8

The National Focus

The Blue Cross Association, which became the national association of Blue Cross plans, had a modest beginning. Originally, a Blue Cross Plan Commission had been developed under the leadership of C. Rufus Rorem to set up guidelines and an approval system for Blue Cross plans. By the late 1940s, the commission was faced with problems of how to handle accounts for firms with employees in more than one Blue Cross territory. In an attempt to solve this problem, an agency, Health Service, Inc., was founded "to operate as a national enrollment office and as an underwriter to fill benefit gaps in national contracts and thus level out the peaks and valleys in benefits among plans."[1]

A corporation was needed to provide stock ownership in Health Service, Inc. A paper, nonprofit corporation was established for that purpose. This was called the Blue Cross Association (BCA) and was separate from the Blue Cross Commission and the AHA. The BCA soon addressed other problems besides those of national accounts: retirement plans for Blue Cross employees, a representation role, need for national advertising, and typical national trade association relations.

While the influence of BCA was growing, the effectiveness of the Blue Cross Commission was declining. By 1960, the Blue Cross Commission had disbanded; BCA became the national organization.

James (Jeb) Stuart,[2] who had acted as president of BCA during the changeover,

master's degree in hospital administration from the University of Minnesota. He went to BCA from the University of Michigan, where he had been the founding director of the Program and Bureau of Hospital Administration. While at Michigan, McNerney led a research staff in an impressive study of hospital and medical economics. This study came about at the request of the governor of Michigan, who wanted information on which the state could base Blue Cross rates.

Under McNerney, the Blue Cross Association grew from a loose-knit organization into one that spoke with authority and influence.

McNerney describes his coming to BCA as president in 1961.

MCNERNEY:[4]

My formal beginning with the Blue Cross Association was in 1961, when I was asked to become its president.

I was in Hawaii with some friends on a Ford Foundation grant. The phone rang. On the other end was Bill McNary, then president of the Michigan Blue Cross Plan. He said, "How would you like to be President of the Blue Cross Association?" I thought about it for about ten seconds. I said, "Yes."

It was interesting because Bill spent another two or three minutes convincing me that it would be a good idea. I said, "Bill, I said yes."

On reflection, either subconsciously or consciously, I still don't know which, I think that the leadership within the Blue Cross movement was preparing for the time that Jeb Stuart would retire as president of BCA and a replacement would need to be found.

Beginning about two years prior to McNary's phone call, I had been getting invitations to appear before Blue Cross plans and some Blue Cross national meetings. I would get up and talk big language and be full of mission, full of zeal. One day, I remember getting up to speak at the MidAtlantic Hospital Assembly. There, sitting in the front row, were van Steenwyck,[5] Rorem,[6] and Colman.[7] This was in advance of the telephone call to me in Hawaii by, say, six months. Why would Rorem, van Steenwyck, and Colman be sitting there? I thought it was strange. I was conceited enough by then to think I was such a good speaker that almost anybody would show up and enjoy it. Later, it occurred to me that they may have been tracking me.

Now maybe none of them would admit that's what they were doing.

Only Rufus Rorem is still alive. I have the feeling that, in an institutional

to Chicago at the age of 36 to assume the presidency of the Blue Cross Association. At that time, BCA's main office was in New York. One of my first decisions was to move the main office to Chicago.

I made the move to Chicago because the leading health and hospital institutions were in Chicago. A lot happens on an informal, everyday basis in most industries. My thought was, why not be part of these informal contacts by being in the same place? At the same time, a national association with members in every state is well located in Chicago for travel and other purposes.

There were some at this point who said we should move to Washington. I resisted it then, and I would still now.

What Washington needs are forces within the private sector that look at the country from a different point of view than that which one gradually assumes when they live in Washington. People who move to Washington, I have observed, become preoccupied with the congressional process, with what Senator X is going to do next. They almost unconsciously seem to mold their lives in reaction to government.

