



eCOMMONS

Loyola University Chicago
Loyola eCommons

Master's Theses

Theses and Dissertations

1954

Blue Cross-Blue Shield : Past, Present, And Future

Edwin Bernard Gilroy
Loyola University Chicago

Follow this and additional works at: https://ecommons.luc.edu/luc_theses

 Part of the [Industrial Organization Commons](#)

Recommended Citation

Gilroy, Edwin Bernard, "Blue Cross-Blue Shield : Past, Present, And Future" (1954). *Master's Theses*. 1028.
https://ecommons.luc.edu/luc_theses/1028

This Thesis is brought to you for free and open access by the Theses and Dissertations at Loyola eCommons. It has been accepted for inclusion in Master's Theses by an authorized administrator of Loyola eCommons. For more information, please contact ecommons@luc.edu.



This work is licensed under a [Creative Commons Attribution-Noncommercial-No Derivative Works 3.0 License](#).
Copyright © 1954 Edwin Bernard Gilroy

BLUE CROSS-BLUE SHIELD

PAST, PRESENT, AND

FUTURE

Edwin Bernard Gilroy was born in Highland Park, Illinois, August 10, 1913.

He was graduated from Highland Park High School, Highland Park, Illinois, June, 1942, and from the University of Minnesota, July, 1943, with the degree of Bachelor of Arts.

by

Edwin Bernard Gilroy

From 1943 to 1945 the author served in the United States Army Air Force. Since 1945 he has been employed in an industrial relations capacity by various Chicago corporations, one being Blue Cross-Blue Shield for a two year period.

The author was recently employed as Industrial Relations Manager, Central Scientific Company, Chicago, Illinois.

**A Thesis Submitted to the Faculty of the Institute of Social and
Industrial Relations of Loyola University in Partial
Fulfillment of the Requirements for the Degree
of Master of Social and Industrial
Relations**

January

1954



TABLE OF CONTENTS

Chapter	Page
---------	------

I. INTRODUCTION

LIFE

Edwin Bernard Gilroy was born in Highland Park, Illinois, August 10, 1923.

He was graduated from Highland Park High School, Highland Park, Illinois, June, 1942, and from the University of Minnesota, July, 1948, with the degree of Bachelor of Arts.

From 1942 to 1945 the author served in the United States Army Air Force. Since 1948 he has been employed in an industrial relations capacity by various Chicago corporations, one being Blue Cross-Blue Shield for a two year period.

The author was recently employed as Industrial Relations Manager, Central Scientific Company, Chicago, Illinois.

VI. BLUE SHIELD PHILOSOPHY AND HISTORY

A. The beginning	34
B. A summary	40

VII. BLUE SHIELD TODAY

A. General explanations	42
B. Basic coverage and rates	48
C. Membership	52
D. Experiences	53

VIII. BLUE SHIELD NATIONAL PROJECTS

A. The Commission	TABLE OF CONTENTS	53
B. Medical Insurance of America, Incorporated		54

Chapter		Page
I.	INTRODUCTION	53
	A. The background.	1
	B. Purpose of the thesis	3
II.	BLUE CROSS PHILOSOPHY AND HISTORY	73
	A. The beginning	5
	B. A summary	7
III.	BLUE CROSS TODAY	
	A. General explanations.	10
	B. Basic coverage and rates.	10
	C. Membership.	14
	D. Experience.	16
	E. Approval Plan Today	20
IV.	BLUE CROSS NATIONAL PROJECTS	
	A. The Commission.	24
	B. Inter-Plan Service Benefit Bank	27
V.	A MASTER PLAN FOR BLUE CROSS PLANS	
	A. Blue Cross Association.	30
	B. Health Service, Incorporated.	32
VI.	BLUE SHIELD PHILOSOPHY AND HISTORY	
	A. The beginning	36
	B. A summary	40
VII.	BLUE SHIELD TODAY	
	A. General explanations.	42
	B. Basic coverage and rates.	45
	C. Membership.	47
	D. Experience.	50

VIII. BLUE-SHIELD NATIONAL PROJECTS

A. The Commission	53
B. Medical Indemnity of America, Incorporated	54

IX. A PERSPECTIVE

A. Successes to date.	56
B. Problems, plans, and possibilities	58

X. CONCLUSIONS	68
--------------------------	----

BIBLIOGRAPHY.	72
-----------------------	----

IV. BLUE CROSS HOSPITAL ADMISSIONS PER 1,000 MEMBERS.	17
V. IN-PATIENT DAYS PER 1,000 MEMBERS	17
VI. AVERAGE LENGTH OF STAY.	18
VII. PERCENTAGE DISTRIBUTION OF INCOME	19
VIII. HOSPITALIZATION AND OPERATING EXPENSES OF BLUE CROSS PLANS BY DOLLARS.	19
IX. GROWTH OF BLUE SHIELD PLANS	47
X. BLUE SHIELD MEMBERS IN ELEVEN STATES AND THE DISTRICT OF COLUMBIA	48
XI. NUMBER OF BLUE SHIELD PLANS	49
XII. BLUE SHIELD PAYMENTS TO PHYSICIANS IN 1931.	50
XIII. BLUE SHIELD INCOME DISTRIBUTION	51
XIV. PERCENTAGE DISTRIBUTION OF TOTAL INCOME	51
XV. RATES OF EIGHT BLUE CROSS PLANS	53

LIST OF TABLES

Table	Page
I. GROWTH OF BLUE CROSS PLANS.	14
II. BLUE CROSS MEMBERSHIP IN TWENTY-ONE STATES AND THE DISTRICT OF COLUMBIA.	15
III. HOSPITAL ADMISSIONS OF BLUE CROSS MEMBERS	16
IV. BLUE CROSS HOSPITAL ADMISSIONS PER 1,000 MEMBERS.	17
V. IN-PATIENT DAYS PER 1,000 MEMBERS	17
VI. AVERAGE LENGTH OF STAY.	18
VII. PERCENTAGE DISTRIBUTION OF INCOME	19
VIII. HOSPITALIZATION AND OPERATING EXPENSES OF BLUE CROSS PLANS BY DOLLARS.	19
IX. GROWTH OF BLUE SHIELD PLANS	47
X. BLUE SHIELD MEMBERS IN ELEVEN STATES AND THE DISTRICT OF COLUMBIA	48
XI. NUMBER OF BLUE SHIELD PLANS	49
XII. BLUE SHIELD PAYMENTS TO PHYSICIANS IN 1951.	50
XIII. BLUE SHIELD INCOME DISTRIBUTION	51
XIV. PERCENTAGE DISTRIBUTION OF TOTAL INCOME	51
XV. RATES OF EIGHT BLUE CROSS PLANS	63

1 H. Ladd Flansley, Budgeting the Costs of Illness, New York,

1947, 1.

CHAPTER I

INTRODUCTION

A. THE BACKGROUND

Our century, the Twentieth Century, may become known as variously the Atomic Century, The War Century, The Depressive Century, or the Collectivist Century. Certainly historians will investigate the harnessing of atomic energies, the World Wars, the effect of world-wide depressions, and the rise of collective action.

The march of Communism and Socialism will surely be studied. Also, the rise of unions must be investigated. And, in our own nation group effort to resolve social problems must be considered. For group effort clearly represents a shift from our complete individualistic philosophy of the nineteenth century.

Among the group efforts to resolve social problems is that to obtain adequate medical care. And in this field of social effort, there is vast change. "So many of the circumstances of living have changed that it has been necessary to abandon the nineteenth century belief that folks ought to take care of such things themselves."¹

1 H. Ladd Plumley, Budgeting the Costs of Illness, New York, 1947, 1.

Our opinions on the subject of how hospital and medical care should be paid are changing. Opinions vary as to whether non-profit associations, private insurance companies or governmental institutions should help the individual citizen. In fact, opinions vary from day-to-day, person to person, and among social and professional groups.

So great do opinions vary, that we often find ourselves discussing and debating this vital question related to health in an atmosphere charged with ignorance, pre-conceived notions, and prejudice. Part of the reason for the muddled waters in the reasoning of financing hospital and medical care is philosophical. Part is due to lack of knowledge.

The purpose of this thesis is addressed to bringing forth facts concerned about non-profit associations. Specifically, to relate how Blue Cross--Blue Shield was born, where it is today, and what appear to be the problems of the future.

Why Blue Cross--Blue Shield? Because it is part of a social movement. Because in a small way the author is familiar with some of its history. And because 43,815,021 individuals residing in the United States, Puerto Rico, Alaska, and Canada were members on December 31, 1952 of Blue Cross.² Also, on that same date and in the same countries 24,770,359 individuals were members of Blue Shield.³

2 Blue Cross Commission, "Blue Cross Fact Sheet," Chicago, 1952, 1.

3 Blue Shield Commission, "Blue Shield Fact Sheet," Chicago, 1952, 1.

4 "Annual Report of the Executive Director," Blue Cross--Blue Shield, Chicago, 1953, 3.

B. PURPOSE OF THE THESIS

Since Blue Cross has approximately 43 million members and Blue Shield 24 million, they represent a fair share of individuals covered by hospital and medical insurance of some type. For this thesis the operations of the Illinois Plan⁴ (Hospital Service Corporation and Illinois Medical Service), The Blue Cross Commission, The Blue Shield Commission, and Health Service, Incorporated will be emphasized.

The Illinois Plan has 2,037,152 Blue Cross members and 679,147 Blue Shield members.⁵ Since the Blue Cross--Blue Shield Commissions are coordinating agencies for all Plans, their operations will be examined. And, Health Service, Incorporated being a new and national Blue Cross project will also be explained.

Out of the paper, the author hopes some information may be added to our knowledge of financing hospital and medical care. And, perhaps it will help remove some of the prejudice for and against private or governmental arguments concerning this public question.

For if the philosophy of Blue Cross--Blue Shield is understood and if facts are known concerning its birth and growth, then some estimate can be made of how the voluntary prepayment method for financing hospital and medical care will meet the obligations of the future as well as the present.

4 Among Blue Cross--Blue Shield Plans, the Plan operating in Illinois, with the exception of a small area around Rockford, is known as the Illinois Plan.

5 "Annual Report of The Executive Director," Blue Cross--Blue Shield, Chicago, 1953, 3.

And is that not the question we ask of all men and all organizations?

CHAPTER II

BLUE CROSS PHILOSOPHY AND HISTORY

A. THE BEGINNING

The seed of the Blue Cross idea was planted in Dallas, Texas in 1921. Here, Dr. Justin Ford Kimball who was Superintendent of Schools during the early 1920's, established a plan to repay teachers' losses they sustained from their salaries while ill.

Dr. Kimball had been an attorney for an insurance company earlier in his life and was familiar with the legal and actuarial problems. He took his efforts to organize a system to repay teachers' losses during the 1920's. In 1925-1926, a plan costing \$1.00 a month with a benefit of \$5.00 a day was put in effect.¹

In June, 1929, Dr. Kimball resigned his position as Superintendent of Schools and became Vice-President in charge of the Dallas Scientific Schools of Baylor University. Though the main university was at Waco, Texas, the Scientific Schools consisting of medical, dental, pharmacy, and nursing colleges and a hospital were located in Dallas.

All of the schools were losing money. But the biggest problem

1 Richard H. Jones, Director, Blue Cross Commission, "A History and Philosophy of Blue Cross," Blue Cross Commission, Chicago, 1933, p. 1.

