the BLUE CROSS® STORY

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BY ROBERT M. CUNNINGHAM

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the public affairs committee

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THE BLUE CROSS STORY

BY ROBERT M. CUNNINGHAM

Mr. Cunningham has been Editor of Modern Hospital *for fifteen years. He has written many articles on hospital and medical subjects, and is author of several Public Affairs Pamphlets, the most recent of which are* Your Operation *and* Meeting the Costs of Medical Care. . . . *This pamphlet was illustrated by Visual Services, Inc.*

EVERY day, hospitals in the United States, admit more than 65,000 patients—as many people as there are in the entire population of cities like Terre Haute, Indiana, and Bethlehem, Pennsylvania. Most of these patients are treated and discharged within a few days; the average stay in a general hospital now is less than eight days. Within that short time, however, the services the patient receives are so intensified and complicated, requiring so much special equipment, material, and personnel, that the hospital bill mounts swiftly to over $200, on the average, and is often much more.

A hospital bill of several hundred dollars would be a hardship for most families and a disastrous blow to the family economy in many instances. Fortunately, for two-thirds of the families incurring hospital bills today, there is no great worry about payment. These families have been budgeting their hospitalization expense as they do other family and household expenses. They have been paying for hospital care month by month, before it is actually needed. Two-thirds of the U. S.

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population is thus prepaying for hospital care through Blue Cross, or through one or another of the numerous insurance programs that have emerged in recent years, stimulated into existence by the growth and popularity of the Blue Cross idea. In 1959, Blue Cross Plans paid nearly $1,500,000,000 for services rendered to Blue Cross members!



Without Blue Cross, some of the families for whom these payments were made would have paid the bills themselves—perhaps using up family savings, or going without something they had hoped and planned to buy, or going into debt. But without Blue Cross, many families simply couldn't have paid their hospital bills at all. The bills for these families would have become a burden on the charitable resources of our hospitals, and on the taxpayers.

HOW BLUE CROSS WORKS

As a prepayment program, Blue Cross, like insurance, is based on the law of averages — in this case the predictability of hospitalized illness and injury among large population groups. Fundamentally, prepayment for hospital expense through Blue Cross is possible because, while we never know when a member of the Smith family is going to need hospital care, we can predict with considerable accuracy how many hospital cases

will occur in a group of 1,000 Smith families. Blue Cross is simply a method of collecting enough from all the Smiths to cover the hospital bill of the Smith who gets sick.

exchanging dollars for service

If Blue Cross were nothing more than a system of collecting from many in order to pay for a few, it might be indistinguishable from insurance and from many benevolent funds and other enterprises based on the principle of predictability. The unique character of Blue Cross emerges from its relationship with the hospitals that render service to Blue Cross members, permitting the members to receive this service without paying for it at the time it is needed. Where insurance and other mutual funds collect dollars from participants and pay back dollars when a loss is incurred, Blue Cross collects dollars from its members and "pays back" hospital service when it is needed. The services are then paid for under separate contracts between Blue Cross and its participating hospitals.

As a member of a typical Blue Cross group, Mr. Smith may pay from $5 to $10 a month, usually by means of a deduction from his paycheck at his place of employment. In return, he and the members of his family who are enrolled with him may receive, without charge, hospital care in a semi-private room for 21 to 120 days in any year, in addition to other needed hospital services such as laboratory examinations, operating room service, and medications. Usually, these benefits are provided for all conditions commonly cared for in the general hospital. Hospitalization for any illness or injury for which the patient is entitled to receive care under the workmen's compensation law or in a veterans' hospital is not included in most Blue Cross Plans.

Of course, there are many different Blue Cross Plans, and several types of contract in each Plan, with varying schedules of rates and benefits. But the basic principles of family coverage providing service in semi-private hospital accommodations are

characteristic of Blue Cross Plans. Blue Cross subscribers may enroll three or more family members at the same rate; some subscribers have a dozen or more children enrolled under a single contract at the family rate; the average subscriber contract covers 2.5 persons.