What government needs in the health field, I believe, is a force or forces that have decided what their mission is, where they want to go. These forces must then work with government, not reactively but proactively. So Washington was rejected.

It was interesting that when I got to BCA Jeb Stuart, to his everlasting credit, said, "There's your chair, I'll see you later." He didn't stay around to second-guess me even though I was obviously wet behind the ears. He just said goodbye and good luck.

Jeb did, however, give me some good advice. He told me that there were three people in the Blue Cross field that I should meet with, and meet with fast. He said, "They are tough to begin with and they are not sure where you are coming from. You had better get out to see J. Phio Nelson, Walter R. McBee, and Robert T. Evans." All three were chief executives of major Blue Cross plans: Nelson was in San Francisco, Oakland technically; McBee was in Texas; Evans in Illinois. Jeb told me, "Make your peace with these fellows."

That was it. That was my portfolio. Well, I got to see those three and a lot of others. Then I started the process of helping to move the Blue Cross Association from being essentially a trade association to what it had to become: that is, a combination of a trade association and an operating arm of the total Blue Cross system.

They were very conversant with Blue Cross and very loyal and dedicated to the idea and ideals of Blue Cross. However, they were a loose organization, held together by individual respect and familiarity with one another. Also, at that point, they were not well tuned to some of the things that were going to lie ahead. So, I had a job to do.

I began by working with that staff to think through how BCA could represent the plans with Washington or industry or labor when there was a national situation; convene meetings to discuss topics of common interest; work with the plans to strengthen them as operational and management entities; and further begin to debate, with a little more forcefulness at the national level, what Blue Cross should be doing and why. More specially, this meant some dialogues about whether Blue Cross simply traded money or whether part of its role was to intervene and help shape the delivery of care.

Through the late sixties and early seventies the Blue Cross Association got itself involved more deeply in plan administrative and operational issues. The means of doing this was the plan performance review program. Through the plan performance review program, we went out into all the Blue Cross plans in the country, on a periodic basis, to examine specific aspects of management and work with them to strengthen their total performance. Where a plan was reluctant to act, the BCA executive committee might talk to the board members of the plan. The plan performance review program provided a discipline. It also gave reality to a striving for excellence.

Other programs were also developed and pursued on a systemwide basis. Cost containment is one example.

I emphasized its importance in the sixties. Fresh out of Ann Arbor, I had a lot of ideas about how to improve the delivery system through the financing process. A fair number of those ideas ended up as polite policy statements, or worse, as exhortations.

In the seventies, however, cost-containment standards were developed which were made a condition of plan membership in BCA. It happened also in Blue Shield. Under the cost-containment program, certain cost-containment activities had to be implemented by the plans. These included utilization review capacity, developing relations with areawide planning, and so forth.

We have also been quite active in urging plans to get into alternative delivery systems, into HMOs. We developed a national network of HMOs.

We grew to a new and different type of maturity.

I want to hasten to add that the end result of all this was not to make Blue Cross

be. Importantly, it has at the same time, through the plans, strong local connections: politically, marketwise, laborwise, and communitywise. It is through this local base that Blue Cross is able to reflect the kaleidoscopic patterns of tradition, income groups, etc. around this country-in effect, to be an integral part of a community.

The question, therefore, becomes: To what degree do you centralize to strengthen the overall Blue Cross system without replacing valuable local capabilities? What emerged was a strategy to centralize or regionalize certain functions like data processing and actuarial work but leave intact provider, professional, and community relations, etc. It's a practical admixture of economies of scale and standards on the one hand and local nuance, political and market relations, and economic attachments on the other.

Nobody that I have discovered yet has a pat answer to the balance required. We are seeking our way in a competitive market, influenced greatly by what it takes to get and keep the business while at the same time do a good job. We are being controlled, in effect, as much by outside practical forces as we are by our own aspirations. If regionalization, a case in point, gets stronger, as it inevitably will, it will be because we will have to drive our retentions down, our administrative costs down, to stay in the market.