CHAPTER II

BLUE CROSS PHILOSOPHY AND HISTORY

A. THE BEGINNING

The seed of the Blue Cross idea was planted in Dallas, Texas in 1921. There, Dr. Justin Ford Kimball who was Superintendent of Schools during the early 1920's, established a plan to repay teachers losses they sustained from their salaries while ill.

Dr. Kimball had been an attorney for an insurance company earlier in his life and was familiar with the legal and actuarial problems. Between his efforts and the memory of monetary losses suffered by the teachers during the influenza epidemics of 1918-1920, a plan costing \$1.00 a month with a benefit of \$6.00 a day was put in effect.¹

In June, 1929, Dr. Kimball was appointed Executive Vice-President in charge of the Dallas Scientific Schools of Baylor University. Though the main university was at Waco, Texas, the Scientific Schools consisting of medical, dental, pharmacy, and nursing colleges and a hospital were located in Dallas.

All of the schools were losing money. But the biggest problem

¹ Richard M. Jones, Director, Blue Cross Commissions, "A History and Philosophy of Blue Cross," Blue Cross Commission, Chicago, 1953, 2.

financially was the hospital deficit. Many of the outstanding hospital bills were owed by teachers who were, for all practical purposes, unable to take care of them.

After carefully studying the experience of the Sick Benefit Plan founded eight years previously, Dr. Kimball decided a hospital insurance plan could be put into effect. So, in the fall of 1929 the teachers were offered an opportunity to subscribe at the rate of 50 cents a month. In return, the teachers would be provided with service benefits at Baylor Hospital.²

By November of 1929, over 75 per cent of the teachers had accepted the proposal. December 20, 1929 was established as the effective date of the program. The first member to be admitted was Mrs. Alma Dickson who suffered a broken leg. Word of her care spread rapidly.

The next group organized was the Dallas Morning News. As luck would have it, one of their young employees soon had an emergency appendectomy. Because of the urgency of the case, the prompt care and payment of the hospital bill, the paper gave extensive news coverage to the case. Shortly thereafter, a large Dallas bank subscribed as a group. Thus, the procession began.³

Men of social purpose visited Dallas to see this new "insurance" in action. By 1933, the American Hospital Association decided to study

2 Ibid., 2.

3 Ibid., 3.

standards to guide the development of the new idea.

Several months later the American Hospital Association's Council on Community Relations and Administrative Practice issued what is now known as the seven essentials for a hospital plan. They are:

1. Stress public welfare
2. Be limited to hospitalization charges
3. Enlist professional and public interests
4. Provide free choice of physician and hospital
5. Be maintained as a non-profit organization
6. Be maintained on a sound economic basis
7. Be promoted in cooperative and dignified spirit⁴

In 1934, an enabling act was passed in New York placing local Blue Cross Plans under state supervision and giving them state and federal tax exempt status.⁵

Then, in 1937, the American Hospital Association established a Commission on Hospital Service. The purpose of the Commission was to approve of Plans desiring to enter the hospital service industry and to evaluate the operations of the Plans previously approved.⁶

B. A SUMMARY

It was in Dallas that the Blue Cross idea began in 1929. The way it began explains the basic operating power that local Blue Cross Plans have today. The idea began with civic-minded men who felt a need for financing health care.

4 Ibid., 4.

5 Ibid., 5.

6 Ibid., 5.

Men came from all over the United States to see the new idea in action. They took the idea back to their local communities and hospitals to put it into effect at home.

In their communities and states, and in conjunction with other public spirited men, the pioneers put to work the idea they found in Texas.

Since, at that time, there was no coordinating agency other than the American Hospital Association's Commission, operations, benefits, and rates varied from Plan to Plan. The standards for approval did prevent abuses of men who desired to enter the field of financing health care. Yet, each Plan grew as an independent organization.

The enabling legislation that was passed in New York in 1934, and set the pattern for similar legislation in other states, had these main provisions:

1. Any non-profit corporation operating a hospital service plan should be exempt from provisions of the insurance laws.
2. A majority of the directors of such corporations must be administrators or trustees of hospitals which have contracted to render service, and should be residents of the state.
3. Such organizations are charitable and benevolent institutions and as such are exempt from State and local taxes except on real estate and office equipment.⁷

Thus, the exemptions from insurance laws and taxes, and the proviso for local control were established.

The Blue Cross Commission of today, with many more functions and responsibilities, grew from the American Hospital Association's Commission. It took its present title in 1946.

⁷ Ibid., 7.

So, with the facts related of how Blue Cross began, and with the importance the local Plan has established in mind, as well as its non-profit status, we must now turn to current and near-current facts.

Keep in mind, the Blue Cross idea began as a local community effort dedicated to aid in the financing of hospital care on a non-profit basis with professional support from educators, physicians, and lawyers.

Initial working capital for Blue Cross Plans has often been provided by civic leaders, charitable foundations, and hospitals. Benefits are in terms of hospital service rather than cash indemnity and are guaranteed by the participating hospitals through contractual agreements between them and the Plans.

The term "service benefits" means that the member receives benefits in terms of hospital service to the extent of his contract, and is billed by the hospital only for such services as are not covered by the Plan contract. This is in contrast to cash indemnity insurance under which the policyholder pays the whole hospital bill and then files a claim with his insurance company for cash reimbursement in the amount specified under his policy.

These service benefits are paid out of Plan subscription income on a basis previously determined by actuarial study, under agreement between Plans, hospitals, and subscribers, and with the approval of the proper regulatory bodies of the state in which the Plan operates.

3. BASIC COVERAGE AND RATES

As one might expect, subscription rates vary considerably among

CHAPTER III

BLUE CROSS TODAY

A. GENERAL EXPLANATIONS

Initial working capital for Blue Cross Plans has often been provided by civic leaders, charitable foundations, and hospitals. Benefits are in terms of hospital service rather than cash indemnity and are guaranteed by the participating hospitals through contractual agreements between them and the Plans.

The term "service benefits" means that the member receives benefits in terms of hospital service to the extent of his contract, and is billed by the hospital only for such services as are not covered by the Plan contract. This is in contrast to cash indemnity insurance under which the policyholder pays the whole hospital bill and then files a claim with his insurance company for cash reimbursement in the amount specified under his policy.

These service benefits are paid out of Plan subscription income on a basis previously determined by actuarial study, mutual agreement between Plans, hospitals, and subscribers, and with the approval of the proper regulatory bodies of the state in which the Plan operates.

B. BASIC COVERAGE AND RATES

As one might expect, subscription rates vary considerably among

individual Blue Cross Plans. The variations exist because of different benefits, operating costs, and costs of hospital service.

Full service benefits are provided among the Plans from twenty-one days to one hundred and twenty days per contract year, i.e., usually from January first to December thirty-first. Nearly all the Plans provide partial benefits, fifty per cent of full benefits, for an additional ninety days.

The larger Plans, such as Illinois, Indiana, Massachusetts, Michigan, New York City and Wisconsin, are tending toward the following benefits:

1. Thirty days of full benefits; ninety days of half benefits; ten day OB allowance; and a \$10.00 private room allowance.
2. Seventy days of full benefits; ten day OB allowance; and a \$10.00 private room allowance.
3. One hundred and twenty days of full benefits; ten day OB allowance; and a \$10.00 private room allowance.¹

OB allowance can go as low as \$80.00 per pregnancy up to full coverage.

Private room allowances can go as low as \$6.00 per day up to an amount equal to the most common semi-private rates in the hospital of the patient's choice. The previous section denotes averages and contracts most in force.

Services usually excluded are:

1. Ambulatory surgery, except for emergency care.
2. Diagnostic studies and rest cures.
3. Occupational injury or ailment.

¹ Blue Cross Commission, Blue Cross Manual, Chicago, 1953, see pages 38, 46, 78, 81, 123, and 232 for benefits of Plans listed.

Also, the initials OB, as used in Blue Cross contracts, refer to obstetrical care.

4. Services of physicians, surgeons, and nurses not employed by hospitals.
5. X-ray therapy, radium therapy, blood or blood plasma.
6. Ambulance service.
7. Mental disorders, chronic alcoholism, drug addition, and pulmonary tuberculosis.²

Policies are sold on a group basis but many of the Plans are now putting into effect, or are studying how to provide, individual contracts. Since Blue Cross grew through group membership one of the most pressing problems is to establish an individual contract at a reasonable rate without infringing on old members. We will discuss this problem later.

One of the leading factors in the extension of benefits has been the influence of unions. The seventy day certificate came out of Detroit and its automobile plants. The one hundred and twenty day certificate came out of Pittsburg and Gary and their steel mills.

Management has generally been credited with stimulating the so-called "cost certificate." Depending on its financial capacity and social maturity management purchases contracts for employees which provide benefits somewhere between thirty days and seventy days. Many of these managements are not entirely social minded. Oftentimes their experience rating is low. And by paying for their contracts on a cost plus a small administrative charge, these companies actually derive a lower rate than the common rates.

As previously suggested, subscription rates on a national basis vary considerably. For instance, the ranges now are:

2 Ibid.

1. Single person--\$.75 to \$2.70 per month.
2. Husband and wife--\$1.75 to \$5.00 per month.
3. Family--\$1.60 to \$5.75 per month.³

National average rates are:

1. Single person--\$2.50 per month.
2. Husband and wife--\$2.91 per month.
3. Family--\$3.22 per month.⁴

Though the rates vary according to Plan location, hospital costs, administrative costs, and actuarial forecasts, all Plans have many benefits in common.

All Blue Cross Plans provide for room and board, general nursing care, use of the operating room, laboratory service, routine medications and dressings, and use of the delivery room. Beyond these basic services Plans also provide special services. Of eighty-seven Plans, the following tabulation gives an indication of such services:

1. Emergency Room	84
2. Special Diets	83
3. Oxygen Therapy	73
4. Pathology	73
5. Anesthesia	72
6. Basal Metabolism Tests	70
7. X-ray	61
8. Electrocardiogram	61 ⁵

Thus, the "states-rights" or "Plan-rights" philosophy that we spoke of earlier, is manifested in benefits and rates.

3 Blue Cross Commission, "The Blue Cross Plans for Hospital Care," Chicago, 1953, 3.

4 Ibid., 3.

5 Ibid., 4.

C. MEMBERSHIPS

Considering that there has only been a loose confederation of Blue Cross Plans since 1937, the growth is amazing and is still going on.

TABLE I

GROWTH OF BLUE CROSS PLANS⁶

<u>Year</u>	<u>Members</u>
1937.	1,364,975
1938.	2,874,055
1939.	4,431,772
1940.	6,049,222
1941.	8,456,267
1942.	10,458,899
1943.	13,005,493
1944.	16,511,198
1945.	19,989,205
1946.	25,876,424
1947.	29,440,914
1948.	32,921,212
1949.	35,918,705
1950.	40,232,697
1951.	41,439,549
1952.	43,815,021

During the same period, the number of Plans increased. In 1937 there were forty. In 1952, eighty-seven were operating. Of these, eighty-one serve the United States and Alaska, five serve Canada, and one serves Puerto Rico.

Recently, there has been a merging of Plan membership, contract coverage, organization of staff and corporate structure. One of the leading reasons is to effect operating economies and efficiencies. Another is to salvage Plans running into financial difficulty. Another is to comply with state insurance regulations.

⁶ Blue Cross Commission, "Blue Cross Fact Sheet," Chicago, 1953, 2. See also Experience of Blue Cross Plans, Vol. IV, 1948-1952, 48.

