Special Communication

The Settlement of the Blue Cross Blue Shield Antitrust Litigation
Creating a New Potential Catalyst for Health Insurance Industry Restructuring

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Abstract

IMPORTANCE The recent settlement of the class action antitrust lawsuit against the Blue Cross Blue Shield (BCBS) Association and 34 plans will bring substantial change to insurance markets in the US; however, not enough is known about the implications for insurance markets and health policy.

OBJECTIVE To detail the nature of the antitrust claims against the BCBS plans and their Association, and the required changes in their business practices that are a critical part of the settlement.

EVIDENCE REVIEW This analysis relies on the court documents that will set the new parameters under which BCBS plans must operate.

FINDINGS For many of the past 70 years, BCBS plans have enjoyed substantial market power in the state in which each operates. Other BCBS plans were not allowed to compete against other “Blues” plans, and any corporation resident in a plan’s territory was allowed to deal solely with the local plan if the corporation sought BCBS insurance for its employees. The settlement recognizes that these restrictions reduced competition; therefore, they are not allowed under federal antitrust laws going forward. The BCBS Association also will have less control over mergers and acquisitions by individual BCBS plans. Finally, the BCBS plans and the Association must pay $2.67 billion in damages to clients.

CONCLUSIONS AND RELEVANCE These findings suggest that BCBS plans will face competition from their fellow plans for business, and they will be allowed to diversify the services they provide. These changes will be likely to threaten the smaller BCBS plans and could bring consolidation to the health insurance industry. These changes should also promote sharper efforts toward health care cost management, with broad implications for other parts of the health insurance industry, and for hospitals and other health care services.


Introduction

Blue Cross Blue Shield (BCBS) insurance companies are an enduring and prominent part of the US health care system. There are currently 36 independent, locally operated BCBS plans resident in every state, indeed covering people in every zip code in the country.1 The plans provided coverage for 109 million people in 2021, contracting with over 90% of hospitals and physicians in the country. Plans generally operate as state-based entities, except for the Health Care Services Corporation, which controls the plans in 5 states, including Texas and Illinois; and Elevance Health, formerly known as Anthem, which consists of 14 state plans. Elevance operates the only for-profit BCBS plans. The plans all collaborate through the BCBS Association.

The BCBS plans were arguably the first US health insurers, growing from an effort started in 1929 to allow prepayment, first of hospital services and then of physician services. The BCBS plans are highly regarded by the public, with a brand that is typically the highest ranked among health

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Over the years, that brand has been closely guarded by the BCBS Association, which sets forth a series of rules to which the licensed BCBS plans must adhere. These rules define the unique nature of the BCBS system: plans have a monopoly in their state on the Blues brand; national employers seeking a BCBS contract generally must deal with the BCBS plan in the state in which the employer is headquartered; and BCBS plans share the rates they have contracted with the health care facilities and practitioners in their state with other BCBS plans, using the so-called Blue Card. Given that BCBS plans are the largest or second largest insurer(s) in nearly every state, rates are very competitive.

These facts are associated with the long evolution of the relationship between the state plans and the BCBS Association, and they are widely accepted in US health care. Yet, they would strike anyone interested in the US law of competition as exceptional, even objectionable. It is difficult to understand why the federal government has shown little interest in the BCBS arrangement as potentially a violation of the antitrust laws. However, during the past decade, a group of private plaintiffs representing both health insurance subscribers (the subscriber class) and health care practitioners (the provider class) have brought a set of private class action claims under the Sherman Act alleging that the arrangements between the BCBS Association and the member plans violated federal antitrust law by allocating territories and limiting competition. Allocation of territories by competitors is a well-recognized antitrust violation.

These class actions were consolidated in the Northern District of Alabama; in April 2018 a judge ruled on the summary judgment motion in the subscriber class litigation that the market allocation strategy at the heart of the “Blues system” was per se a violation of Section 1 of the Sherman Act. In light of this ruling, and its affirmation by the Tenth Federal Circuit Court of Appeal, the subscriber class of plaintiffs and the BCBS Association and its members have now agreed to a settlement that pays the subscribers $2.67 billion. Perhaps much more important to the shape of the US health insurance industry, the settlement provided injunctive relief that created what the plaintiffs correctly identified as “significant, unprecedented, and far-reaching changes to the Blue Cross Blue Shield Association rules and regulations.” Given the central role that BCBS plans play in the US health insurance industry, it is important to understand the implications of these changes on business going forward.

