans "still tend to be big, bureaucratic organizations. They are major cargo ships trying to navigate around a bunch of speedboats." Sluggishness, if you will, is apt to happen to organizations that have grown large. Ask the big three auto makers, IBM, and Eastman Kodak. The internal interests of the company tend to overcome consumer interests, internal territorial disputes become endemic, and key market changes are denied or ignored. Or the cart is put before the horse, as in going public to get equity capital before knowing how to spend that capital.

To their credit, some Plans acting individually have started to deal aggressively with institutional rigidities. But not all—by any measure. The vulnerable Plans need to be reminded, forcibly, that change just doesn't happen. It first takes a vision and then rigorous strategies rooted in a market analysis. It takes looking outward. To effect change, Plans need to recruit new skills and talents at all levels, including their board of directors. The old mindset of indemnity, sales, claims administration, underwriting, and so on, dampens initiative and slows the pace. Too often, internal jurisdictions, bedded in the 1980s, are protected while playing the wrong game.

To survive, Plans must accept the fact that the public and buyer are now in charge, and that they are moving at a quickening pace. It is tempting to underestimate both propositions. It is easy to be lulled into complacency because of trends that were a long time coming into wide use. Consider: Practice guidelines were developed in the late '50s (almost 40 years ago), and only now are being used on a significant scale. The public has been complaining about high costs since the '60s. HMOs have been championed aggressively by labor and the federal government since the '70s. There is a strong temptation to feel that the future will never happen, so why not just sit tight and do nothing. A dangerous notion, to be sure. For example, between the 1950s and 1980s health institutions and carriers—intimidated by professionals—exerted strong forces against change. Vested interests prevailed, professionals were on pedestals. No more. Now the consumer has taken over *and* is better armed with information, not to mention skepticism. A remarkably different scene from days of yore.

2. The Blues must become *even more* energetically involved in influencing public policy, not as a defense against comprehensive health care reform, but with the dead certain knowledge that, absent reform, the Blues and others at risk will not be able to compete effectively in the future. A great deal is at stake here. Among other challenges, the Blues must face up to the need for some form of mandated benefits, some version of community rating and control over excess underwriting, some sort of provisions for portability, and some way to remove payments for GME and medical research from the patient payment process. Without enlightened regulation, competition among carriers, HMOs, and delivery systems could become counterproductive and certainly inimical to Plans.

Substantive involvement will require allies and a careful crafting of the message as a public/private partnership. It was a blessing that the Clinton program never saw the light of

day, but a tragedy that some type of reform was not put in place.

3. Finally, let us turn to structure. Significant loss of market share on a national basis (from 37% in 1981 to 24.6% in 1995) should be a wake-up call, but there are other symptoms over the years that should not be ignored by Plans. Here are some significant ones:

- In 1965, there was a great deal of unrest among the Blues about the intermediary role under Medicare; the prime contract was signed with two major Plans claiming they would not participate (ultimately, they did).
- In the late '60s, Blue Cross Plans voted, by a margin of six among more than 2,000 weighted votes, that HMOs were acceptable benefit options—hardly a landslide even though the market had started to speak about the virtues of HMOs to anyone who would listen.
- It was like pulling teeth to get the medical necessity program going on a modest level and then to make it work—despite strong employer pressure to seek value.
- In recent years, Plans have spent millions on studies of the overall Blues System with seeming little change or advancement to show for it.

Decisions have come too slowly and often with too much compromise. Frequently, egos were at stake, not legitimate issues. Add to this the fact that territorial discipline seems to be breaking down rapidly. As of year-end 1994, 61 Plans had established 568 subsidiaries/affiliates, the vast majority of them for-profit corporations. Under various structures, Plans are moving into markets in contiguous states as well as leapfrogging across state lines. Representatives of Plan subsidiaries, such as Wellpoint Health Networks, speak openly of acquiring other Blue Plans. Often the driving force is what is available, or who is vulnerable, vs. an overall market plan for the overall Blues system.

Two brief observations should be made in closing. First, the number of Plans should be

determined by what it takes to do the job most effectively, once there is reasonable consensus with the Blues System on a vision and market strategies. If this means reducing the total to 20 or 30 regional Blue entities, so be it. Local sensitivities and linkages can be preserved through local sub-boards and managers. Further consolidation may be needed to achieve adequate access to capital, to attract the caliber of management needed and to achieve adequate economies of scale. Though it certainly would be better to decide structural issues while Plans are healthy, instead of under a scenario where they desperately need help or are despairing enough to sell to outside buyers.

Second, the role for a centralized organization, such as the Blue Cross and Blue Shield Association, should be redefined on the basis of market need rather than within the narrower scope of tradition. The *we/they* dance (Plan/Association) must stop. There is clear potential, beyond economic scale opportunities, associated solely with the time-honored functions of representation, health services research, education, and Plan performance. For example, should the Association take on a changing Medicare function wherein Plans are service centers? Should there be a better managed care framework for an aged population that is highly mobile? Is there significance in the fact that the Blues national market share of the Federal Employees Benefits Program is 43% while, overall, the Plan's national market share is currently 24.6%? Alternatively, should each Plan go its own way? The only ones that appear to hold that hope about the Blues are their main competitors.

Facing the challenges outlined here will be no mean feat. Competition from new quarters (provider networks and business coalitions), plus old quarters (insurance companies and HMOs)—and even from within the Blues' ranks—makes it all the more imperative that, acting collectively, Plans give these challenges their best effort—and that they do it now.

Plans cannot fully unlock their considerable potential without adding public members to the Blue Cross and Blue Shield Association's board. Consider, for example, the experiences some major corporations have had with too many inside directors and too many cronies from the Old Boy network. Consider as well the trouble the Joint Commission on Accreditation of Healthcare Organizations had dealing with major strategic issues with a board dominated by providers and professionals—even to the point of almost losing deemed status—until public members were added. Note the favorable impact public members have had on the Plan Performance Board.

Pawns of the Plans should not be put on their boards as representing the so-called public. Instead, the emphasis should be on garnering the brightest and best people—including those representing appropriate diversity. Without this fresh input, old cliques, rivalries, and the drag of bureaucracy will prevail.

Some Plans will produce wealth and capital for growth through better focus and synergies. A national organization that is, selectively, operational as well as a trade association partner will add to this wealth through further synergies.

This new wealth can be used for several purposes. It can be given in part to stockholders; it can be used to accelerate the Blues into managed care entities, new information systems, and numerous other innovations. It can be used to maintain community accountability by continuing attempts to provide some security for those people who exist at the margins in the face of a government not inclined to help.

What *is* the Blues' vision, defined by what structure and what set of strategic directions?

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