Illinois is a good example for merging. Whereas previously Plans operated in Chicago, Rockford, Peoria, Decatur, and Alton, only Chicago and Rockford still exist.

Throughout the nation membership coverage varies from state to state. Generally, the more heavily populated states along the eastern seaboard and the midwest states have higher memberships than the sparsely settled states of the west, southwest, and west coast. The southern states do not have many members. In 1952, about half of the forty-eight states covered twenty per cent or more of their populations.

TABLE II

BLUE CROSS MEMBERSHIP IN TWENTY-ONE STATES
AND THE DISTRICT OF COLUMBIA⁷

<u>State</u>	<u>Per Cent of Population</u>
Rhode Island	78.3
District of Columbia	68.3
Delaware	62.3
New York	47.7
Pennsylvania	46.8
Ohio	46.3
Michigan	44.4
Massachusetts	43.1
New Jersey	38.6
Maryland	36.1
Maine	32.7
Minnesota	32.5
Colorado	32.3
New Hampshire	31.8
Vermont	31.8
Missouri	27.8
Illinois	26.1
Wisconsin	25.4
Indiana	23.1
Iowa	23.1
Kansas	23.1
Wyoming	21.3

⁷ Blue Cross Commission, "Blue Cross Fact Sheet," Chicago, 1953, 1.

All other states account for less than twenty per cent of their population. Nationally, approximately twenty-five per cent of the population is covered by Blue Cross membership.

In Canada, the Manitoba and Ontario Plans cover forty-one and thirty-five per cent of their populations, respectively. New Brunswick, Quebec, and Alberta cover twenty-one, fifteen, and twelve per cent of their populations, respectively.⁸

D. EXPERIENCE

With the increase in membership has come an increase in hospital admissions.

TABLE III

HOSPITAL ADMISSIONS OF BLUE CROSS MEMBERS⁹

Year	In-Patients	Out-Patients	Total
1948	3,611,213	313,502	3,924,715
1949	4,047,677	464,652	4,512,329
1950	4,607,153	660,956	5,268,109
1951	4,991,933	815,139	5,807,072
1952	5,329,886	966,109	6,295,995

Of the total admission claims only about one per cent are denied. For instance, in 1952 of the total In-Patient admissions merely 59,211 were disapproved.

⁸ Ibid., 1.

⁹ Ibid., 2. 1948 is the first year that complete statistical studies were made.

Not only have total admissions risen, but also admission rates per 1,000 members have risen.

TABLE IV

BLUE CROSS HOSPITAL ADMISSIONS
PER 1,000 MEMBERS¹⁰

Year	Number
1948. . . . .	.117
1949. . . . .	.118
1950. . . . .	.121
1951. . . . .	.123
1952. . . . .	.126

In these five years, the proportionate rate of increase is approximately ten per cent. This upward trend is also reflected in the number of In-Patient days per 1,000 members, as shown in the following table.

TABLE V

IN-PATIENT DAYS
PER 1,000 MEMBERS¹¹

Year	Number of Days
1948. . . . .	.883
1949. . . . .	.880
1950. . . . .	.899
1951. . . . .	.905
1952. . . . .	.925

¹⁰ Blue Cross Commission, Experience of Blue Cross Plans, Vol. IV, Chicago, 1953, 3.

¹¹ Ibid., 33.

Except for 1949, there has been a definite increase. In fact, the increase over the past five years approximates five per cent. This upward trend, of course, raises a basic question. How will the Plans retain rate and financial stability and yet continue service benefits?

Part of the answer resides in the average length of stay of Blue Cross members. Though the length of stay is not diminishing by any great amount, the trend is clearly downward. As a matter of fact, for Blue Cross members the average length of stay is less than for other hospital patients.

TABLE VI
AVERAGE LENGTH OF STAY¹²

Year	Blue Cross Patients	Other Patients (By A.H.A.)
	Days	Days
1948	7.65	8.7
1949	7.55	8.3
1950	7.51	8.1
1951	7.51	8.3
1952	7.40	8.1

Of great interest, in the experience of Blue Cross Plans, is the distribution of income. Here, clearly, the trend is to pay more for hospitalization and less for operating expense.

¹² Ibid., 21.

¹³ Blue Cross Commission, "Blue Cross Fact Sheet," Chicago, 1953, 3.

¹⁴ Ibid., 3.

TABLE VII
PERCENTAGE DISTRIBUTION OF INCOME¹³

Year	Plans	Present and Reserve Funds For Hospital Expenses	Funds For Operating Expenses
1942	66	87.8%	12.2%
1943	76	87.6	12.4
1944	73	87.7	12.3
1945	86	87.7	12.3
1946	87	87.0	13.0
1947	90	88.9	11.1
1948	90	90.3	9.7
1949	90	91.2	8.8
1950	90	91.6	8.4
1951	87	91.9	8.1
1952	87	92.5	7.5

The trend continued in the figures shows that operating economies have been made. Dollar figures also show the same trend.

TABLE VIII
HOSPITALIZATION AND OPERATING EXPENSES
OF BLUE CROSS PLANS BY DOLLARS¹⁴

Year	Present and Reserve Funds For Hospital Expenses	Funds For Operating Expenses
1948	\$270,928,123	\$30,857,205
1949	327,857,819	34,256,230
1950	470,690,520	28,923,417
1951	484,738,670	44,063,724
1952	575,152,893	48,487,834

¹³ Blue Cross Commission, "Blue Cross Fact Sheet," Chicago, 1953, 2.

¹⁴ Ibid., 3.

Summary: No approval will be given where area, population, and risk are inadequate.

Thus, we can conclude membership growth has been astonishing. It is continuing, though at a diminishing rate. Today, about twenty-five per cent of the national population is covered. And, with the increase in growth is an increase in incidence and utilization. The standards in establishing Dollar figures show Blue Cross has become a multi-million dollar business. Institutionally, it is effecting operating economies.

E. APPROVAL PLAN TODAY

As with membership and experience, the Blue Cross Approval Program of the American Hospital Association and the Blue Cross Commission has changed. In 1933 these seven essentials were issued as guides for hospital plans:

1. Stress public welfare
2. Be limited to hospitalization charges
3. Enlist professional and public interests
4. Provide free choice of physician and hospital
5. Be maintained as a non-profit organization
6. Be maintained on a sound economic basis
7. Be promoted in cooperative and dignified spirit

Now, the approval program embraces three different groups of essentials. They are:

1. General principles for approval of Blue Cross Plans
2. Standards of operation for approval
3. Principles governing relationship between Plans and hospitals

The general principles are five in number. They are:

1. Blue Cross Plans must adhere to the standards established by the American Hospital Association and the Commission
2. A Plan's Board of Governors should include representatives of the public, the hospitals, and the medical profession
3. All qualified hospitals should have an opportunity to contract to provide benefits in the enrollment area

4. No approval will be given where area, population, and risk are inadequate
5. Plans should arrange for service benefits¹⁵

The standards for approval of a hospital service organization as a Blue Cross Plan today number ten. They range from board membership through benefits and promotion. The prime effort of the standards is to establish reputable operating organizations. Here, briefly described are the standards:

1. One-third of the governing board must come from hospitals, and one-third from the public
2. The Plan must be operated on a non-profit basis, and no board member may be paid for services
3. Benefits must be calculated in order to return seventy-five per cent of members' hospital bills for period of coverage
4. Adequate financial reserves must be maintained. Adequate means sufficient funds to meet hospital and operating expenses for a period of three months
5. Plans must contract with hospitals for benefits
6. Accounting and statistical records must be maintained as may be reasonably required by the Blue Cross Commission
7. No fees or commission will be paid by Plans for administration or promotion to employees
8. Plans must participate in all national programs where seventy-five per cent of all Plans participate
9. No Plan need conform to the standards if a state law prohibits it
10. Failure to meet standards may mean withdrawal of Blue Cross name and support¹⁶

Not satisfied with general principles and standards, the American Hospital Association and Blue Cross Commission also have established principles governing the relationship between hospitals and Blue Cross Plans.

¹⁵ American Hospital Association and Blue Cross Commission, "Blue Cross Approval Program of the American Hospital Association, Chicago, 1952, 8.

¹⁶ Ibid., 10--12.

These principles serve to protect the interests of the contracting parties, and the public. The principles are sub-grouped into four parts. The first relates to hospitals, the second to Blue Cross Plans, the third to methods of payment, and the fourth to rates.

In essence, the first sub-group obligates hospitals to provide proper facilities and good service to Blue Cross members, guarantees hospitals a fair rate not in excess of normal costs, obligates hospitals to operate efficiently and on a stable financial basis.¹⁷

The second sub-group is much the same. Except that the obligations fall on the Blue Cross Plans.¹⁸

The third sub-group outlines how reimbursements should be made to hospitals. The reimbursements may be a flat rate, based on some relation to cost, and according to accommodations and services.¹⁹ The last is the most frequently used method. Though it is the most difficult to determine actuarially, it is the fairest for the patient and the hospital.

The fourth sub-group points up the importance of rates. It outlines the framework for financial responsibility of Plans and hospitals. Both must remain solvent and strong in order to perform their missions, namely, to serve the member patient.²⁰

17 Ibid., 13--15.

18 Ibid., 15.

19 Ibid., 16--17.

20 Ibid., 18--19.

The present principles and standards are quite different from those of the early days. They have evolved over the years to their present stringency because the Plans themselves have become concerned about unwelcome strangers.

With the rush of people to become members in hospital service organizations selfish men tried to take advantage of the boom. But by moving swiftly the Blue Cross Commissioners prevented the Blue Cross name from being scandalized.

The growth of membership in Blue Cross forced the need for a coordinating agency. By World War II this need was more than apparent.

Shortly thereafter, the Blue Cross Commission came into its own, having

previously been a wing of the American Hospital Association. To the operation of the Commission and the Inter-Plan Service Benefit Bank we now turn.

Field work is performed in the Chicago Office, except when national meetings are held in other major cities such as New York, Boston, Miami, or San Francisco.

Field trips by the Commission Staff are necessary. The Staff advises local Plans, and the meetings of national financial, operating, enrollment, hospital relations, and personnel committees demand time. Even these committees are broken into sub-committees. Coordinating these activities in order to achieve, at the local Plan level, better performance necessitates constant attention.

CHAPTER IV

BLUE CROSS NATIONAL PROJECTS

A. THE COMMISSION

Abstractly, the presence of a Blue Cross Commission that operates on a national basis is interesting in itself. For the Commission represents a surrender of complete states rights on the part of local Blue Cross Plans. As have other social institutions, the Plans have found there are advantages in operating within a confederate framework.

The Commission in terms of concrete examples coordinates joint programs at the national level. Headquarters are located in Chicago, Illinois. It is there plans are made and projects are evaluated. All of the administrative work is performed in the Chicago office, except when national meetings are held in other major cities such as New York, Boston, Miami, or San Francisco.

Field trips by the Commission Staff are necessary. The Staff advises local Plans, and the meetings of national financial, operating, enrollment, hospital relations, and personnel committees demand time. Even these committees are broken into sub-committees. Coordinating these activities in order to achieve, at the local Plan level, better performance necessitates constant attention.