I don't mean to drain out of our history the desire to do a good job and to serve the community better. I do, however, want to underscore the fact that we are continually shaping and reshaping ourselves in a pluralistic, competitive market. Simultaneously, we are trying to achieve self-stated objectives. We are not yet institutionalized to the point where we are not plastic and experimenting.

National Association: Merger

Through the 1960s and 1970s the Blue Cross Association developed programs to represent plans as well as to assist them in their operations. The Blue Shield Association (previously, the National Association of Blue Shield Plans) was undertaking many of the same kinds of activities for its member medical plans. In some parts of the country Blue Cross and Blue Shield plans competed with each other; in other areas the two were a single corporate entity. At the national level, however, they were separate and autonomous, each with its own staff and board. In the late 1970s the two associations merged.

the national and local levels typically always worked closely together. This basic generalization, however, has to be qualified. In a few sections of the country Blue Cross and Blue Shield plans competed. In some sections of the country the two were allied but not well coordinated. In some sections of the country they were organized as one corporation.

This type of variation was sustainable when life was a little less complicated and markets were less competitive.

In the 1970s, however, the environment shifted. Consumers became more informed and had more opinions about how care should be rendered. Also, they were more critical of the performance of health benefit carriers.

Accounts [purchasers] got more articulate and experienced. The economy moved from a supply economy to a demand economy. The federal government was faced with health care cost problems and started to grapple with them. The number of competitors to Blue Cross and Blue Shield grew. You found a more businesslike environment, one which was much more demanding, much more critical, and much more highly penalizing of weakness.

Then not only did Blue Cross have to start to examine concepts of centralization and regionalization, to make better use of limited resources, but also it had to ask the question: What about the relations between Cross and Shield? Were there redundancies and overlaps that were hurting the total system of plans?

When a few of the plan presidents looked at the national associations, they found redundancies. Not only were there people in the Blue Cross Association and the National Association of Blue Shield Plans doing similar things, overlapping, but the national voices were not always synonymous. We weren't always saying the same things in Washington.

Initially some plan presidents got together informally to talk about combining the two associations. Rump meetings were held, I would be invited, and in those days Ned Parrish [president of the National Association of Blue Shield Plans] would also be invited.

I think it is fair to say that from the very beginning the Blue Cross Association thought that combining the two associations was a sound idea. There was a need to bring the two together. But the Blue Shield Association, as it is now called, with equal enthusiasm at first thought it should not be done.

There was a fear on the part of the Blue Shield Association that in any consolidation they might not come out equal. Some physicians feared that through such a consolidation the

to formal meetings then to the members discussing it openly. It involved the appointment of committees, the conduct of formal surveys, the formulation of formal recommendations, and finally a vote on -the issue.

During that time, I was encouraged to keep a low profile because I was potentially part of the problem. What would happen to Blue Shield if McNerney were to become the chief executive officer? If I were to have gotten too assertive at that point, it could have prejudiced the question. So, for a while I played a less visible role. I offered my opinion when asked, and I was asked.

Considering market forces, the need to have a more collectively organized posture toward the government, the outright need to save dues money by cutting out redundancies, and the fact that the public viewed the two associations as the same anyway, it was time that the two became the same. The evidence became overwhelming, and the consolidation was voted.

Following the merger, a chief executive officer had to be found to direct the new consolidated organization. After much speculation, McNerney was selected to be the first chief executive officer of the combined associations.

McNERNEY:[9]

Maybe I shouldn't be this personal, but it has been reported that, when the search committee asked a lot of people about the new position, they were told by both the hospital and the doctor representatives, as well as by various consumer and public representatives, that they should move in my direction. That sounds bumptious, and certainly opposition was expressed within and without the system, but I want to make the point that by then the American Medical Association had changed.