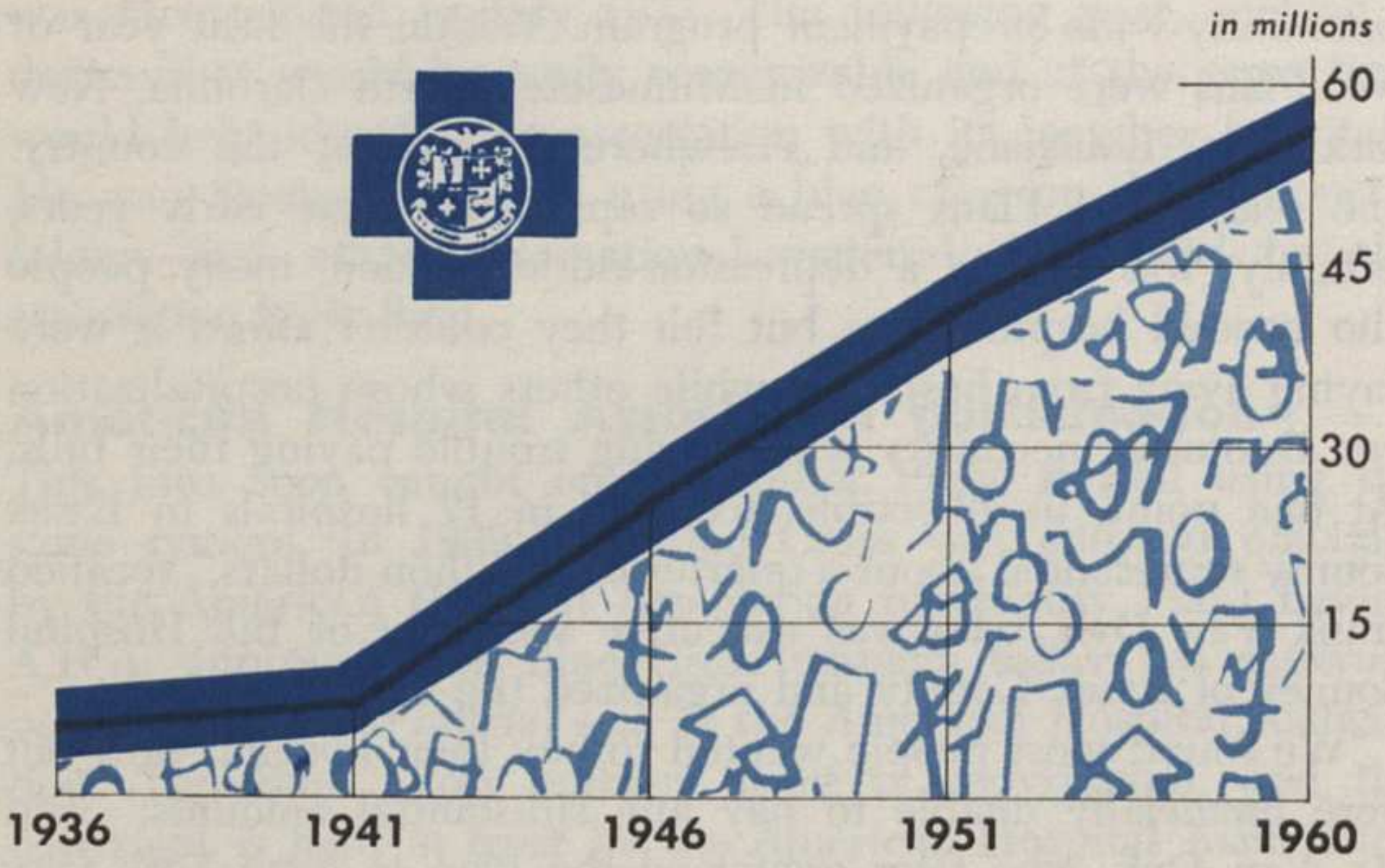
nonprofit community service

Blue Cross Plans are incorporated under not-for-profit charters, as is customary with private institutions performing a public function. Blue Cross Plans are approved by the American Hospital Association, and, as a condition of approval, the Plans must be organized as nonprofit or voluntary enterprises, and their governing bodies must include representatives of the participating hospitals, as well as the general public.