Examples of national activities are:

1. Transfer of members from one Plan to another upon change of residence. Such occurs frequently, and the member, if not to continue in the enrolling group, may transfer to a non-group membership. Or the member may transfer as a non-group member to another locale
2. Consolidated billing and uniform enrollment procedures for employees of national firms enrolled through two or more Plans. Thus, large corporations operating on a national basis may be assured of common enrollment and billing methods
3. Preparation of statistical and financial statement. Thus, Plans may determine national trends and plan accordingly
4. Administration of national conventions to enable Plans to exchange information, and derive the benefit of others' experience, and to listen to prominent advisors in the insurance and medical fields
5. Administration of the Inter-Plan Service Benefit Bank
6. The reciprocity procedure to serve members hospitalized while temporarily in residence in the area of a Plan other than their own¹

These national services rendered by the Commission are a recognition on the part of local Plans that a national organization could help them. When the idea of such a group was proposed, however, resistance was met. It is a credit to members of the Commission and the men in the local Plans who persisted in their efforts to see the idea grow and flourish.

Though foresighted officials of the local Plans could see the advantages of national services, the natural human lassitude and unwillingness to change delayed the founding of the Commission.

Today, however, when an individual or family moves from one area of the country to another, an immediate transfer of Blue Cross membership can

¹ Blue Cross Commission, "Blue Cross Fact Sheet," Chicago, 1953, 2.

be effected. Assuming the member continues to pay subscription dues, there is no loss of benefits or delays in financing hospital care. Consolidated billing makes membership possible in Blue Cross for employees of corporations operating on a larger than just statewide basis economically and with dispatch on the part of the corporation. Membership dues are usually paid to the Plan where headquarters for the corporation are located. This Plan in turn sends funds, according to members, to other Plans where employees reside.

Benefits are paid according to the structure of the local Plan. Rates, of course, are based on the same policy. Though the administration of billing a large corporation operating on a coast-to-coast basis is a prodigious job, it is being done. We will discuss phases of this problem again.

The preparation of statistical studies has, indeed, aided the Plans immensely. For through the studies, the Plans have guide posts for drawing comparisons relative to their utilization, incidence, and disposition of income.

Certainly the Plans have benefited from their annual meetings. Such meetings range through general policy discussion to sales policy, internal office procedure, and standardization of tabulating equipment uses. Besides being informational, the meetings have served to weld eighty-seven autonomous companies into a corporate confederation. This feeling of unity has made the steps to nation-wide thinking and operating easier.

In fact, were it not for the feeling of unity and the educational aspects of the meetings, the Inter-Plan Service Benefit Banks would not be

presently operating. Since the operation of this branch of the Commission is an important one, we will examine it in a separate section.

B. INTER-PLAN SERVICE BENEFIT BANK

The Inter-Plan Service Benefit Bank is a means to accomplish two basic purposes. First, the facilities of the "bank" allows a Blue Cross member to finance hospital care as easily when he is away from home as when he is in his home Plan area. Second, it gives Blue Cross member hospitals a reliable system for the establishment of credit for hospitalized out-of-town and out-of-state Blue Cross patients. The entire mechanism is guided by contractual agreement among Blue Cross Plans through the Blue Cross Commission.

The Inter-Plan Service Benefit Bank went into operation in May of 1949.² Two years of study concerning basic policy and procedure, and tests preceded actual installation. Essentially, the operation is that of a clearing house for hospital stays of members away from their own area during hospitalization.

Through the Inter-Plan Service Benefit Bank over 18,000 Blue Cross members are admitted monthly to hospitals out of their Plan area and receive Blue Cross Service benefits.³ Thus, each month 18,000 credit and collection problems are solved for hospitals.

² Harold Baumgarten, Blue Cross Commission, "Inter-Plan Service Benefit Bank Reaches Milestone of Service," Reprint from Hospitals, Journal of the American Hospital Association, Chicago, 1953, 1.

³ Ibid., 1.

Not only have Blue Cross members national facilities for financing health care, but hospital expenses have been alleviated in credit and collection costs. The "bank" offers a credit guarantee almost invariably by the end of the first twenty-four hours of care.

The authors, or perhaps a better term would be inventors or pioneers of the "bank" idea, had several problems to contend with. While their basic purpose was to render better service to Blue Cross members, they could not disturb the autonomy of local Plans and hospitals. Thus, the pioneers approached the problems cautiously in the beginning.

The need for a central clearing agency was obvious in instances where a Blue Cross member was to receive benefits outside his immediate Plan area. So the "bank," as it presently operates, recognizes the autonomy of the local Plans and hospitals, yet renders a better service to the Blue Cross member and extends the service benefit principle beyond the provincial limits of local operations.

Briefly, this is how the "bank" works. Assume a member from the Illinois Blue Cross Plan is hospitalized in Minneapolis, Minnesota. He is admitted to the hospital just as though he were a member of the Minnesota Plan. He receives the same service as that of a Minnesota member.

Shortly after admission, the hospital notifies the Minnesota Plan that an Illinois Blue Cross member is a patient. The Minnesota Plan telegraphs the Illinois Plan asking for confirmation of membership and eligibility for benefits. The reply, by telegraph, is made within twenty-four hours.

When the confirmation arrives the Minnesota Plan notifies the hospital. After the patient is discharged, the bill is paid by the Minnesota Plan through its normal procedures.

The "bank" reimburses the Minnesota Plan for payment according to a formula related to actual hospital costs in Minnesota and average hospital costs in Illinois. Debits and credits are made to the Plan's deposit accounts in the "bank," and at the end of each quarter the balance is adjusted to the amount of deposit each Plan is required to maintain.

Since the Inter-Plan Service Benefit Bank began operations in May, 1949, over 454,000 cases and forty-four million dollars have been cleared through the bank.⁴

Besides the service rendered Blue Cross members and hospitals of the nation, the Inter-Plan Service Benefit Bank has succeeded in lessening much of the provincial feelings on the part of the local Plans.

⁴ Ibid., 1.

CHAPTER V

A MASTER PLAN FOR BLUE CROSS PLANS

A. BLUE CROSS ASSOCIATION

As the Blue Cross Commission grew, it became more and more apparent to the local Plans that the advantages of a national organization clearly outweighed the disadvantages. Also, the local Plans became aware that a pressing need of Blue Cross was to find a mechanism whereby employees of national groups could receive uniformity of benefits irregardless of where they lived or where they were hospitalized.

The research on the operations of the Inter-Plan Service Benefit Bank convinced the local Plans that extension of benefits outside their limits was good. But foreseeing that when members complained that benefits in one area were better or worse than in their own, an answer had to be found. Moreover, the consolidated billing procedures for national accounts apparently practical, necessitated prodigious effort.

Thus, in 1948, the Blue Cross Association Contribution Agreement was drawn up. Credit for this instrument, again, must go to the pioneers in the Commission and certain of the larger Plans. For they foresaw the need prior to the time the Inter-Plan Service Benefit Bank went into operation.

1 Blue Cross Commission, 30 Cross Association Contribution Agreement, Chicago, 1948, 5.

2 Ibid., 5.

Yet it took three years to open corporate offices. Not the least among the reasons for the lengthy period was the fear of local Plans that much of their autonomy would be lost. Convincing the officials of these Plans the idea was sound took time and effort.

The Blue Cross Association is a corporation. Briefly, its purposes are to supplement the activities of the Blue Cross Commission. The activities are:

1. Establishment of mechanisms for facilitating enrollment activities of Blue Cross Plans
2. Provide actuarial service
3. Provide other services as may be required⁵

Section 2, Article I, of the Association Agreement clearly recognizes the autonomous nature of the local Plans, and states that due consideration to their needs, facilities, resources, and practices will be given.⁶ Such a section was clearly needed to convince the local Plans that their entity would be preserved.

The effect of organizing the Blue Cross Association was to establish the corporate holding mechanism for a stock insurance company that would engage in the health and accident business. Secondly, the Blue Cross Commission could establish stability of policy and freedom of administration for the stock insurance company through the buffer of the Blue Cross Association.

⁵ Blue Cross Commission, Blue Cross Association Contribution Agreement, Chicago, 1948, 5.

⁶ Ibid., 5.

Though the charter of Health Service, Incorporated was drawn up in 1949, it was not until 1951 that the corporation opened its doors for business. From the meetings over the two-year period four basic principles emerged to guide the operations of Health Service, Incorporated. To these principles and to Health Service, Incorporated itself we now turn.

B. HEALTH SERVICE, INCORPORATED

In April, 1951 the Advisory Committee to Health Service, Incorporated approved four basic principles. The essence of these principles follows:

1. Health Service, Incorporated will write a basic national contract that will aim for uniformity of benefits and meet competition.
2. Each Plan will decide for itself to write the basic Health Service contract.
3. If a Plan chooses to not write the basic Health Service contract or specific contracts of Health Service, Incorporated, then Health Service, Incorporated may enroll the group in that Plan area.
4. All Plans are obliged to negotiate with Health Service, Incorporated on any national group within their areas whether they choose to participate or not.⁷

Thus, the local Plans always had the privilege to participate in the activities of Health Service, Incorporated. Yet, if they refused, Health Service, Incorporated was free to enroll members directly.

At the Annual Conference of Blue Cross Plans in 1951 a resolution was adopted concerning Health Service, Incorporated. The resolution covered the enrollment and service to national groups and asked for cooperation by the Plan according to the principles. The resolution also covered the use of the Inter-Plan Service Benefit Bank. The use of the "bank" was

⁷ Blue Cross Commission, Health Service Procedures, Chicago, 1951, 1.

offered to members enrolled through Health Service, Incorporated.⁸

Health Service, Incorporated makes it possible for a national account to secure service benefits under a single insurance contract at a fixed and level annual rate. In addition, the enrollment procedure of Health Service, Incorporated simplifies the multitude of details involved in group arrangements.

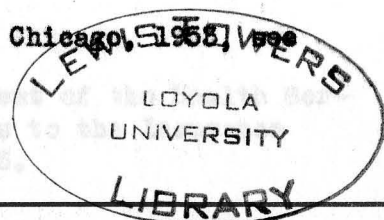
In fact, uniformity of rates, benefits, accounting procedures, enrollment of personnel, and administration are the key to the entire operation of Health Service, Incorporated.

The basic contract for semi-private accommodations of member hospitals for either thirty, seventy, or 120 days additional hospital benefits are as follows:

1. Bed and board including special diets
2. General nursing service
3. Use of operating room, delivery room and treatment rooms and equipment
4. All drugs and medicines, used during such hospitalization, which are listed in the "U. S. Pharmacopoeia," "National Formulary," or "New and Non-Official Remedies," at the time of admission, and which are commercially available for purchase by the hospital where the member is confined.
5. Dressings, splints, and casts
6. Such regularly provided services as laboratory examinations, electrocardiograms, basal metabolism tests, physical therapy, oxygen, anesthetics, x-ray examinations administration of blood and blood plasma, and intravenous injections and solutions⁹

⁸ Ibid., 1.

⁹ Blue Cross Commission, Blue Cross Manual, Chicago, 1955, special series section.