Several years earlier [the mid-1960s] I had been cited for malfeasance by the AMA house of delegates (it had to do with the development of HMOs). There were memories about that, but a lot of water had gone under the bridge since. When the chips fell, the AMA and

A Different Point of View

An interested observer of the development and progress of Blue Cross was Daniel Pettengill. Pettengill joined the Aetna Life and Casualty Company in 1937. His connection with Aetna's health insurance business began

in 1946, and he was a vice president of the company from 1964 to 1978. During the 1960s and 1970s, Pettengil was a major spokesman for the commercial insurance industry on health matters. His observations on the development of health insurance in the United States and the problems and progress of Blue Cross provide an interesting counterpoint to the comments in the previous chapters and to McNerney's views.

PETTENGILL:[10]

In 1937, which is the year that I first went to work for the Aetna, the Aetna wrote its first group hospital expense benefit policy for an employer. It provided a $3.00 daily room and board benefit and a $15.00 benefit as the maximum allowance for ancillary services. Interestingly enough, that was very adequate for the day.

My point is simply that it was a relatively easy matter in those early days to design a hospital benefit that was adequate and yet had a modest, finite dollar limit.

Shortly after I came, Aetna introduced the medical expense benefit which paid for physician office and home visits, as well as in-hospital visits. It's important to point out that this benefit was for the services of attending physicians in nonsurgical cases. Later, we also introduced coverage for diagnostic X-ray and laboratory examinations.

The primary competition, in terms of physician service benefits, were the Blue Shield plans. Blue Shield, however, did not expand its benefits beyond inpatient services for quite some time. As a result, because Blue Shield was better known and more familiar, many physicians did not realize that under many insurance company group policies the patient might have available benefits for home and office calls-and more importantly, diagnostic X-ray and laboratory examinations. Not surprisingly, physicians would admit Aetna-covered patients to the hospital, thinking they had to admit them in order to get the diagnostic examination paid for. They assumed that Aetna had the same coverage as Blue Shield, and they knew that they had to do that under their Blue Shield plan.

This was an unfortunate situation, and for many years we were unable to correct this false impression.

In terms of the development of health benefits, one of the most important innovations was created in 1948. In that year, the executives of the General Electric Corporation [sic] became concerned about the "high cost of health care," particularly with respect to serious

Club was a club to which the General Electric executives belonged. Actually, they took the coverage out as one of the fringe benefits of belonging to the club.

This experiment immediately created tremendous public interest. The typical health benefit policy in the late 1940s, while adequate for an acute, short-term episode, didn't really provide enough help if you got into a real serious or drawn-out medical problem. So there was real pressure on the insurance industry to move ahead with this kind of product. And we did.

Aetna and other major group underwriters went to work; we studied the limited experience that the General Electric executives had, and we came up with major medical coverage in the beginning of the 1950s. I think the Aetna wrote its first policy in 1951.

Major medical benefits became the most rapidly growing form of benefit coverage. This was simply because people who had basic hospital-surgical benefits wanted to add, to superimpose major medical on top of their basic program in order to reduce their potential risk.

The next question for insurers was, why do you have a set of basic hospital, surgical, medical, and diagnostic benefits and then superimpose a major medical benefit? It makes for a very complicated plan to describe to employees and an expensive one to administer with all the separate benefits to calculate and pay. In 1953 the United States Fidelity and Guaranty Company in Baltimore, Maryland, decided to purchase a single-benefit, comprehensive plan for their employees. All medical expenses incurred in a 'given year were to be combined, the employee was to pay a front-end deductible (I believe it was $50), and then the plan would pay 80 percent of the excess up to a $10,000 maximum lifetime. This comprehensive approach, though logical, is not as popular as first-dollar basic hospital-surgical benefits plus supplementary major medical.

The Blues at first were reluctant to write the supplementary major medical benefits. Their reluctance I believe was due to the fact that major medical didn't fit nicely into their respective areas of operation. The Blue Cross plans had their contractual arrangements with hospitals, and the Blue Shield plans had their arrangements with physicians. So the major medical concept of lumping together all medical expenses in a given period (usually a year), applying a deductible of, say, $100, and then paying 75 percent or 80 percent of the excess up to some specified maximum dollar amount just didn't fit conveniently into their method of

In addition to what might be called philosophical differences, there are business practice distinctions between commercial insurance companies and Blue Cross and Blue Shield plans. These differences shape the competitive position of each and influence their ultimate success in the marketplace.