Unquestionably, it is this community character of Blue Cross that has made possible its phenomenal growth; 57,000,000 members have been enrolled in thirty years — more by far than have ever joined a voluntary enterprise in a like period in all the world's history. Generally speaking, the public representatives on Blue Cross boards of directors have been civic-minded leaders of business, industry, and the professions who approached their assignments with Blue Cross, as they would a similar responsibility for the community chest or any other voluntary activity, solely with a view to serving the public interest. These men and women have served without pay or reward of any kind, often devoting many hours to the development of Blue Cross policies and the solution of Blue Cross problems. Others who contribute their time and services freely to Blue Cross are the representatives of subscriber groups in industry, labor, and farm organizations.

early history of blue cross

The Blue Cross concept originated in Dallas, Texas, in 1929, when Justin Ford Kimball, Ph.D., executive vice president of Baylor University, worked out a plan under which Dallas school



teachers paid a small sum per year to the university hospital and were assured of receiving hospital care without charge when they needed it. The plan became effective December 20, 1929, with 75 per cent of all the eligible teachers in Dallas participating.

The Baylor Plan was an immediate success. Soon others besides school teachers asked to be included, and other hospitals began experimenting with similar programs. In 1931, the Baylor program was described at the annual meeting of the Texas Hospital Association, and details of the plan were also presented that year to the American Hospital Association. By that time, it was apparent that single hospital, single group programs were limited in usefulness and caused endless complications in cities having several hospitals.

In 1932, a group of hospitals in Sacramento, California, joined together in organizing a community-wide prepayment plan in which the hospitals jointly agreed to provide service for mem-

bers of subscribing groups. The same year, the Hospital Council of Essex County at Newark, New Jersey, undertook a similar, community-wide prepayment program. Within the next year or two, Plans were organized in Minnesota, North Carolina, New York City, Louisiana, and elsewhere throughout the country. One reason the Plans spread so rapidly in those early years, certainly, was that in a depression-ridden nation, many people who needed hospital care but felt they couldn't afford it were staying away from hospitals, while others whose hospitalization was absolutely necessary were having trouble paying their bills. "At one point, uncollectible accounts in 17 hospitals in Essex County represented about a quarter of a million dollars," recalled Frank Van Dyk, who was executive secretary of the Hospital Council of Essex County and organized the Newark Plan.

"We found most people wanted to pay their hospital bills but were financially unable to pay any substantial amounts," said Mr. Van Dyk, who later organized the Plan in New York City and who is still an executive of the nation's largest Blue Cross Plan. "The natural conclusion was that if people could afford to pay a dollar a week, or some stipulated amount per month, they probably could do it much more conveniently when they were not burdened with expenses incident to hospital care."

Mr. Van Dyk visited Dallas to observe the Baylor Plan in operation and concluded that the most feasible solution was a community-wide, multi-hospital program.



the blue cross symbol

Another early leader of the hospital service prepayment movement was the man who later contributed the symbol under which 57,000,000 people are enrolled today — the Blue Cross. * This was E. A. van Steenwyk, now director of Philadelphia's

*Mr. van Steenwyk died in 1962, after publication of this edition. At that time he had completed many years of service as president of the Philadelphia Blue Cross Plan.

Blue Cross Plan. Mr. van Steenwyk was the first executive of the Hospital Service Association of St. Paul, Minnesota, which was incorporated in July 1933. The following year, seeking a device that would be easily recognizable and at the same time would help identify the association with its member hospitals, Mr. van Steenwyk started using a blue cross on the stationery, folders and other informational material distributed by the association in St. Paul.

American Hospital Association participation

This idea soon caught on, and other Plans started using the same symbol. In 1939, the Blue Cross was adopted officially by the American Hospital Association to identify Plans having A.H.A. approval. The Blue Cross emblem today has superimposed upon it the official seal of the American Hospital Association. The Blue Cross emblem itself is copyrighted, and the copyright is held in trust by the American Hospital Association under a special licensure agreement among all the participating Blue Cross Plans. Use of the symbol is thus governed by the American Hospital Association; Plans using the emblem meet A.H.A. standards of approval, and the words "Blue Cross" have long been accepted by the public, as well as by the hospitals and physicians, as assurance of the nonprofit, community sponsorship that has characterized these hospital service prepayment Plans since their beginning thirty years ago. While only a dozen of the hospital service Plans have the words "Blue Cross" as a part of their official corporate names, all the Plans are known informally by that name and use the Blue Cross emblem. The most commonly used words in the official names of Blue Cross Plans are "hospital service corporation," or "hospital service association," or simply "hospital service." Other titles are "associated hospital service," "group hospital service," and "group hospitalization."