Maternity benefits may be had with an \$80.00 allowance or with full maternity service. Newborn children under an existing coverage contract are covered from birth. Private room allowances may vary from \$6.00 per day to \$8.00, \$10.00, or an amount equal to average semi-private room charges per day in addition to other hospital charges.¹⁰

Services excluded are those usually excluded in Blue Cross contracts:

1. Ambulatory surgery, except for emergency care within twenty-four hours of accidental injury
2. Hospitalization for professional and diagnostic studies, and rest cures
3. Hospitalization for occupational condition, ailment, or injury
4. Services of physicians, technicians, and nurses not employed by hospitals
5. X-ray therapy and radium therapy
6. Procurement of special braces and equipment
7. Ambulance service
8. Hospitalization for mental disorders, chronic alcoholism, drug addiction, and pulmonary tuberculosis¹¹

On December 31, 1952, Health Service, Incorporated was authorized to do business in the following states:¹²

Arizona
Arkansas
California
Delaware
District of Columbia
Florida
Georgia
Idaho
Illinois

Kentucky
Louisiana
Maine
Maryland
Michigan
Minnesota
New Hampshire
New Mexico
New York

Oklahoma
Oregon
Pennsylvania
Rhode Island
Texas
Utah
Virginia
Washington
West Virginia

¹⁰ Ibid.

¹¹ Ibid.

¹² Health Service, Incorporated, Annual Statement of the Health Service, Incorporated of Chicago in the state of Illinois to the Insurance Department of the State of Illinois, Chicago, 1953, 13.

Since such heavily populated states as Connecticut, Indiana, Massachusetts, New Jersey, Ohio, and Wisconsin are missing from among the list of states where Health Service, Incorporated is authorized to do business, it is obvious the corporation is yet in its infancy.

Yet, the Blue Cross social idea has another instrument to extend coverage and minimize the variance of benefits. Through this young corporation, plus the Inter-Plan Service Benefit Bank, Blue Cross is becoming a national institution.

Now, let us leave Blue Cross and turn to Blue Shield. We will return to Blue Cross and its complete operation again. The Blue Shield Medical Care Plans require our complete attention.

About the turn of the century a pioneer medical care institution was established in Tampa, Florida.¹ It was a community organization and it is still in existence. Unlike most medical care plans, it was organized as a society not only to provide medical and hospital care, but also for general welfare purposes. Income is derived from members' dues and social activities. The income provides for wholly-owned medical and hospital facilities, and for salaries of a panel of physicians.²

County-wide medical service bureaus sprung up shortly before, during and after World War I. Most of these bureaus were located in the Pacific Northwest with Eugene as the largest center of activity.

¹ Blue Shield Commission, "The Blue Shield Medical Care Plans," Chicago, 1933, 1.

² Ibid., 1.

CHAPTER VI

BLUE SHIELD PHILOSOPHY AND HISTORY

A. THE BEGINNING

Concurrent with the problem of financing hospital care is that of financing medical and surgical care. The Blue Shield Plans are the companion institutions of Blue Cross Plans. They were established to finance the payments of physicians' fees incurred during a hospital confinement.

About the turn of the century a pioneer medical care institution was established in Tampa, Florida.¹ It was a community organization and it is still in existence. Unlike most medical care Plans, it was organized as a society not only to provide medical and hospital care, but also for general welfare purposes. Income is derived from members' dues and social activities. The income provides for wholly-owned medical and hospital facilities, and for salaries of a panel of physicians.²

County-wide medical service bureaus sprung up shortly before, during and after World War I. Most of these bureaus were located in the Pacific Northwest with loggers as the largest number of members.

1 Blue Shield Commission, "The Blue Shield Medical Care Plans," Chicago, 1953, 1.

2 Ibid., 1.

The first state-wide medical care Plan was the California Physicians' Service. It was established by the California Medical Association in 1939.³ Enrollment was limited to employed persons earning less than \$3,000.00 per year. Physicians were reimbursed on a unit basis; the unit having a value of a fee for an office visit.

Experience in the early years was unfavorable. Demand, or incidence, was far greater than anticipated, and in order to keep the corporation solvent the unit was devalued. In 1941, with a modification of rates and benefits there resulted a more favorable value of the unit.

Even prior to this date, the American Medical Association had recognized the growth potential and social significance of medical care services. In 1934, the House of Delegates adopted a set of principles to guide the establishment and growth of these Plans. Certain of these principles still guide the activities.

1. All features of medical service should be under the control of the medical profession
2. No third party must be permitted to come between the patient and his physician
3. The confidential nature of the patient-physician relation must be preserved⁴

In 1942, due to the pressure of state medical associations, the House of Delegates approved the service benefit principle. The following year a Council on Medical Service and Public Relations was established by

3 Ibid., 1.

4 Ibid., 1.

the American Medical Association. This Council cooperated with state Plans, and rendered advice to the Plans and the Public.

The Council also formulated a preliminary set of "Standards of Acceptance for Medical Plans." Plans that met these standards are granted the privilege of using the approval seal of the Council on Medical Service. In addition to the general principles previously listed, there were several others:

1. Approval by the local county or state medical association
2. Maximum benefits consistent with sound financial operation
3. Benefits may be in terms of either cash indemnity or service units
4. Sound enrollment and administrative practices⁵

In 1945, at a session of the House of Delegates of the American Medical Association the principle of voluntary health insurance was endorsed.⁶ From the endorsement and further conferences, a non-profit association known as Associated Medical Care Plans was chartered in Illinois. It was sponsored by the medical profession and closely allied with the activities of the American Medical Association.⁷

The principal reason for a separate agency being chartered was to minimize, if not escape, litigation and judicial decision involving the American Medical Association.⁸ Within a year eighteen Plans had become a part of the Associated Medical Care Plans.

⁵ Ibid., 5.

⁶ Frank E. Smith, Director, Blue Shield Commission, "The Growth of Prepaid Medical Care Plans," Blue Shield Commission, Chicago, 1951, 1.

⁷ Ibid., 1.

⁸ Ibid., 1.

In 1948, a brand label entitled Blue Shield was adopted. Appropriately, the name of the association was changed in 1950 from Associated Medical Care Plans to Blue Shield Medical Care Plans.⁹

Throughout the growth of Blue Shield, it has been the companion of Blue Cross. An overwhelming majority of the enrollment in successful Blue Shield Plans has been done in cooperation with Blue Cross Plans. This has been a harmonious and logical arrangement since in most areas the Blue Cross Plans were already operating and were willing to make available their energies and experience.

The degree of cooperation varies. The most common arrangement is for the two Plans to be separate corporations but to have a single executive director, administrative and sales staff, and employee group. Another arrangement is complete integration and still another is complete separation.

Single administration of separate corporations is the arrangement most favored. First, such an arrangement alleviates the fears of physicians and hospital administrators that the other group wants to control a Plan. Second, the arrangement recognizes that Blue Cross Plans were developed first, and offer the Blue Shield Plan knowledge of health care financing. Thirdly, in substance the state enabling laws that require separate corporations for hospital and medical prepayment associations are met.¹⁰

9 Ibid., 1.

10 Blue Shield Commission, "The Blue Shield Medical Care Plans," Chicago, 1953, 3.

Enabling legislation for Blue Shield Plans is very similar to that enacted by the states for Blue Cross Plans. The non-profit regulations, governing board provisions, and reporting procedures to state insurance departments and offices are virtually identical.

The State of California was the first state to enact enabling legislation in 1939.

Like Blue Cross, the Blue Shield Plans have a national coordinating agency through their Commission. It is also located in Chicago, Illinois. The Blue Shield Commission, however, is organized somewhat differently and operates quite differently. We will examine this phase of Blue Shield operations again.

B. A SUMMARY

Like Blue Cross, Blue Shield grew from a seed that was planted by a professional man. But unlike Blue Cross, Blue Shield does not have laymen controlling it.

The American Medical Association, and state and county medical societies have to a very large degree controlled the policies of the Blue Shield Commission and the Blue Shield Plans. It is, of course, true that business administrators execute the policies established by the Blue Shield governing boards. But these boards are overwhelmingly represented by physicians.

In examining Blue Shield the depth of knowledge found in Blue Cross Plans is lacking. Consequently, while the pattern for the future of Blue Cross can be determined, such is not the case of Blue Shield. Only recently

can it be said that Blue Shield is operating on a national scale. And really, having only formally existed since 1946, the history of Blue Shield is brief.

BLUE SHIELD TODAY

A. GENERAL EXPLANATIONS

Working capital for Blue Shield Plans came from two sources. One, public spirited citizens, physicians, and public officials such as Mayors, Councilmen, and Aldermen supplied venture funds to begin operations. Two, Blue Cross Plans got some funds for the initial operation of their sister-organization.

Blue Shield benefits are one of three types. There is the straight service-benefit contract. Under it, the member is entitled to such medical or surgical services as are included in the contract and as may be needed. The physician accepts from the Plan, as full payment, the fees for his services as established under his contract with the Plan.

Then, there is the straight indemnity contract. Under it, the member receives cash or credit in predetermined amounts toward the physician's fee. With this arrangement, the physician is free to charge the patient fees of his own decision.

Actually, the Blue Shield contract that is most common today is one which is a combination of service and indemnity. That is, the member whose annual income is below a certain amount receives service benefits, but a member with a greater income, receives only specified credits toward

CHAPTER VII

BLUE SHIELD TODAY

A. GENERAL EXPLANATIONS

Working capital for Blue Shield Plans came from two sources.

One, public spirited citizens, physicians, and public officials such as Mayors, Councilmen, and Aldermen supplied venture funds to begin operations. Two, Blue Cross Plans set aside funds for the initial operation of their sister-organization.

Blue Shield benefits are one of three types. There is the straight service-benefit contract. Under it, the member is entitled to such medical or surgical services as are included in the contract and as may be needed. The physician accepts from the Plan, as full payment, the fees for his services as established under his contract with the Plan.

Then, there is the straight indemnity contract. Under it, the member receives cash or credit in predetermined amounts toward the physician's fee. With this arrangement, the physician is free to charge the patient fees of his own decision.

Actually, the Blue Shield contract that is most common today is one which is a combination of service and indemnity. That is, the member whose annual income is below a certain amount receives service benefits, but a member with a greater income, receives only specified credits toward

the physician's total bill.¹

Certainly, the service benefit contract is the most favorable type from the point of view of the member. He knows he is fully protected. For the physician, one practical advantage is that prepayment reduces his collection losses. Subscription rates, however, must be maintained at a level acceptable and within the reach of the public. This may mean the Plan's income will be insufficient to reimburse the participating physicians adequately. Another problem connected with service benefits is the problem of determining what a patient's annual income is. An additional difficulty is posed by the problem of constantly determining who in the membership of the Plan is over and under the specified limits.

An indemnity contract eliminates the administrative difficulties connected with the service benefit contract. It is, of course, advantageous to the physician. The indemnity contract puts a floor under the physicians' charges without establishing a ceiling. Because of this, the member has no assurance of what proportion of the physician's bill will be covered or how much he will be charged personally for the physician's services.

To date, surgical fees have been emphasized by Medical Care Plans. This has been natural since surgical procedures are frequently more costly than medical therapy. Slowly, however, Blue Shield coverage is being extended for medical therapy for office and home visits.²

1 Blue Cross Commission, "The Blue Shield Medical Care Plans," Chicago, 1953, 4.

2 Ibid., 5.

Agreements between Blue Shield Plans and their participating physicians are characterized by three main features:

1. The physician agrees to abide by the rules of the Plan
2. When there is a service benefit contract, the physician agrees to accept the Plan's payment as full reimbursement for his services
3. In the event a Plan cannot pay the agreed upon reimbursement in an indemnity contract, the physician agrees to accept the pro-rata payment from the Plan³

Payment in most cases is made by the Plans to the physician. Provision is usually made, however, to reimburse the member if he pays his physician prior to the time Blue Shield makes its payment.