PETTENGILL:[11]

The effect of some of these differences, as contrasted with the example of major medical, are in favor of the Blues. I think you can see this in the experience we all had with the Federal Employees' Health Benefits Program [FEP].

The FEP is also in and of itself an important event in the history of both the commercial insurers and the Blues.

In terms of business practices, it should be appreciated that, in general, insurance companies did not permit employee-pay-all plans, because they didn't get satisfactory participation and the experience was generally poor. The Blue Cross and Blue Shield plans, on the other hand, did. Also they were a bit more aggressive in this regard. They would usually make arrangements with one or more of the employer's employees to act as their agent and go around on payday and collect the employee contributions. As a result, I would estimate that, in the case of federal employees, about half of those employees had local Blue Cross and Blue Shield coverage on an employeepay-all basis at the time Congress was considering a uniform health insurance plan for federal employees. The Blues, of course, were pushing that their plan be the federal plan.

Henry S. Beers, who was then the vice president in charge of the Aetna group division and who subsequently became president of the company, felt very strongly that coverage of the federal employees by only the Blues would adversely affect insurance company business. So he went to work and lobbied Congress that the federal employees program ought to be either just an insurance company plan or a choice between a Blue plan and an insurance company plan. As I'm sure you can imagine, it was that choice situation which appealed to Congress, because no congressman wants to offend any constituent. By giving the employees the right to choose between a Blue plan and an insurance company plan, a congressman could say, I gave you a choice, I didn't pick for you.

Because Congress did decide that there was to be a choice between the Blues and the insurance companies, both types of insurers have survived. The Blues did gain an advantage

Thus, the Blues ended up with 54.4 percent of the enrollees, the commercial insurance companies with 26.7 percent, and employee unions with the remainder. I don't believe the numbers reflected a true preference for the Blues. Rather, I think they reflect the fact that the Blues had federal employees working as agents, something Aetna was not allowed to do.

Another point to keep in mind about the federal employees program is the fact that the various local Blue plans did not initially have a good record of continuing benefits for retired employees. This was due in part to the differences in benefits of the local Blue plans and the fact that many retirees moved to an area served by a different Blue Cross plan. This problem should not have been a factor for federal employees, because the high and low options of the Government-Wide Services Benefit Plan were to be uniform regardless of where an employee worked. But the fear remained. As a consequence, many federal employees, when they reached retirement, switched from the Blue plan to the indemnity plan which the Aetna administered.

While the total number of persons enrolled in the indemnity benefit plan remained relatively constant, this influx of the retirees from the Blues meant that there were fewer and fewer new active employees. This was a great disadvantage in the sense that the retiree has a higher claim cost than the active employee.

In a fundamental sense, I think the FEP saved the Blues, because it gave them the ability to offer a uniform plan nationwide for the first time–an ability the insurance companies had always had and had used effectively. Furthermore, it united them at a time when their prestige in the group health insurance field was slipping.

Pettengil then spoke of what a great boon it was for Blue Cross Association to become the fiscal intermediary for Medicare. Blue Cross was particularly well suited for the work because of its claims experience and mechanisms, and Medicare business became a major portion of the Blue Cross workload.

PETTENGILL:[12]

Medicare was an even greater savior, because it lowered the high expense rates of the smaller Blue plans. Remember, the Blues are an aggregation of a lot of local plans, frequently one per state, but, in some states, several per state. In 1965, many of these plans were

Walter McNerney achieved for the Blues a major success, for which they should be eternally grateful.

The Blue Cross-hospital relationship was also noted by Pettengill as a business practice that worked to the advantage of Blue Cross.