The American Hospital Association had taken its first step toward official interest in the hospitalization prepayment move-

ment in 1933, when it issued a series of recommendations that were known as "Essentials of an Acceptable Plan for Group Hospitalization." As listed at that time, the essentials covered the following phases of Plan organization and operation:

1. *Emphasis in the Plan's operation should be on public welfare as opposed to the special interests of any particular group.*

2. *Benefits in contracts offered participating groups and members should be limited to hospital services.*

3. *The Plan should seek to enlist the interest of public and professional groups on a community-wide basis.*

4. *Nothing in the operation of the Plan should limit free choice of physician and hospital by subscribing members.*

5. *The Plan should be incorporated not-for-profit.*

6. *Rates charged to subscribing members, and payments to participating hospitals, should be so arranged as to provide for economically sound operation.*

7. *Promotion methods and enrollment of members should be conducted by cooperative and dignified methods in keeping with the Plan's identification with hospitals.*

The essentials have been revised and elaborated many times as Blue Cross Plans have developed during the last thirty years, but the basic principles have remained consistent throughout that period. Plans will be approved by the American Hospital Association only if they live up to these principles.

Blue Cross Association

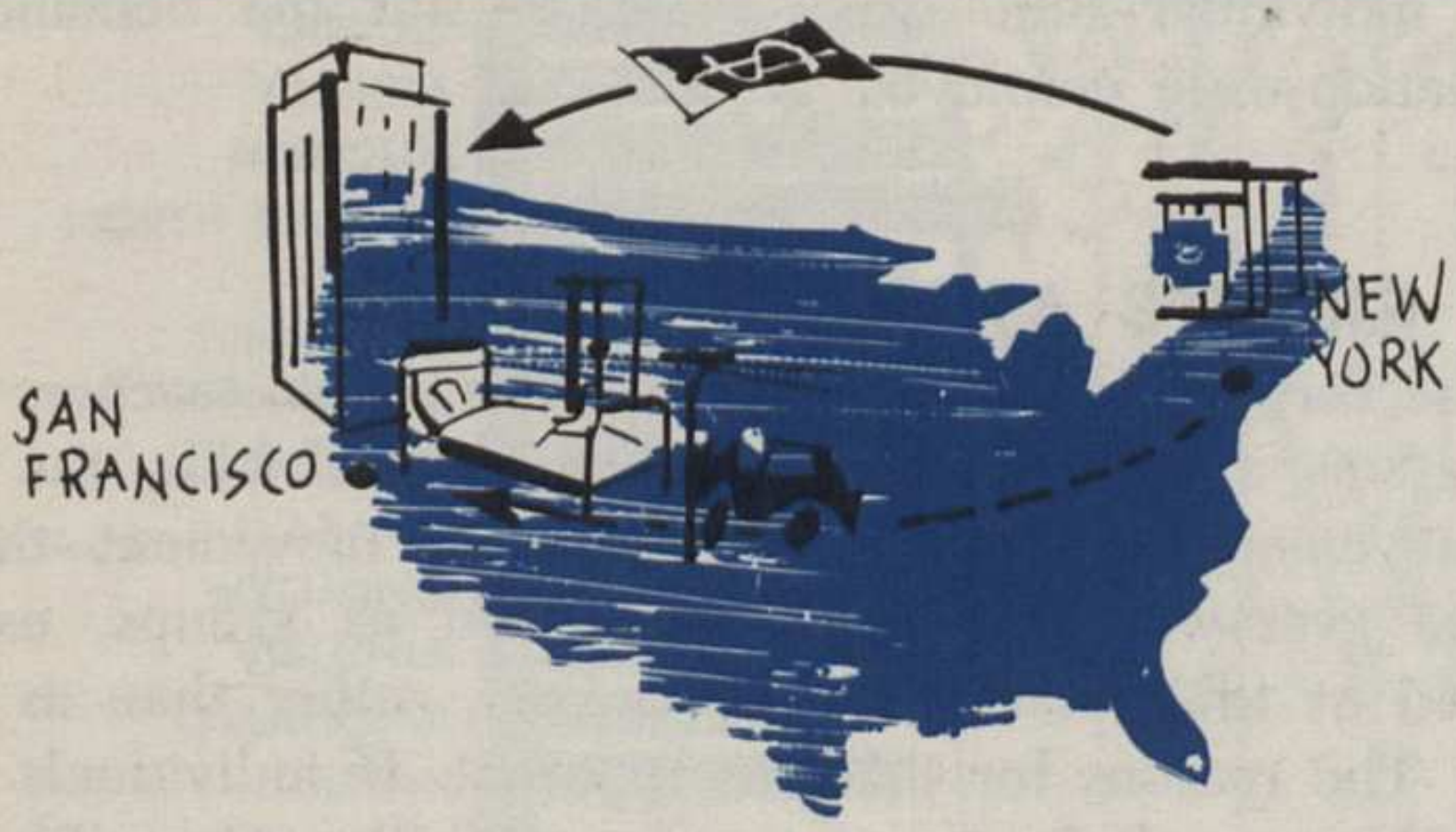
Because the Blue Cross Plans are separate corporations in separate jurisdictions, each Plan having its own contracts and its own schedules of rates and hospital benefits, it has been difficult for employers having plants and offices all over the country to enroll their employes in Blue Cross on a uniform basis. Sometimes, these national employers have preferred to buy a national insurance policy; usually these policies offer less