Medical care presents a tremendous problem in determining subscription rates. Incidence per 1,000 members, utilization per 1,000 members, and payments per 1,000 members are extremely difficult to chart and predict. The salient reason for this is due to the individualistic billing practices traditionally a part of the medical profession. While physicians' services, from the contract viewpoint, may be standardized by counties and states, fees vary according to districts, clientele, and practices.

Unlike hospitals where operating and administrative costs can be stabilized, as is the case for most institutions, the individual physician establishes his costs according to his skills, experience, size of practice, type of patient, ability of patient to pay, professional reputation, services required, and general economic conditions.

3 Ibid., 5.

3 Illinois Medical Service, "The General Blue Shield Subscription Certificate," Chicago, 1942.

There are few common denominators for an actuary to build a rate prediction upon.

With this in mind, let us turn to basic coverage and rates.

B. BASIC COVERAGE AND RATES

Blue Shield coverage and rates vary from Plan to Plan. The influence of the local medical society, Blue Cross administrative staff, and operating costs are factors which determine contract rates and benefits.

Sometimes a Plan will begin business with a surgical contract. Then, after a period of operating solvently the Plan will offer a supplementary contract which covers non-surgical physicians' services. If the Plan can assume the added liability at a rate within the reach of the public, the final step is to combine the surgical contract and the non-surgical rider into a comprehensive contract. This movement is of very recent origin.⁴

Benefit schedules cover numerous services. Without detailing the entire list, a list follows of common services covered.⁵

1. General Surgical Benefits:

- A. Abdomen
- B. Abscesses and Infections (Incision and Drainage)
- C. Amputations
- D. Arteries and Veins
- E. Bones and Joints

⁴ Ibid., 5.

⁵ Illinois Medical Service, "The General Blue Shield Subscription Certificate," Chicago, 1951.

- F. Fractures
 - G. Dislocations
 - H. Breast
 - I. Chest
 - J. Ear, Nose, and Throat
 - K. Eye
 - L. Gallbladder and Biliary Tract
 - M. Genital System
 - N. Goiter
 - O. Hernia
 - P. Kidney and Bladder
 - Q. Neurosurgery
 - R. Rectum and Anus
 - S. Tendons and Bursae
- 2. Obstetrical Care
 - 3. General Medical Care:
 - A. Hospital Visits
 - B. Hospital Treatment, including Accident Treatment
 - 4. Specialty Benefits:
 - A. X-Ray Service
 - B. Radiation Therapy
 - C. Clinical and Surgical Pathology
 - D. Anesthesia

For the most part Blue Shield subscription rates run less and never more than Blue Cross rates. They vary from locale to locale and, as might be anticipated, parallel closely the companion Blue Cross rate.

If a Blue Cross Plan has a relatively high rate, then chances are the Blue Shield rate will be high. And vice-versa.⁶ Where a Plan has faced a narrow spread of risk medically, or has been managed poorly, the rate, naturally, has climbed.

⁶ Blue Shield Commission, "The Blue Shield Medical Care Plans," Chicago, 1953, 6.

"Plan-rights" philosophy underlies many of the variations between Blue Shield Plans. Yet considering the youthfulness of the Blue Shield idea one is surprised more do not exist. Perhaps the guidance and lessons learned by the Blue Cross Plans are responsible.

C. MEMBERSHIP

The growth of Blue Shield is even more amazing than that of Blue Cross. In seven years time the number of members equals what it took Blue Cross to reach in ten. And the peak of growth may still be ahead.

TABLE IX

GROWTH OF BLUE SHIELD PLANS⁷

Year	Members
1946	1,826,719
1947	5,791,179
1948	8,911,225
1949	12,260,045
1950	16,629,596
1951	21,130,996
1952	24,770,359

Blue Shield Medical Care Plans are now in operation in forty-two states, the District of Columbia, eight Canadian Provinces, and in the

⁷ Blue Shield Commission, "Blue Shield Fact Sheet, Chicago, 1953, 1.

territories of Puerto Rico and Hawaii.⁸

There are only eleven states, and the District of Columbia, where more than twenty per cent of the population are covered by Blue Shield contracts.

TABLE X

BLUE SHIELD MEMBERS IN ELEVEN STATES
AND THE DISTRICT OF COLUMBIA⁹

State	Per Cent
Delaware	59.5
District of Columbia	45.2
Michigan	43.1
Connecticut	30.4
Massachusetts	29.9
New Hampshire	27.5
Vermont	27.5
New York	25.6
Colorado	25.3
Ohio	22.7
Indiana	22.5
New Jersey	20.6

Canadian membership approximates one million members which is about eight per cent of the population. Membership in the United States runs slightly over sixteen per cent of the population.¹⁰ Since over 14,000 people joined Blue Shield each working day in 1952, the membership figures are

⁸ Ibid., 1. Blue Shield Plans are not chartered in Connecticut, Idaho, Louisiana, Rhode Island, Vermont, and Washington.

⁹ Ibid., 1.

¹⁰ Ibid., 1.

certain to grow. The rate of increase of membership growth is holding steady.¹¹

During the period from 1945 to 1952 the number of Blue Shield Plans has grown from nine to seventy-eight.

TABLE XI

NUMBER OF BLUE SHIELD PLANS¹²

Year	Plans
1946, March	9
1946, December	18
1947	48
1948	55
1949	68
1950	72
1951	78
1952	78

At the same time, the number of physicians participating under Blue Shield contracts attained a figure of 118,000.¹³ Of this figure, 92,345 physicians signed participating agreements with Plans offering service benefits. Approximately 26,000 signed participating agreements with Plans offering indemnity benefits.¹⁴

¹¹ Ibid., 4.

¹² Ibid., 2.

¹³ Blue Shield Commission, "Facts About Blue Shield, " Chicago, 1952, 5.

¹⁴ Ibid., 5.

¹⁵ Ibid., 3.

D. EXPERIENCE

Statistically, the experience of the Blue Shield Plans has not been as well recorded as that of the Blue Cross Plans. There are obvious reasons why this is so. First, Blue Shield is much younger than Blue Cross, and the men administering Blue Shield have not had an opportunity to initiate statistical studies. Second, Blue Shield is still, as a dynamic institution, in a growth cycle. Presently, more attention is being given to sales than to administration. Third, and perhaps most important, neither physicians nor their office employees are trained to assemble the data used by Blue Shield personnel. Unlike trained hospital administrators, physicians are not a good source for statistical data. Some idea of where Blue Shield income goes can be gained from the following table:

TABLE XII

BLUE SHIELD PAYMENTS TO PHYSICIANS IN 1951¹⁵

Benefit	Cases	Amount
Maternity	439,683	\$21,754,279
Appendectomies	133,396	14,112,222
Tonsillectomies	333,708	11,454,833
Herniotomies	46,493	4,307,942
Hemorrhoidectomies	57,791	3,548,687
All other surgery	1,601,189	71,980,585
Medical care	614,306	16,224,929
Anesthesia	374,725	7,757,595
X-Ray	514,000	8,153,728
Other ancillary	993,369	5,760,427
	5,108,660	\$165,055,227

¹⁵ Ibid., 6.

Dollar distribution of Blue Shield income can be found in Table XIII.

TABLE XIII

BLUE SHIELD INCOME DISTRIBUTION¹⁶

Year	Medical and Surgical Expenses	Operating Expenses	Reserve Funds
1948	\$ 55,161,457	\$10,189,826	\$ 6,109,934
1949	79,218,673	13,919,164	6,380,884
1950	115,906,544	19,259,891	12,453,087
1951	165,055,277	25,677,455	16,540,395
1952	\$208,514,177	\$31,281,695	\$22,195,869

Percentage distribution of the total Blue Shield income dollar can

be found in Table XIV.

TABLE XIV

PERCENTAGE DISTRIBUTION OF TOTAL INCOME
DOLLAR OF BLUE SHIELD PLANS¹⁷

Year	Medical and Surgical Expense	Operating Expense	Reserve Funds
1947	78.24%	15.60%	6.16%
1948	77.19	14.26	8.55
1949	78.99	13.88	7.13
1950	78.51	13.05	8.44
1951	79.63	12.39	7.98
1952	79.29	11.89	8.82

It is interesting to note that when the percentage figures of Blue

¹⁶ Blue Shield Commission, "Blue Shield Fact Sheet," Chicago, 1953, 2. Statistics concerning Blue Shield Reserve Funds are not available. The author calculated the Reserve Funds by utilizing the data in Table XIII and Table XIV.

¹⁷ Ibid., 2.

Shield and Blue Cross are compared, the stability of the Blue Shield figures is clearly apparent. While the Blue Cross figures show a trend to smaller operating expenses with higher benefits going to the member, the Blue Shield income appears to be going into reserve even though operating expenses, relatively, are diminishing. In other words, even though Blue Shield operating expenses are decreasing, Blue Shield members are not receiving added benefits. The funds are going into Reserve rather than to Medical and Surgical Expenses.

Twenty-nine men comprise the governing board of the Blue Shield Commission. Seven of the men are known as Commissioners-at-Large and are elected by the Plans themselves. The other twenty-two come, two each, from the eleven districts the Plans are divided in. From each district, one Commissioner represents the Executive Directors and one Commissioner represents the governing boards.

At present, the Blue Shield Commission is governed by eighteen physicians and eleven laymen. The East Coast and the Midwest dominate the Commission from a geographical point-of-view.

Like the Blue Cross Commission, the Blue Shield Commission is patterned after a trade association. It has no supervisory or disciplinary

1. Blue Shield Commission, "Facts About Blue Shield," Chicago, 1952, p.

CHAPTER VIII

BLUE SHIELD NATIONAL PROJECTS

A. THE COMMISSION

The Blue Shield Commission came into being with the first Blue Shield Plan. It was 1949, however, before the Commission was separated from the formal domination of the American Medical Association, and became an independent institution.

Twenty-nine men comprise the governing board of the Blue Shield Commission. Seven of the men are known as Commissioners-at-Large and are elected by the Plans themselves. The other twenty-two come, two each, from the eleven districts the Plans are divided in. From each district, one Commissioner represents the Executive Directors and one Commissioner represents the governing boards.

At present, the Blue Shield Commission is governed by eighteen physicians and eleven laymen.¹ The East Coast and the Midwest dominate the Commission from a geographical point-of-view.

Like the Blue Cross Commission, the Blue Shield Commission is patterned after a trade association. It has no supervisory or disciplinary

1 Blue Shield Commission, "Facts About Blue Shield," Chicago, 1952, 6.

authority over its member Plans, except to determine whether or not a Plan has continued to comply with membership standards.

Headquarters of the Blue Shield Commission are located in Chicago, Illinois. All administrative duties are performed in this office. The primary functions of the Commission are to disseminate information of national value, and coordinate national projects.

The member Plans, through the Commission, always have the opportunity to obtain information about rates, benefits, and procedures of other Plans. Field trips and national meetings are constantly being planned, executed and evaluated. All functions are aimed at raising the operating efficiency of the member Plans.

Unlike Blue Cross, the Blue Shield Plans have no Inter-Plan Service Benefit Bank. As a consequence, when a member requires a physician's services away from the locale of his Plan, the physician renders the bill directly to the patient. The patient then either pays the physician or waits until he returns home. There, he renders the bill to his Plan.