PETTENGILL:[13]

Probably the most important relationship between Blue Cross plans in particular and the hospitals is their payment arrangement. Traditionally, Blue Cross plans paid hospitals on either a cost basis or a discounted charge basis. In either event, Blue Cross paid a differential price which was less than the hospital's listed full charges-the price charged to commercial insurance company beneficiaries.

I know of situations where the hospital charge differential (the Blues' discount) had become so great that an employer could not afford to insure his group plan with an insurance company. From a purely economic perspective his only choice was to go with Blue Cross. In that kind of situation the hospital becomes trapped, for it has essentially nowhere to go to recover its deficits.

The ultimate answer to this kind of situation has to be reasonable equality of charges for all types of carriers. But equality doesn't exist today, although the insurance companies have tried their darndest to secure it.

The problem started way back in the Great Depression, when several hospitals asked insurance companies to write hospital expense insurance and we, properly, said it's not insurable. So the hospitals formed their own entities to write the coverage, and these eventually became the Blue Cross plans. Because, relatively speaking, both the benefits sold and the amounts of service provided by hospitals were modest, Blue Cross succeeded in those early days. Insurance companies, seeing the market, responded by writing health coverages in order to compete.

But neither type of carrier, Blue Cross nor insurance company, was insuring in the normal sense. They were and still are providing an annual budgeting mechanism. At the end of each year, the insurer reassesses and says, "Next year the budget's got to be bigger. So if you want the same benefits, Mr. Employer or Mr. Union, you have to pay more." Essentially, that's been the story ever since about 1961. We're kidding ourselves when we

the Pennsylvania Supreme Court say, yes, this is discrimination but the state may do so if it chooses. The state licenses the Blue Cross plan. If it chooses to discriminate, the state has the power to discriminate. So, it has been established that there is discrimination, but, unfortunately, there is not a thing insurance companies can do about it.

There was one other advantage that some Blue Cross plans had initially, but I think it's pretty well gone now. Michigan was a classic example. Namely, the hospitals actually reinsured the Blues. Thus, if, at the end of any year, Blue Cross had suffered a financial loss, the member hospitals had to pay a special assessment to bail out the plan. Such reinsurance, however, has pretty well disappeared.

But the fact that the hospital will sell service to the Blues at cost or less, then charge the public rates for those same services which are higher than costs has been the Blues' greatest advantage. For example, in the Federal Employees' Health Benefits Program, I estimated, and the Civil Service Commission never denied it, that Blue Cross enjoyed at least the equivalent of a 10 percent discount. It wasn't an actual discount per se, but the amounts that Blue Cross plans were paying the hospitals were at least 10 percent below the charges that commercial companies were having to pay under the indemnity benefit plan.

Medicare eased the discount problem initially. But the present situation, where a state merely holds down the rates that Medicaid, and in some cases Blue Cross, will pay but not what the hospitals can charge the rest of the people, has made it worse than ever.

Nevertheless, hospitals should set charges at amounts reasonably related to their costs. Those charges should then be the basis of payment for everybody, whether it is a Blue Cross plan under an agreement whereby it pays the hospital directly or whether it's an insurance company which, because it sells such modest benefits, the hospital wouldn't touch with a ten-foot pole. The point is that everybody should pay the same fair charge for a given service at a given hospital.

Has the competition between the Blue Cross plans and the commercial insurance companies been good for the country?

PETTENGILL:[14]

Ever since the 1944 Southeastern Underwriters decision [which prohibited collective

lunch in New York City and would discuss group insurance problems. Group insurance in those days was as nice a controlled commodity as you would hope to see. There was a lot of competition in the individual insurance business, but the group side was remarkably controlled.

Now, in one sense I don't think this control actually hurt the American people, because you've got to remember the insurance companies were competing against Blue Cross and Blue Shield, so there was competition. And many of the decisions the committee made dealt with how to compete with the Blues. Furthermore, in the early days of group health insurance, this competition was vital. Because if the nation had only had the Blues, it would not have had the development of new coverages anywhere near as rapidly as they actually occurred. The insurance companies were constantly trying to find ways to compete against the Blues' discount, their preferred tax status, etc.

