the Blue Cross story
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The name Blue Cross has reached a goal that is the dream of every service or product: It has become a household word. It is difficult to find anyone who doesn't have at least a general idea of what you mean if you say, "I have Blue Cross."

But in spite of all the general impressions about it, relatively few people know the details of what Blue Cross is; where it came from; and especially what it does.

That's why this booklet was prepared—to tell the Blue Cross story. Not only the story of its well-known protection for individuals against the cost of health care, but also its widespread and growing activities to broaden the availability, increase the quality and control the cost of health care—for the benefit of the nation as a whole.

Let's start with an overall look at the Blue Cross system. Then we'll go back to the beginning and trace its development.

Blue Cross now serves close to 100 million persons. It pays more than five billion dollars a year for hospital and other health care benefits for its own subscribers. It serves as the fiscal agent through which federal and state governments pay nearly six billion dollars a year for services to Medicare and Medicaid beneficiaries.

In addition, in all parts of the country, Blue Cross Plans are taking the initiative in organizing health care services and facilities more efficiently; finding ways to control or reduce health care costs; and establishing programs to bring health services to the poor.

The Blue Cross organization is large and complex, with 74 separate nonprofit Blue Cross corporations (known as Plans) in the United States and one in Puerto Rico. There are also four Plans in Canada and one in Jamaica.

All of the Plans are members of the Blue Cross Association in Chicago, Illinois, that makes national policy, sets standards and contracts for nationwide programs such as Medicare.

The Blue Cross Association also acts as spokesman or agent for Blue Cross Plans in matters of national or regional concern, such as governmental relations, public relations, research, relationships with other national organizations (in and out of the health care field) and the collection and interpretation of statistical data.

The Blue Cross system has nearly 50,000 employees, whose activities are directed by approximately 2,000 public-spirited persons who serve on Blue Cross Plan boards of directors.

Blue Cross contracts with member hospitals to provide health care services to the millions of people who have Blue Cross protection. Hospitals in the United States admit nearly 100,000 patients every day. When they are discharged, an average of eight days later, their bills for diagnosis and treatment typically run several hundred dollars. If not covered by some kind of protection program, that amount would be a hardship for most families and a disaster for some. In certain cases the hospital would never be paid, causing an adverse impact on the whole community, since hospitals—like all other necessary service institutions—must be supported if they are to remain available to the people of the community.

Fortunately, three out of four Americans are protected by Blue Cross or one of the many other hospitalization plans that have emerged in recent years—most of them as a response to the popularity and growth of Blue Cross.
the beginning

During the 1920s, hospitals in several states offered their communities a new method of paying for hospital care in advance of need. The best known of the plans, at the Baylor University Hospital in Dallas, Texas, attracted the attention of communities throughout the nation.

In 1929, Justin Ford Kimball, PhD, vice president of Baylor University, conceived a plan for a group of school teachers. Each one would pay a small amount every month to the university hospital, and it would provide them with hospital services at no additional cost when the need arose.

The plan was an instant success. The teachers told their friends about it, and others were soon clamoring for membership. Other groups were formed, each having an agreement with a single hospital.

The idea was especially appealing as the nation plunged into the greatest Depression it had ever known, making it difficult enough for millions of persons to meet their day-to-day living expenses, much less the price of illness or accident.

It was quickly apparent, however, that single-hospital, single-group programs such as Baylor's had limited usefulness. Complications arose as members of one paying group needed care and wanted to get it at another hospital.

An improvement in the idea came in 1932 when hospitals in Sacramento, California, joined together to organize a similar but community-wide prepayment plan. (Blue Cross is called a "prepayment plan" because the monthly subscription charge, in effect, pays in advance—"pre-pays"—for services to be provided when they are needed. However, the health care services provided are not limited by the amount the individual has "pre-paid" with his monthly subscription charges.)

The Sacramento hospitals agreed jointly to provide services for members of several subscribing groups, all organized at member's places of work.

At about the same time, the Hospital Council of Essex County at Newark, New Jersey, started a community-wide prepayment program, supported by all 18 hospitals in the county. Within the next two years, hospitalization plans were organized in Minnesota, North Carolina, New York, Louisiana and elsewhere, most often with the help and guidance of educator C. Rufus Rorem, PhD, supported by a grant from the Julius Rosenwald Foundation.