If a member requires treatment at the place of his residence, the member can either pay the physician's fee or have the Plan do so. To establish an Inter-Plan Physicians Bank would necessitate a large staff. Keeping financial and medical records of treatment rendered by 118,000 physicians presents tremendous administrative problems.

B. MEDICAL INDEMNITY OF AMERICA, INCORPORATED

Originally known as National Blue Shield Service, Incorporated, Medical Indemnity of America, Incorporated is the national enrollment agency

of the Blue Shield Plans.² Considerable controversy occurred over the chartering of this corporation. The initial concept of Medical Indemnity of America, Incorporated was to charter it in conjunction with Health Service, Incorporated.

The American Medical Association opposed the idea. Thus, a separate stock insurance corporation was chartered in the State of Ohio in 1950. The Blue Shield Plans raised \$383,000 among themselves in order to do so, and in Ohio in May, 1951, the company was granted a license to do business.³

Medical Indemnity of America, Incorporated is making application for licenses to do business in other states. It has only just begun to serve its initial purpose, i.e., that of being a national agency for Blue Shield Plans.

Let us now turn and look with a perspective at the adolescent Blue Cross, and the infant Blue Shield. With a perspective we can examine problems confronting the two organizations, what is being planned to solve the problems, and what possibilities exist to solve problems not yet in the discussion or planning stage.

2 Frank E. Smith, Director, Blue Shield Commission, "The Growth of Prepaid Medical Care Plans," Blue Shield Commission, Chicago, 1951, 3.

3 Ibid., 4.

1 Health Insurance Council, "Annual Survey, "Facts and Figures: Coverage in the United States," New York, 1953, 7.

CHAPTER IX

A PERSPECTIVE

A. SUCCESSES TO DATE

Our nineteenth century beliefs that folks ought to take care of financing health care themselves have changed. We now pool our money for use when we need hospital bed care and physicians' services rather than try to do the job individually.

At the time the Blue Cross idea began to spread, the nation was embarking on group experiments to rid the economy of a depression. Furthermore, laboring men began to unite into strong organizations to better their wages, hours, and working conditions. These latter group efforts were sanctioned, indeed fostered, by the federal government. In a like manner, the enabling legislation of the states fostered the growth of the non-profit hospital and medical Plans.

Today, in the United States, an estimated 91,667,000 individuals are covered by hospitalization insurance, 73,161,000 are covered by surgical insurance and 35,797,000 are covered by medical insurance.¹ Of these totals, Blue Cross contracts cover 43,815,021 individuals for financing hospital care and Blue Shield contracts cover 24,770,359 individuals for

¹ Health Insurance Council, "Annual Survey," "Accident and Health Coverage in the United States," New York, 1953, 7.

financing surgical and medical care. Certainly, a respectable representation.

In fact, Blue Cross-Blue Shield have stimulated private insurance carriers to re-examine health insurance and to re-enter, aggressively, the business of selling, and administering health insurance. But, even more, the Blue Cross-Blue Shield growth has prompted the private insurance carriers to improve their benefits, rates, and services.

Since their founding, Blue Cross-Blue Shield have strengthened themselves. The organic relationships they maintain with hospitals and physicians have been strengthened. Strengthened by a mutual respect and understanding of each other's problems and plans. The administrative staffs of the Plans and the two Commissions have worked hard to convince hospital administrators and physicians that they are not interested in entering the professions of hospital care and medicine.

In turn, the hospital administrators and physicians have come to appreciate the strength the voluntary prepayment Plans can give their hospitals, practices, and communities.

The basic strength of Blue Cross-Blue Shield resides in service benefits especially for the lower income groups. Fortunately, the Plans that do not now have service benefits are studying them closely. Leading officials of the Plans and the Commissions are working constantly to see that the policy of service benefit coverage becomes standard.

Along with the service benefit, as a strength is the prompt establishment of credit when a Blue Cross card is presented at a hospital admitting desk by a patient. Though Blue Shield has not as yet equalled Blue

Cross in the establishment of credit, it has alleviated the collection problem of physicians.

Along with the service benefit practice and the establishment of credit as an asset is the Blue Cross-Blue Shield not-for-profit corporate basis. The Plans provide means for individuals to put money aside until needed. When illness strikes, the Plans do not profit from the misfortune. Such a concept reflects Christian thinking in action.

The Blue Cross-Blue Shield Plans, continuing to think in a philosophical vein, do even more. Certainly the problems of financing health care is a community problem. They have aided their communities and the nation, and consistently have done so on the principle of subsidiarity. The local Plans have met and overcome local problems. Only when national problems have arisen have the national organizations acted. Thus, staff bureaucracy has been avoided, and local responsibility developed.

But the Blue Cross-Blue Shield idea is not without problems. As they have grown, so have the problems. And, so also, have the plans for resolving the problems.

B. PROBLEMS, PLANS, AND POSSIBILITIES

One of the foremost problems confronting Blue Cross-Blue Shield is membership. Both have enjoyed rapid and substantial growth. But Blue Cross membership is leveling and Blue Shield membership will probably follow the same pattern.

Competition from private insurance companies is one reason membership growth is leveling. Yet another reason is the methods for enrolling

individuals as members. Group enrollment has been the key. But such a practice is limited. Most large companies now have group hospitalization and medical insurance. It is the small company or store, or farmer that still offer considerable enrollment possibilities. This potential, if enrolled by present enrollment practices, would never be realized because of the tremendous costs involved.

Already Plans have begun what is known as Direct Pay Member Enrollments. These enrollments have been carried on by solicitation through hospitals and newspapers. The potential member mails in information to the Plan office and is accepted or rejected on the basis of age and stated health conditions.

For small groups, mail and telephone enrollment service has been initiated. Plan employees, through well conceived schedules and forms have enrolled groups of fifteen members or less by telephone instructions and mailed instructions. For Plans in large industrial areas where many small organizations flourish, or where distances between organizations is great, the telephone and particularly the mail enrollment procedures can be greatly utilized.

Related to the problem of increasing membership is that of coverage for individuals retired from the labor market. Recent attempts by such large groups as certain Bell Telephone subsidiaries, Ford Motor Company, and General Motors are convincing Plan personnel and business leaders that pension groups can be successful.

These companies have offered Blue Cross-Blue Shield to their retired employees, and the billing has gone through the companies. Thus, one

of the administrative problems has been overcome. But the experience of the pension group is still unknown. Certainly, the need for hospital and medical care is greater after age sixty.

A special rate for only people over sixty is almost prohibitive because of the high rate of hospitalization. But if a rate can be devised that will include all members, including those over sixty, seventy, and eighty, then Blue Cross-Blue Shield can open a tremendous aid to aged people. Also, it may be possible for Blue Cross-Blue Shield to cooperate with community, county, state, and federal authorities in establishing groups for the aged individuals desiring coverage who do not now have the means of financing health care.

Another problem confronting the community and Blue Cross-Blue Shield is that of financing health for the indigent. Such financing can only be done by prepayment insurance methods if charitable and governmental authorities can convince communities and Blue Cross-Blue Shield people the job can be done effectively. The group enrollment and administrative methods are feasible for indigent individuals if the group can define indigence, enroll indigents on a temporary basis, remove indigents when they become self-supporting, and the community is willing to assume the rate.

Perhaps tax supported hospital and medical facilities are a better alternative. Yet, even they cannot offer the care of privately supported institutions. The problem remains, however, and the community and Blue Cross-Blue Shield will be asked for an answer in the next decade.

Perhaps one of the most discussed problems confronting not only

Blue Cross-Blue Shield but all insurance companies and the nation is financing health care for catastrophic diseases and accidents. An ill-fate of health in a family can ruin it. And the ravages of a lengthy or crippling disease can strike anyone.

For Blue Cross-Blue Shield to resolve the problem for its members by extending contract benefits and raising rates would be difficult. Hospital admissions are climbing. In-Patient days are climbing. Where and when the peak will be is difficult to estimate.

In addition, the average length of stay under the present standard certificates is slightly in excess of seven days. If benefits were extended, to a full year of benefit coverage, the distinct possibility arises that rates would climb beyond the reach of the public.

At present there are three possibilities. One is to establish a supplementary contract with the deductible clause feature. In this case, a patient would be covered by basic Blue Cross-Blue Shield benefits under the standard contracts until the period elapsed. Then, there would be an absence of coverage and the patient-member would pay medical costs until a pre-determined time lapse, dollar expenditure, or service rendered amount, or a combination had been reached.

At that time, full benefits would come into effect again for an extended period of time or dollar amount in the form of service benefits until the contract limit had been reached.

Another possibility is to have Blue Cross-Blue Shield write the basic contract, and a private insurance company write an indemnity catastrophic

contract. The limitation could be in the neighborhood of a total expense of ten thousand dollars. This possibility raises the question of revising the non-profit community nature of the Blue Cross-Blue Shield philosophy. While the loss of the community nature would not be too serious, that of the non-profit would.

Not only will enabling legislation have to be examined, but also the support of organized labor and the community must be considered. To date, the public has looked upon the funds entrusted to Blue Cross-Blue Shield as going to a non-profit institution. Also, much of the support organized labor has given Blue Cross-Blue Shield has been because of its non-profit philosophy. To modify this philosophy might endanger the life of Blue Cross-Blue Shield, and deserves the closest of scrutiny.

A third possibility resides in the area of community, state, or federal support. In this method governmental institutions would underwrite the catastrophic coverage of the Blue Cross-Blue Shield contracts. Perhaps a program of health grants-in-aid is feasible. Whatever is done, the medical profession must be convinced that "socialized medicine" is not around the corner, that the Blue Cross-Blue Shield Plans will administer the distribution of the funds, and political patronage and bill padding can be absolutely minimized if not eliminated.

Of the three, and from a long range view, the last possibility exists as an answer. The nation, as it becomes more health conscious and as its population ages, will not be satisfied with a method of financing health care which excludes catastrophic diseases.

Now, we come to two salient and necessarily joint problems. Rates and benefits. They vary considerably from Plan to Plan. That rates should vary is secondary in importance to benefits. Costs of service are bound to vary. But that level and uniform benefits are unknown, except in leading Plans and Health Service, Incorporated, is not good.

Though persons may be afflicted with similar diseases requiring similar hospital and medical care, their financing of the cure may be entirely different due to their place of residence and hospitalization.

Table XV shows variance of rates. Though benefits are not listed, coverage and service vary also.

TABLE XV

RATES OF EIGHT BLUE CROSS PLANS¹

State	Group		Direct*	
	Single Rate	Family Rate	Single Rate	Family Rate
California,	\$1.85 ^m	\$5.75	\$ 8.05 ^m	\$24.55
Northern	2.50 ^f		10.75 ^f	
California,	1.70 ^m	5.25	8.55 ^m	19.65
Southern	2.35 ^f		10.20 ^f	
Florida	1.30	3.50	4.35	12.45
Illinois	2.15	6.50	9.00	16.95
Missouri	1.50	3.75	6.00 ^m	13.50
			7.50 ^f	
Massachusetts	1.65	4.40	6.50	13.25
Michigan	2.60	6.35	8.65	20.95
New York	1.60	4.36	6.00	15.00

* All Direct rates are paid quarterly

m male

f female

¹ Alex Wilde, Statistician, Hospital Service Corporation, "Rates of Eight Blue Cross Plans," Chicago, 1953.

Certainly, studies should be undertaken to resolve the problem. The operations of the Inter-Plan Service Benefit Bank have made the public aware of the differences. The public, through purchases of national products, expects to receive a nationally similar commodity. Indeed, through chain stores, automobile dealers, appliance dealers, and private insurance companies the public is assured what they purchase is distributed on a national scale.