coverage or protection than Blue Cross, but they do enable the employer to make a single contract covering employes in several states, paying the same rate for the same benefits.

In order to meet this problem, the Blue Cross Plans in 1956 broadened the scope of the Blue Cross Association, which had been organized initially in 1948 to operate a company that would offer a single contract for national employers. One of the jobs of this association is to consult with national employers, find out what type of coverage is best suited to the employes' needs, and then arrange for the contracts to be written by the participating Blue Cross Plans in the areas served.

The association also represents Blue Cross in contracting with the Armed Forces of the United States to provide care in community hospitals for the dependents of servicemen. This is the "Medicare" program under which Blue Cross Plans in 34 states and territories are assisting the government in the care of several hundred thousand patients every year.

The Blue Cross Association also operates an "Inter-Plan service Benefit Bank," which makes it possible for subscribers to be hospitalized away from home and outside the areas served by the Blue Cross Plans to which they belong. The bank arranges with the Plan in the area where the member receives hospital



service to provide the benefits of Blue Cross membership; the local Plan makes payment to the hospital in accordance with its regular, existing arrangement, and then in turn collects the payment from the member's "home" Plan.

To discharge all these tasks efficiently, the Blue Cross Association operates a nationwide, 19,000-mile private wire system, interconnecting all the Blue Cross Plans. The affairs of the Association are managed by a board of governors consisting of 22 executives of participating Blue Cross Plans and three appointees of the American Hospital Association.