Sponsorship of the new organizations was varied. In some communities the council of social agencies was the sponsor; in others, it was local business groups, the community fund or the hospital council. But almost everywhere, enthusiastic community leaders gave their support to the new way for people to assure hospital care when it was needed.

In St. Paul, Minnesota, a schoolteacher named E. A. van Steenwyk became the first executive of the Hospital Service Association of Minnesota, incorporated in 1933. By that time, the group hospitalization idea had gained recognition among hospitals, but was still looking for clear public identity so it could grow even faster.

Mr. van Steenwyk began using a blue cross on his stationery, information folders and posters as an identification symbol. Naturally enough, people in St. Paul began calling the Hospital Service Association the "Blue Cross" plan. The name caught on as other newly formed plans adopted the symbol.

The rate of growth in the early years shows how eagerly people gripped by Depression welcomed the new kind of help. At the end of the first year, 1,500 members had joined the pioneering program in Dallas. A decade later—in 1939—there were more than three million members of Plans all over the United States.

Since that time, the words "Blue Cross" have come to be accepted by the public, by hospitals and by health professionals as assurance of high standards of service.
Blue Cross has several distinguishing characteristics.

For one thing, it is not only involved in protecting people against the cost of health care; it is deeply involved in activities to reduce the cost and improve the quality and availability of care for everyone. Some of those activities are described in this booklet.

For another, Blue Cross traditionally provides “service benefits” for its subscribers rather than fixed dollar benefits (usually called “indemnity” benefits).

To the average person, Blue Cross coverage may appear to be like insurance. But it is different in the important area of benefits. That difference is probably the main reason why Blue Cross has become such an important protection to so many people.

Like insurance, Blue Cross is based on probabilities—the predictability of hospitalized illness and injury among large numbers of people. While no one knows when a member of any one family will need hospital care, statistics can predict with near certainty how many hospital cases will occur in a group of a thousand families.

The amount paid—the “prepayment”—by all of the subscribers in a Blue Cross Plan covers the bills of the ones who need care. Many Blue Cross subscribers, by the way, now get care outside of a hospital, but hospitalization was the beginning of Blue Cross and remains its most financially important coverage.

However, if Blue Cross were nothing more than a system of collecting from many to pay for a few, its coverage would be the same as that provided by insurance companies, benevolent societies and similar enterprises that operate on the principle of predictability.

Blue Cross’ difference lies in its relationship with hospitals that serve Blue Cross subscribers, permitting subscribers to receive the care they need when they need it.

Insurance companies usually collect dollars from participants and pay back dollars when a specified loss is incurred. Blue Cross collects dollars from its subscribers and “pays back” services.

For example, Blue Cross tradi-
tionally doesn't pay you so many dollars a day toward your hospital room; it provides a semiprivate room. It typically doesn't offer a certain number of dollars for nursing service; it provides nursing service.

The cost of the services provided to Blue Cross subscribers by the hospital is then paid for under separate contracts between Blue Cross and its member hospitals.

While Blue Cross programs have varying rates and benefits, the basic principle of coverage for service in a semiprivate hospital room is characteristic. And eight out of 10 Blue Cross subscribers who are hospitalized find that 90 per cent or more of their hospital costs have been paid.

Another aspect of Blue Cross coverage is that most of it is provided on a group basis. For many years, nearly all Blue Cross groups were organized at places of employment. That is still the prevailing practice, although many large groups have been organized under other sponsorship. Many employers contribute part or all of the cost of coverage for their employees and their families.

Most Blue Cross subscribers — more than 62 million of them — do have group coverage. However, Blue Cross popularity is such that 12,000,000 persons who are not members of any group subscribe individually. Included in that figure are 4,000,000 people 65 or older who have subscribed for Blue Cross protection to supplement their Medicare coverage.

An advantage of predominantly group coverage is economy of administration. If all of Blue Cross' millions of subscribers had individual programs, and had to be billed individually, clerical details would be more costly and prepayment rates would be forced higher.

Instead, for groups, the Plans collect a single payment each month or quarter from the employer who, in turn, may deduct some part of the payment from employees' paychecks. A similar advantage applies to enrolling new members which, like collection, can be done more economically in large groups.

Those and other savings are obvious in the efficiency of Blue Cross. For the nation as a whole, less than six cents of every dollar paid into Blue Cross goes for administration. Nearly 95 cents of every dollar paid by subscribers is available to pay for health care benefits.