Perhaps the operations of Health Service, Incorporated will bear fruit in the direction of initiating level benefits throughout the nation. Data will be made available through its experiences of national contract coverage.

Concurrent with the problem of level rates and benefits is the problem of rising rates. Due to the rising costs of hospital and medical service plus the upward trend of incidence, Blue Cross-Blue Shield have shown a pronounced move upward. Blue Cross rates, however, are the rates that have really taken the brunt of the inflation spiral. The period from 1946 to 1953 has been critical in this respect.

A history of rates of the Illinois Plan as an example, shows this upward trend. From 1937 to 1945 rates changes were relatively unknown.² Usually, these changes were made in order to increase benefits. But from 1946 to 1953 the rate movement each year with the exceptions of 1949 and 1952

² Alex Wilde, Statistician, Hospital Service Corporation, "Hospital Service Corporation; History of Rates and Benefits," Chicago, 1953, 2.

is up.³ In one year X-ray and obstetrical benefits were reduced.

In some cases the rates doubled, while in other cases they increased almost four times that paid by members in 1938. Naturally, the question arises of what lies ahead. Will rates continue rise? Or will rates stabilize? If rates do climb where will they level? Basic to these questions is that of the public's acceptance of rate increases and the public's willingness to pay the increased rates.

If the economy generally stabilizes chances are good that hospital and medical costs will stabilize also. Thus, one large factor contributing to the increased rates is corrected. This, in itself, is very important. Blue Cross-Blue Shield is one enterprise where service costs are, to a very large degree, beyond the control of the administrators. Though the member contracts with Blue Cross-Blue Shield for the financing of care, separate institutions and individuals perform the service at an expense which may be unknown to the contracting parties.

With a service benefit philosophy at the heart of the Blue Cross-Blue Shield social idea, the Plans are peculiarly sensitive to price movements of the economy. If the economy nationally moves into a relatively stable period, or a slightly declining period, the service benefit philosophy appears safe, at least for the duration of such a period. If, on the other hand, the economy has not run the full course of inflation, then, the service benefit philosophy may be shaken.

3 Ibid., 2.

Part of the responsibility for stabilizing health care costs resides with hospital administrators and the medical profession.

Hospital services are fast becoming the major component in the cost of total health care. Hospitals, in terms of dollar expenditures, occupy the position of the nation's fifth largest industry.⁴ Gone are the days when a retired banker or civic minded citizen could administer the activities of a hospital.

Advances in medicine, treatment of diseases, and uses of therapeutic devices and equipment have combined to compound the complexity of administration. One of the most important features of hospital operations is that the end product is not a thing. The hospital product is a combination of many services intended to make human beings healthier and happier.

Today, with more than ninety million individuals covered by some sort of protection for the payment of health care, the burden of paying hospital costs is being shifted from those who are ill to those who are healthy.⁵ No member of a hospital board or staff can ignore the implications of this shift in financing health care. Individual citizens and employers are and will continue to look askance at the ever increasing costs involved in health care.

Most assuredly, the questions being asked of hospital administrators about costs will be asked of physicians. Each group must assume their

⁴ Harry Becker, Associate Director, Commission on Financing of Hospital Care, "The Emerging Science of Hospital Administration; The Role of the Hospital Accountant," Chicago, 1953, 2.

⁵ Ibid., 5.

share in the responsibility of serving the individual citizen well and within his reach financially.

It is, indeed, heartening that Blue Cross Plans are working through visitation programs, discussion groups, and seminars to inform hospital personnel of their problems and plans. Also, the establishment of a non-profit institution such as the Commission on Financing of Hospital Care should help. Such a group can study, report, advise, and educate all parties to the broad social responsibilities of financing health care.

Leading universities are introducing courses leading to degrees with major work in hospital administration. Like industry, hospitals are now searching for policies, procedures, and methods to serve their patients with the highest quality of care at the lowest cost. Planning, organizing, staffing, directing, coordinating, reporting, and budgeting will become as common in hospitals tomorrow as they are in well managed firms today.

Like other groups of social action, the people within the Blue Cross-Blue Shield institutions have worked within our capitalist concept of

business and our federalistic form of government.

In addition, Blue Cross-Blue Shield has the active support of

hospitals, industry, labor, agriculture, and the medical profession.

In fact, prominent and respected men from all elements of our national life

now sit on the governing boards of the local Plans and national organizations

CHAPTER X

CONCLUSIONS

The purpose of this thesis was addressed to bringing forth facts concerning the non-profit associations Blue Cross-Blue Shield. Specifically, their histories, experience, problems, and plans. What conclusions can be drawn from the facts that have been presented?

We can conclude that Blue Cross-Blue Shield is young and, at least for the present, growing. And growing with a sense of responsibility to its members, the hospitals, physicians, and the nation.

The concept of voluntary, group prepayment for health care fits better into our economic and social notions than the idea of compulsory governmental health insurance. The world shaking events of the first half of the twentieth century have left an indelible impression on the nation. Like other groups of social action, the people within the Blue Cross-Blue Shield institutions have worked within our capitalistic concept of economics and our federalistic form of government.

In addition, Blue Cross-Blue Shield has the active support of hospitals, industry, labor, agriculture, and the medical profession. In fact, prominent and respected men from all elements of our national life now, sit on the governing boards of the local Plans and national organizations.

This is in contrast to ten and fifteen years ago, when the problem of seating new members was a difficult one to overcome.

The local or community strength of Blue Cross-Blue Shield appears good. Both began as local institutions. That is where the basic strength resides. Perhaps it is time for the people leading Blue Cross-Blue Shield to re-examine their objectives, if they have not done so already. Perhaps, now is the time to clearly define national objectives and to set in motion the necessary policy and administrative action for a national organization.

Rather than lose basic local strength, the author believes a national policy on sales, finance and administration will strengthen the entire local operation. The lessons of managing a national organization learned by many other businesses serving the American public could well be put to use by Blue Cross-Blue Shield people.

There is an apparent move in the direction of centralized policy and decentralized operations. The establishment of Health Service, Incorporated, and Medical Indemnity of America, Incorporated are indicators of this trend. They deserve, and rightfully so, careful attention.

Another sound move that is underway is the merging of Plans. Are eighty-seven Blue Cross Plans and seventy-eight Blue Shield Plans necessary to serve the public? Can this number exist with a reasonable degree of financial stability? If not, precautions must be taken to secure the monies entrusted to those Plans that may be endangered by adverse economic conditions.

Of the two institutions, Blue Cross most assuredly is demonstrating more success and maturity than Blue Shield. Though the Blue Shield Plans

show higher financial reserves proportionately, it must be remembered that neither institution should be concerned primarily with reserve strength. On this point, the Blue Shield people and the medical profession must take steps to insure a higher proportion of medical and surgical costs are financed by member subscription income.

This study and perspective suggest further studies. Of immediate interest would be a study of factors comprising total hospital costs as well as factors comprising total medical, including surgeon, costs. Certainly hospital administrators would benefit even from a local study.

A broader and much more difficult and complex study would be one showing the relation between hospital and medical costs and price moves within the economy.

For Blue Cross-Blue Shield a study of Plan administration might bear fruit, although such a subject presents overwhelming problems because of the number of Plans operating today. An obvious study for the future is an analysis of rates, benefits, reserve ratios, and operating costs of the national Blue Cross-Blue Shield Plans just now starting.

Of course, the success of the Blue Cross-Blue Shield idea depends to a very large degree, on the success of the nation in resolving not only health problems but all types of social problems on a voluntary basis. Who, today, will venture an estimate of the democratic forces at work in the nation and the world?

But, whatever the future brings, the concept of financing health

care through-group action has been planted and nourished well from humble beginnings by Blue Cross-Blue Shield.

III. PRIMARY SOURCES

Blue Cross Commission, Blue Cross Association Registration Manual, Chicago, 1948.

Blue Cross Commission, Health Service Procedures, Chicago, 1951.

Wilde, Alexander, Statistician, Hospital Service Corporation, "Rates of Night Blue Cross Plans," Chicago, 1953.

II. SECONDARY SOURCES

A. BOOKS

Blue Cross Commission, Blue Cross Manual, Chicago, 1955.

Blue Cross Commission, Experiences of Blue Cross Plans, Vol. IV, Chicago, 1955.

Flumley, H. Ladd, Budgeting the Costs of Illness, New York, 1947.

B. PERIODICALS

Health Insurance Council, "Annual Survey: Accident and Health Coverage in the United States," New York, 1955.

C. ARTICLES

Baumgartner, Harold, Blue Cross Commission, "Inter-Plan Service Benefit Plans: Reaches Milestone of Service," Reprint from Hospital, Journal of the American Hospital Association, Chicago, 1955.

BIBLIOGRAPHY

I. PRIMARY SOURCES

Blue Cross Commission, Blue Cross Association Contribution Agreement, Chicago, 1948.

Blue Cross Commission, Health Service Procedures, Chicago, 1951.

Wilde, Alexander, Statistician, Hospital Service Corporation, "Rates of Eight Blue Cross Plans," Chicago, 1953.

II. SECONDARY SOURCES

A. BOOKS

Blue Cross Commission, Blue Cross Manual, Chicago, 1953.

Blue Cross Commission, Experience of Blue Cross Plans, Vol. IV, Chicago, 1953.

Plumley, H. Ladd, Budgeting the Costs of Illness, New York, 1947.

B. BOOKLETS

Health Insurance Council, "Annual Survey; Accident and Health Coverage in the United States," New York, 1953.

C. ARTICLES

Baumgartner, Harold, Blue Cross Commission, "Inter-Plan Service Benefit Bank Reaches Milestone of Service," Reprint from Hospitals, Journal of the American Hospital Association, Chicago, 1953.

III. UNPUBLISHED MATERIALS

American Hospital Association and Blue Cross Commission, "Blue Cross Approval Program of the American Hospital Association," Chicago, 1952.

Becker, Harry, Associate Director, Commission on Financing of Hospital Care, "The Emerging Science of Hospital Administration; The Role of the Hospital Accountant," Chicago, 1953.

Blue Cross Commission, "Blue Cross Fact Sheet," Chicago, 1953.

Blue Cross Commission, "The Blue Cross Plans For Hospital Care," Chicago, 1953.

Blue Shield Commission, "Blue Shield Fact Sheet," Chicago, 1953.

Blue Shield Commission, "Facts About Blue Shield," Chicago, 1952.

Blue Shield Commission, "The Blue Shield Medical Care Plans," Chicago, 1953.

Health Service, Incorporated, "Annual Statement of the Health Service, Incorporated of Chicago in the State of Illinois to the Insurance Department of the State of Illinois, Chicago, 1953.

Hospital Service Corporation and Illinois Medical Service, "Report of the Executive Director," Chicago, 1953.

Illinois Medical Service, "The General Blue Shield Subscription Certificate, Chicago, 1951.

Jones, Richard M., Director, Blue Cross Commission, "A History and Philosophy of Blue Cross," Blue Cross Commission, Chicago, 1953.

Smith, Frank E., Director, Blue Shield Commission, "The Growth of Prepaid Medical Care Plans," Blue Shield Commission, Chicago, 1951.

Wilde, Alexander, Statistician, Hospital Service Corporation, "Hospital Service Corporation; History of Rates and Benefits," Chicago, 1953.