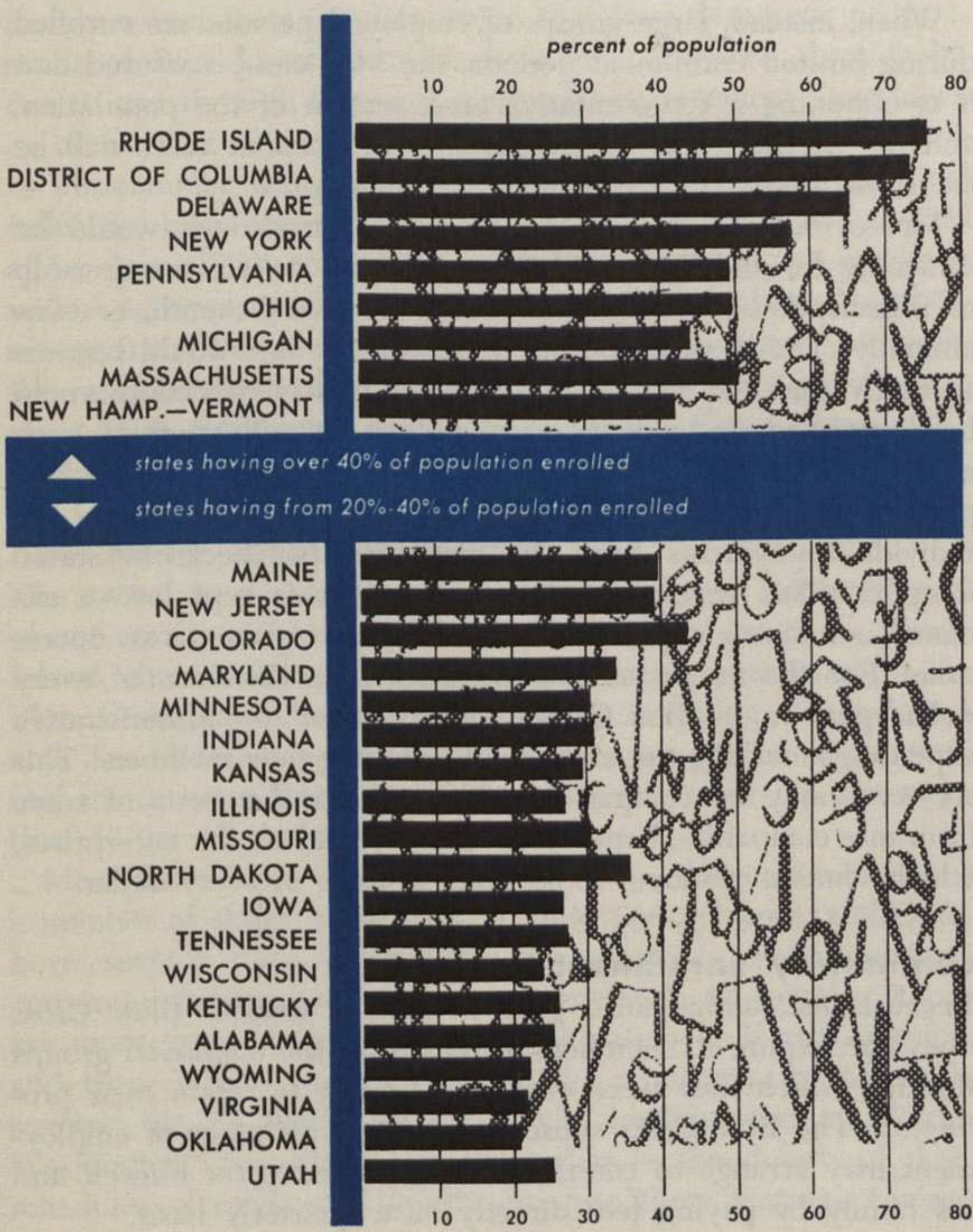
Health Service, Inc.

In addition to the association, Blue Cross Plans also operate a stock casualty insurance company, Health Service, Inc., which was organized in 1948 to help meet the needs of national and international employers for uniform contracts. If a Blue Cross Plan is unable to provide any part of the service needed by members of a national group, Health Service, Inc. will underwrite these benefits. This company also offers special types of coverage not included in Blue Cross contracts, and has initiated experimental programs in new types of coverage, such as comprehensive health and medical benefits. In effect, Health Service, Inc. thus acts as an "equalizer," adjusting the contracts of the various individual Blue Cross Plans to suit the demands of large, nation-wide employed groups.

HOW GROUPS ARE ENROLLED

From the very beginning, when the Dallas school teachers were organized as a group to prepay their hospital bills, the Blue Cross movement has been primarily a group movement—that is, members everywhere have been enrolled as groups, usually organized at their places of employment, rather than as individuals. The reasons for this are apparent. If individuals were permitted to enroll freely as members of Blue Cross Plans at

MORE THAN HALF OF THE UNITED STATES HAVE OVER 20% OF THEIR POPULATION ENROLLED IN BLUE CROSS



any time, many people would wait until some member of the family became ill, then rush to sign up in order to have the hospital bill paid for by Blue Cross. As a result, the rate of hospitalization among members would be excessively high, and the saving effected through prepayment would vanish.

When, instead, large groups of employed persons are enrolled during limited enrollment periods, the Plan can be assured that it is obtaining a representative cross-section of the population, and the predictability of the number of hospital cases will be the same as it is for the general population.