* * *

Both the Blues and the insurance companies have lost a substantial portion of the group health care insurance market. It has been lost to selfinsurance. The loss has been the result partly because of the premium tax and partly because of claim reserves.

In virtually all states, if an employer self-insures his group plan, he is not subject to premium taxes. Let's face it, for a large employer, the premium tax was frequently 40 percent to 50 percent of the total administrative cost of the benefit. Forgetting the claims, say the insurer's actual expense rate was 3 percent and the premium tax was 2 percent, so a large employer would have to pay an insurance company a total of 5 percent over claims. Whereas, if the employer self-insured, he could save the 2 percent premium tax or 40 percent of the total expense. This assumes he could administer the plan as cheaply as the insurance company, which is questionable, but large employers often feel they can.

The other problem was the claim reserve, and this applied to both the Blues and insurance companies. An insurance company, and in most states the Blues as well, is obligated to set up a reserve for claims which have been incurred but haven't yet been paid. Such claims range all the way from the accident that just happened but which the insurer does not yet know a thing about, to the claim that has been reviewed and approved but the check has not yet been mailed to the claimant. The claim reserve is the actuary's best estimate of the aggregate of all these claims that are in process.

So large employers argue, if we self-insure, we won't have to pay premium taxes, which will save us anywhere from 2 percent to 3 percent, depending on the state, and we won't have to set up claim reserves.

Thus, employers started to self-insure. They found, however, that the job of claims administration was not simple. As a result, there was pressure on the insurance company to sell its claim administration services. In other words, the employer self-insured but then hired the insurance company to settle the claims. Most insurance companies refused to write such administrative services contracts for a long, long time.

Unfortunately, or fortunately, depending on which side of the fence you sit on, independent agencies started to say, "We'll be very happy to settle the claims for you." And then one insurance company after another weakened and agreed to sell their claim service. *

Self-insurance has had the same effect as far as the Blues are concerned. Indeed, I suspect an administrative service contract is more difficult for Blue Cross plans because they are used to paying costs to hospitals rather than charges.
I think that's the thing that is hurting the Blues.

* * *

I think the American Hospital Association finally came to realize that the long-term solution that's viable, from the hospital's point of view, is to set charges so that they are reasonably related to the cost of the service provided, but with a little margin. After all, you've got to set your charges today and your costs don't get incurred until tomorrow. It's humanly impossible to set your charges precisely equal to your costs. You've got to have a little margin in there for breakage.

The following observations by Robert Sigmond expand on McNerney's comments about performance discipline and striving for excellence.

SIGMOND:[15]

Maintaining performance levels is a very complicated process. Let me see if I can discuss it in terms of different levels. But, let me talk about Blue Cross.

First and most formally, the plans must conform to the approval standards which were originally developed by Rufus Rorem and have been amended from time to time. The plans

could lose the Blue Cross symbol by action of the board on recommendation of the approval committee. In practice that has not happened in over 20 years and it's not likely ever to happen again.

At least once every three or five years there's a full-fledged site visit [plan performance review visit]. This visit has to do with fiscal stability, with management, with relationships, with hospitals-the whole approval standards. It is very much like a joint Commission on Accreditation [of Hospitals] visit or an AAMC [Association of American Medical Colleges] visit for accreditation of a medical school. The visits always result in assessments, in which areas of performance weakness and strength are pointed out.

This is all done in a relatively confidential manner, with nothing said to the public, etc. But, of course, the reports of this activity go to the board of directors of the BCA, which is made up of plan executives. As a result, any plan executive who gets a critical letter tends to respond. If his response is inadequate, that fact will be reported to the board. There are different kinds of actions that are taken. Really, the most extreme action that I can think of that's been taken in the last few years was when, following a number of intermediate steps, the BCA executive committee requested the chief executive officer of a plan to arrange a meeting with his board. The meeting took place and had considerable effect. So that kind of thing goes on.