### Hospital and Insurer Market Dynamics

Hospitals and insurers have a long history of negotiating rates. The logic in the market is simple: if a hospital system is large enough, then an insurer must have them in the network, and must pay high rates. Alternatively, if an insurer controls a large portion of the market, the hospital system must be in its network, and will accept lower rates. This incentive to create market power has attracted the attention of federal antitrust enforcement for a long time.

The stakes for market leverage are quite high, and hospitals, even in the face of antitrust scrutiny, continue to consolidate. In 2016, 90% of hospital markets were highly concentrated by standard antitrust definitions. Creating market leverage works. The range of estimates of the increase in hospital prices in a particular market after a major merger runs up to 40%, with estimates of greater than 20% not unusual.

In their defense, hospitals will counter that they face consolidated insurance companies. MedPAC agrees with this observation. Based on a state analysis, 11 major metropolitan areas had super-concentrated insurers in 2003, and 21 in 2017. Much of this super concentration in particular states has been associated with the size of the local BCBS plans. There is a destructive circularity in the arguments that hospitals and insurers use to justify consolidation.

The BCBS plans have thrived on their local market share, gained in the 1950s and 1960s, to get the best rates from hospitals and physicians. For example, in the group market serving large employers, the overwhelming number of BCBS plans have a market share greater than 50%, with a
share greater than 90% not uncommon. Having market share of this size means that practitioners must accept comparatively lower rates of reimbursement from BCBS plans.

This creates a strong advantage for the BCBS plans in what is essentially the local business: small employers located wholly within the state in which the plan operates. However, historically it has not helped them in terms of providing coverage for large multistate employers because the local Blues plan could use its market leverage only in contracts with the practitioners in its exclusive state or regions.

To remedy this competitive disadvantage, Blues plans decided to work together to share their networks with one another, using the so-called BlueCard. The BlueCard program means that any national employer who contracts with the Blues plan located in their headquarters' state gets to access the Blues rate in every state. Essentially, the BCBS plans share their excellent local networks with one another, enabling them to compete for large multistate employer business. When the BlueCard was put in place in 1995, BCBS plan enrollment, which had been declining, began to rise again, according to court documents (April 5, 2018).

The other key part of the BCBS collaboration is defining the territory. Simply put, each state is to have 1 BCBS plan. This arrangement is maintained by the BCBS Association and holds nearly universally except for some historical accidents on the West Coast (Anthem BCBS and Blue Shield of California; Regence BCBS of Idaho; Regence Blue Shield of Washington and Premera) as well as divisions of the states of New York and Pennsylvania into regions. So, competition between BCBS plans is carefully limited.

As well, each plan has an exclusive right to sell BCBS products in its own state. If a multistate employer wants a BCBS plan, it must use the local plan. So, for example, Walmart, headquartered in Bentonville, Arkansas, must use BCBS of Arkansas if it wants Blues coverage for its employees.

This 1 Blue per 1 state arrangement was nearly universal until the late 20th century when BCBS of California and Anthem BCBS in Indiana instigated a cascade of mergers that created what is now Elevance Health. The consolidation process may have persisted. However, attorneys general in a number of states began to question whether there was any real value created by these larger for-profit entities, and several mergers were halted.

The Antitrust Litigation in Alabama

It is in this context that the class action in the Northern District of Alabama lands. On August 9, 2022, Judge Proctor gave final approval to the settlement. The parties will now move forward to clear up the variety of complicated issues that attend disbursement of the $2.67 billion to the class of subscribers (and to their lawyers). But it is the required changes in business practices that are most important for the health care system going forward.

In its final decision, the court found that the BCBS Association and the member health plans were essentially dividing the market for health insurance and refusing to compete with one another. The requirements for new business practices, negotiated between the plaintiffs and the BCBS Association and affiliated plans, reflected antitrust principles that should have been applied long ago.