Moreover, with millions of members enrolled, it would be unwieldy for Blue Cross Plans to bill and collect membership or subscription fees from every member every month, or even annually. The clerical and administrative details would become so costly that the economies of Blue Cross membership would be diminished. Instead, the Plans collect a single payment each month or quarter from the employer on behalf of all the employes who are enrolled, and the employer in turn deducts the individual payments from the employes' paychecks at stated intervals. This way, the collection expense is kept low—a circumstance that is apparent in the efficiency of Blue Cross operations. For the nation as a whole, less than six cents of every dollar paid in to Blue Cross Plans is spent for administrative expenses, including the expense of enrolling new members! This six cents may be compared with administrative costs of some insurance companies, benevolent societies, and similar enterprises, which sometimes mount to 33 cents or more of every dollar.

community enrollment periods

Because its fundamental goal is public service, Blue Cross does not require its members to remain in the employed groups through which they were enrolled in order to retain their protection. The Blue Cross subscriber leaving his place of employment may arrange to continue his membership for himself and his family by paying fees directly on a quarterly basis.

During the first ten years or so of its existence, Blue Cross enrolled most of its members in groups at places of employment, with the cooperation of the employer. Then, early in the 1940's, industry and organized labor became interested in helping to provide health protection for industrial employes and for union members and their families. Since that time, hundreds of thousands of Blue Cross members have been enrolled through industry and through unions. Unions and management have taken an active part in many industry-wide Blue Cross contracts such as those under which the workers in the automobile and steel industries have been enrolled. Frequently management has paid all or part of the cost of Blue Cross membership for employes under agreements negotiated as a regular feature of labor-management contracts. With these and other forces at work, the rate of growth of Blue Cross has increased to a point where more than 8,000 new members join Blue Cross Plans every working day!

how many members today?

The extent to which Blue Cross has become an accepted part of our society may be seen in the fact that in one state, Rhode Island, three-fourths of the entire population is enrolled in the Blue Cross Plan. Several other states, including Pennsylvania and New York, have enrolled half or more of the population, and many more states have Blue Cross membership for more than 40 per cent of the population.

Most Blue Cross Plans are statewide in their operation, but a number of states, such as New York, Pennsylvania, and Ohio, have several Blue Cross Plans in operation under separate corporate charters and separate management. All together, there are more than 80 approved Plans operating in North America, and there is one in Puerto Rico. The population of Alaska is covered by the Blue Cross Plan with headquarters at Seattle, Washington. The Plans vary somewhat in the details of their schedules of rates and benefits because these features emerge

from local hospital practice and the nature of hospital costs and services may differ from one part of the country to another.

More than 6,000 hospitals, representing 85 per cent of the total bed capacity of general hospitals, participate by contract in the various Blue Cross Plans, rendering service to Blue Cross subscribers and their families and accepting payment for these services from the Plan.

supervision by the states

Some Blue Cross Plans are subject to regulation by the insurance departments of the various states, to the extent that the departments must approve the rates charged to subscribers, benefits, payments to hospitals, and other contractual details. The insurance departments in these states also require financial audits, offering assurance to the public that the Plans maintain adequate reserves and remain financially stable. In most cases, jurisdiction by the state insurance department was provided for in enabling legislation passed by the states at the time the first nonprofit Plans were organized in the 1930's. In some states the enabling acts make it possible for Plans to operate without insurance department jurisdiction; the nonprofit nature of the Plans and the public representation on their boards of directors are felt to be an adequate guarantee of operation in the public interest.

SERVICE INSTEAD OF CASH

The Blue Cross method of providing benefits in the form of hospital service, instead of in dollar indemnities—while more likely to meet the family's need at the time hospital care is required—has made frequent rate increases necessary in recent years, because, in a period of rapidly mounting hospital costs, Blue Cross Plans have had to increase their payments to hospitals for the services they have rendered to members. In the early days of Blue Cross, hospitals usually were paid a flat rate

of $5 or $6 a day for all services required by Blue Cross members; today, most Blue Cross Plans pay hospitals on the basis of the actual cost of the care rendered, as determined by cost accounting studies.

Thus rates charged to subscribers for their memberships have had to be increased over the years to keep pace with the rising cost of hospital care.

Insurance companies, on the other hand, usually keep on charging the same amount for hospitalization policies, which pay the policy-holder a stated number of dollars per day for hospitalization. But, as hospital bills have gone up, the policy that pays $15 a day has covered a smaller and smaller portion of the bill and thus has afforded less and less real protection against the expense of hospitalization. Blue Cross, on the other hand, covers 89 per cent of the entire hospital bill for the average Blue Cross patient. Not everyone, however, has clearly understood the difference between service and cash benefits, and so there have been some complaints when Blue Cross rates have been increased.