Action moves from an exchange of letters through to a delegation of plan executives that meet with the plan CEO, and so on. I don't want to mislead you: I cannot imagine a situation where BCA would actually take the symbol away any more, but that doesn't mean that it is a totally powerless process. It is a very powerful process.

Second, BCA is the prime contractor for Medicare. The plans subcontract with BCA. Nationally, as a group, the plans handle more Medicare money than subscriber money, especially in the smaller plans. If these plans didn't have Medicare, they'd be dead.

BCA has the power-obviously through the board structure-to say that this plan isn't measuring up and it's threatening the prime contract with Medicare, which means it's threatening the stability of every Blue Cross plan. So, Blue Cross might have to take Medicare away from the Oklahoma plan and give the work to the Texas plan. That sort of thing has been done.

Point three is national accounts. A national account is an employer who has employees in various plan areas but whose health benefits are uniform and centrally administered through common policies.

viously is the control plan for all the Detroit auto companies, and the Pittsburgh plan for the steel companies. The Allentown Plan-Allentown, Pennsylvania-probably wouldn't exist if Bethlehem Steel went to commercial health insurance. It's there because Bethlehem Steel wanted to have its own Blue Cross plan.

Now again, the national association has the power, by the agreement of the plans, that, if a national account control plan is doing an unsatisfactory job, after going through an appropriate process, to take its role as head of the syndicate away. To say, for example, "Sorry Michigan, the Illinois plan is going to handle General Motors."

Well, aside from the financial implications of that, there would be a lot of embarrassment. The national association doesn't do something like this very often, but it has been done.

Finally, when a plan gets into real trouble, it doesn't get into trouble with the national association, it gets into real trouble with the state insurance commissioner.

One of the things Rufus did early on was sponsor model legislationenabling acts for establishing local Blue Cross plans. The enabling acts almost all provide for the insurance commissioner to supervise the plan.

Now, we get calls in Chicago. There have been two of them since I've been there in five years, two that I know about. An insurance commissioner calls McNerney, "I'm in trouble." He doesn't say to McNemey, "You're in trouble," he says, "I'm in trouble."
McNerney says, "What are you in trouble about?"

"I'm going to have to declare plan X bankrupt. I can't afford to do that politically. You've got to help me."

I'm fantasizing that conversation, but in effect an insurance commissioner with a problem Blue Cross plan has got a problem on his hands. He doesn't have that many people to turn to, and BCA is there. He invites in the national association-and BCA has every reason to call the plan and say, "Hey, we'd better come in."
They usually say yes.

In the two situations I know about, the national association representatives sat down with the plan's board and urged that they get new management. The insurance commissioner is usually scared to death and accepts that course of action. BCA doesn't take over the

Notes

(Transcripts of the oral histories cited here are housed in the library of the American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 60611. The Oral History Collection is a joint project of the Hospital Research and Educational Trust and the AHA.)

1. Odin W. Anderson, *Blue Cross Since 1929* (Cambridge, Mass.: Ballinger, 1975), pp. 59-60.

2. Stuart was interim president of the Blue Cross Association from 1959 to 1961. Formerly he had directed the Cincinnati Blue Cross Plan.

3. See Profiles of Participants, in the center of this book, for biographical information.

4. Walter]. *McNerney, In the First Person: An Oral History.*

5. E. A. van Steenwyk was chief executive officer of the Philadelphia Blue Cross Plan.

6. C. Rufus Rorem. See Profiles of Participants for biographical information.

7. J. Douglas Colman was chief executive officer of the New York City Blue Cross Plan.

8. *McNerney, Oral History.*

9. Ibid.

10. *Daniel Pettengill, In the First Person: An Oral History.* See Profiles of Participants for biographical information.

11. Ibid.

12. Ibid.

13. Ibid.

14. Ibid.

15. *Robert M. Sigmond, In the First Person: An Oral History.* See Profiles of Participants for biographical information.