There are 4 major new changes that the Blues agreed to in the settlement. First, national accounts with more than 5000 employees are no longer restricted to the local Blues plan. In particular, they can seek a second bid for service from another BCBS plan, enabling the employer to require that the 2 Blues plans compete with one another. This is perhaps the most important competition change because now small Blues plans face competition from larger ones.

Second, BCBS plans had been restricted by the BCBS Association from engaging in business activities outside of the Blues branded health insurance, a requirement known as the "National Best Efforts." Specifically, the National Best Efforts rule, adopted in 2005, required plans to derive two-thirds of their national health insurance revenue (revenue attributable to health care plans and related services and hospital services) under its Blues brands. This not only restricted the businesses
in which the BCBS plan could engage outside of health insurance, but also insulated BCBS plans from being purchased by outside organizations with other business models. Going forward, the National Best Efforts clause will no longer be enforced.

The National Best Efforts amendments are overshadowed by the Local Best Efforts rule. This rule, adopted in 1994, requires that at least 80% of annual health revenues for a Blues plan be derived from its BCBS-branded business. The settlement caps this requirement at 80%. Nonetheless, a BCBS plan in a state still must have most of its health insurance business under that Blue brand. Actually, the settlement has had little change on the local Best Efforts rule.

The original rationale for local and national best efforts was, at least in part, to ensure the integrity of the Blues plans in each state. Once other plans began to rely on one another, through the Blue Card, they all had incentives to ensure the local Blues plan had a good network, negotiated hard, and attracted business. The national and especially the local best effort ensured that health insurance remained the principal business of the local Blues.

Third, historically, the BCBS Association has had some control over acquisitions of Blues plan. That is now more limited. The BCBS Association can object to an acquisition of a Blues plan, but that dispute is then mediated by a monitoring committee, set up under the settlement. If the monitoring committee cannot resolve the dispute, it goes to binding arbitration. That arbitration must account for the need to promote competition and to protect the Blues brand.

Fourth, the use of most favored nation (MFN) clauses is limited. These clauses, which are not allowed in certain states, require practitioners to give BCBS plans rates as low as any competitor. Going forward, if a BCBS plan has a greater than 40% market share in commercial health benefits and the state does not otherwise regulate the situation, the plan cannot use MFN strategies except in special circumstances.

The settlement is binding on all the subscriber plaintiffs, the BCBS plans, and the BCBS Association. Recently, 3 employers appealed the settlement, but this is unlikely to make substantial changes to the terms of the settlement. However, the BCBS antitrust litigation is not finished. The practitioner plaintiffs’ class is currently seeking certification and $4.3 billion damages.

Implications of the Settlement

The modifications in the ways that the Blues plans do business wrought by the subscriber settlement are substantial. Competition in insurance markets heats up. The second bid option is an opportunity for every commercial client to get lower rates from a competing Blues plan. Employers will no longer be bound to the BCBS plan in their state.

Blues plans vary in size and in their scope of capabilities. Those in larger states, or the multistate plans (Health Care Services Corporation and Anthem) may have a variety of cost reduction products that small states cannot offer. One can imagine that the larger and perhaps more ambitious plans may aggressively bid on national accounts, or even on large local clients (eg, state and municipal governments) that previously had been reserved for the local Blues plans. In turn, this could create pressure among smaller plans to consolidate to develop competitive resources. The only relief for the local Blues plans is that if business goes to a competing plan, the competitor plan must pay the local plan a Local Service and Support Fee for beneficiaries residing in the local state. This would be more important for clients that are mostly locally based (eg, municipal governments) than for multistate employers.

Going forward, individual clients can request another Blues bid. This new competitor will pay some fees to the local plan for the client’s state residents. Otherwise, the new competitor can use the Blue Card rates. For example, it does not have to negotiate new hospital contracts. It will apply its own care management and utilization management strategies and, perhaps, be able to offer clients an improved price. The same applies to new alternative payment models, which would be based on the same Blue card rates but could be more efficacious.
The changes in the national best efforts rule also fuels the potential of consolidation. A large state-based plan is no longer restricted in the business it can undertake outside of its local branded Blues business. For example, a plan such as this could now purchase and operate a national care management company, which could then be used to make its forays into other states more attractive. Or it could buy insurers outside its original state. Thus, the horizon opens substantially for ambitious plans.