FUTURE OF BLUE CROSS

Blue Cross and hospital people are aware that the prepayment method must be extended into areas and types of service that have been covered only experimentally and occasionally up to this time, if the public demand for complete health service through voluntary prepayment is to be met. Among the new services that remain to be developed by Blue Cross Plans, with the cooperation of hospitals and physicians, are the following:

1. *Enrollment of the nongroup population.* Most of the people who are not now enrolled in Blue Cross or hospitalization insurance plans are in the "nongroup population"—either self-employed, retired, or working in small businesses that employ only one or two persons and cannot be considered "groups" for purposes of Blue Cross enrollment. The nongroup popula-

tion includes an estimated 55 to 60 million, and while most Plans have made some arrangements to enroll them, Blue Cross Plans must find a more effective and economical method of enrollment so that they can all enjoy the benefits of prepayment. In addition, some arrangement between Blue Cross and local government agencies needs to be worked out in all Plan areas, as has been done in some, to permit the Blue Cross method to be used in paying for hospital and medical care of the indigent and unemployed population.

2. *Health care for the aged.* With 1,000 men and women reaching age 65 every day in the United States, the problems of providing satisfactory health services and facilities for the aged population have been commanding increasing attention. Various proposals have been made to provide federal funds to assist in meeting the health needs of the aged population. Most medical and hospital groups have sought to resist the expansion of government programs into new areas, and many feel that the best way to make federal or state government participation unnecessary is for local authorities to support expanded service for the aged through Blue Cross, if possible by paying for nursing home, convalescent home, home nursing and other services needed by the aged through Blue Cross Plans. Already there are millions of men and women over age 65 who are enrolled in Blue Cross. To meet the rapidly growing need, service for this group must be broadened and enrollment methods improved.

3. *Preventive medicine and rehabilitation services.* Increasingly, medical authorities understand that complete health care includes not just necessary treatment of the acutely ill and injured, but added service to rehabilitate the patient and to return him to his family and job at the earliest possible moment, and preventive service, such as periodic medical examinations, aimed at keeping people well. Like hospitalization and other services for the acutely ill, preventive medicine and rehabilitation services ought to be made available through prepayment. Many

think these services might be included in some way among the benefits of Blue Cross membership.

4. *Mental disease and tuberculosis.* Some Blue Cross Plans include benefits for nervous and mental diseases and tuberculosis, but others exclude these patients because so often hospitalization in these cases has been in state institutions at government expense. Increasingly, however, patients with mental disorders and tuberculosis are accepted for treatment in general community hospitals. Blue Cross must "catch up" with modern hospital practice by making these benefits uniformly available.

5. *Complete medical service through prepayment.* Finally, in order to enable the public to prepay all its health care in the simplest, most economical fashion, closer cooperation between Blue Cross, Blue Shield (the parallel, nonprofit prepayment program for surgical and medical services) and other medical prepayment plans is needed.

In many areas the Blue Cross and Blue Shield Plans cooperate closely and, in fact, some of the Plans are under a single management. But in some other states the Plans are far apart, even competing, and the public is faced with higher costs and needless complications in paying for medical and hospital service.

As these problems are resolved and these opportunities for expanded service fulfilled, the same public interest and community support that have made Blue Cross what it is today will see that Blue Cross keeps pace with the growth of our population and the ever-increasing use of our hospital system. The hospital, once a walled fortress, set apart from the rest of the community and feared as something mysterious and forbidding, has become in our time as much a part of community life as the home, the church, and the school. It is Blue Cross, more than anything else, that has brought the hospital into the community. A strong Blue Cross will keep hospital and community together in the years ahead.

PAM
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The Blue Cross Plans
for prepaid hospital care
are local non-profit corporations
sponsored by your community hospitals.

They are organized to make the services
of the hospital available
to the people of the community
on a prepayment basis.

The companion Blue Shield Plans,
with the same health objectives,
are sponsored
by the physicians
to make surgical and
certain medical services
available to the people
of your community
on a voluntary, prepayment basis.

Blue Cross and Blue Shield
make it possible
for millions of persons
to voluntarily budget
their hospital and medical-surgical
expenses.

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