Few plans have shown such an ambition, but there is some precedent. For example, Highmark BCB is originally the Blues plan for Western Pennsylvania. In 2011, Highmark merged in BCB of West Virginia after a 12-year affiliation. In 2012, it absorbed BCB of Delaware; in 2015, BCB of Northeastern Pennsylvania; and in 2021, the former HealthNow New York (the BCB plan for Western New York). Highmark also operates HM Insurance Group, which sells re-insurance and stop-loss products; United Concordia, which provides dental insurance; the Allegheny Health Networks, which operates more than a dozen hospitals and numerous outpatient centers; and HM Health solutions, which provides claims processing and other back-end functions for health plan clients.

All of this has developed under existing rules, but the second bid provision as well as the lifting of the National Best Efforts rule will no doubt propel further diversification and competition. In the past, Highmark had to be careful with its nonbranded business to avoid trespassing the National Best Efforts' two-thirds branded revenue rule. This is no longer the case. Energetic Blues plans can now openly pursue an Optum-style strategy, developing a line of care management and data analytics capabilities that they can sell to others. It would seem the changes in the BCBS Association’s approval rights for mergers also could lubricate further rolling up, such as Highmark has done.

The waiver of the National Best Efforts rule appears also to open the door for non-Blues insurers to buy Blues plans. Their non-Blues branded insurance business no longer disqualifies them as long as they have relatively little of this business in the target state.

The most likely scenario for further consolidation is quiet affiliation and merger between the remaining non-profit Blues, a strategy such as the kind that Highmark has pursued. This does not require the kind of politically fraught conversion to a for-profit and development of a residual nonprofit foundation that occurred during the Elevance roll up. Nor does it necessarily need approval from state health insurance commissioners. Alternatively, plans developing care management and analytics capabilities may just sell these services to other plans, avoiding all the political entanglements associated with a merger.

Generally, in health care today, size matters. The top 10 hospital systems now control 24% of the market, and their revenues are growing at twice the rate of the rest of the market. Mergers are increasingly creating regional systems, such as the recently announced merger of SCL Health in Colorado with Intermountain Healthcare, based in Salt Lake City, Utah. This new entity will operate 33 hospitals and 385 clinics. With the demand for hospital beds decreasing over the next decade while ambulatory demand presumably grows, small hospitals simply will not have the capital for transformation. More consolidation will occur.

Blues plans will have to be prepared to match the leverage that ever larger hospitals systems will bring. Perhaps even more compelling, Blues plans will have to match their insurer’s competition, which continues to move toward vertical integration of health care services with insurance. Large insurers are now combining health insurance with a variety of other services, including provision of care. Optum, which provides pharmacy benefit management, data analytics, and physician care, is owned by United Health Group, which also owns the United health insurance company. Along the same lines, CVS Health recently purchased Aetna, the health insurer. Anthem is carefully investing in care management and practitioner and hospital partnerships. Eventually other insurers, specifically regional Blues plans, will have to figure out how to add these capabilities. Small plans in small states may simply not have the capital to add capabilities, especially if they begin to lose business to a second Blues plan that is being allowed to bid on their local clients.
Conclusions

Predictable change is afoot for the BCBS world. Market forces themselves have been putting pressure on the smaller Blues plans, but the Blues infrastructure partially protected them. Now that this protection is removed as anticompetitive, change will most likely quicken. It is difficult to estimate exactly how the evolution will proceed, but further consolidation seems highly likely. It may seem paradoxical that an antitrust ruling intended to unleash market forces could in turn create the context for new mergers and collaborations. However, we must remember that antitrust law protects competition not competitors. The Alabama class action exposes new market forces, and they will create more rapid change in the insurance industry generally, and among the BCBS plans in particular. Whether these changes will ultimately reduce cost or improve quality remain open questions.

ARTICLE INFORMATION

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REFERENCES