In contrast, insurance companies use an average 21 per cent of premium income for operating expenses, leaving less than 80 cents to reimburse policyholders for hospital expenses.

Finally, there are other advantages to Blue Cross coverage. Because its objective is to meet need, Blue Cross does not drop subscribers if they leave the groups through which they were enrolled. The subscriber who leaves his job can continue his protection for himself and his family on a nongroup basis.

Subscribers who move from one state to another can transfer their coverage from one Plan to another.
Blue Cross not only serves the public, but is governed to a large extent by the public. All Blue Cross Plans are operated on a voluntary, not-for-profit, community-service basis, most pursuant to special enabling legislation which regulates their activities.

Furthermore, they comply with standards that require their governing boards to include representatives of the general public as well as representatives of participating hospitals. Plans across the nation are taking steps to increase public representation on their boards. In March, 1971, the Board of Governors of the Blue Cross Association declared that the majority of members of Plan governing boards should be persons who do not derive income from providing or administering health services. That cannot be done in every case, since some Plans are required by state law to have board majorities of health professionals.

By mid-1972, 31 Plans (representing 53 per cent of total Blue Cross enrollment) will have consumer majorities on their boards, upon full implementation of bylaw revisions. If you also count as public members those persons serving on hospital boards as lay trustees who are not health professionals, then 47 Plans (with 68 per cent of total Blue Cross enrollment) will have majority consumer representation.

It is the community representatives on Plan boards—civic-minded leaders of business, industry, labor, the professions and consumer groups—who have seen to it that benefits were expanded consistently as consumers' needs grew and new services developed.

An outstanding example is the growth in coverage for ambulatory and outpatient care. The year 1969 was the first in which the rate for outpatient visits (128 per 1,000 Blue Cross subscribers) exceeded the rate for inpatient admissions (124 per 1,000).

In 1970, Blue Cross subscribers utilized their benefits for hospital admissions at a rate of 128 per 1,000, while the rate for outpatient visits was 147 per 1,000. Between 1965 and 1970 the hospital admission rate for Blue Cross subscribers actually decreased by 14 per cent. The use of outpatient benefits went up by 73 per cent in that same number of years.
Back in the ‘30s, while Blue Cross was expanding, another concept was putting down roots in American industry. It was the concept of industrywide labor organization, as opposed to craft unions that had set the pattern of the American labor movement up to that time. Beginning in the mining industry, industrywide organization of workers was spreading to the automobile, steel, rubber, electrical and other industries.

Passage of the first Social Security Act in 1935 turned the attention of employers, labor leaders and the public to such nonwage benefits as pensions and insurance. Health insurance had been discussed, but was omitted from Social Security. However, employers noted employee interest in voluntary group hospitalization programs.

Many companies made them available through payroll deduction. And very soon union leaders and management saw them as potential benefits to be considered at the bargaining table.

In 1940, a historic contract—the first of its kind—was signed between the United Automobile Workers and the Ford Motor Company. It included payroll deduction for Blue Cross and Blue Shield as a benefit for employees. Chrysler and General Motors followed the next year.

As industry expanded in the late ’30s and early ’40s to meet the demands of national defense and war, health insurance gained acceptance as a benefit of industrial employment. It continued to grow in the years following the war, with employers paying an increasing share of the cost.

However, nationwide contracts providing health care benefits ran into geographical problems. Blue Cross Plans are individual corporations with separate jurisdictions—some statewide, others not. Each Plan has its own programs and its own schedule of rates and benefits. That was—and is—best to meet the needs of each Plan’s own area. But it created problems for a company with employees...

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in many different cities and states.

To give his employees the obvious advantages of Blue Cross service benefits, the employer had to deal with many different Plans. Furthermore, the cost and benefits would vary from one location to another.

To help offset those problems, the Blue Cross Association developed the capability of arranging national contracts. It consults with employers to find out what type of coverage is suited to employees' needs in all locations, and then arranges for contracts with Blue Cross Plans in all of the areas served.

The success of that program can be seen in the fact that seven of the 10 largest corporate employers in the United States now provide Blue Cross benefits for employees and their families. In order of their number of employees, those companies are American Telephone and Telegraph, General Motors, Ford Motor, International Business Machines, Chrysler, Western Electric and U.S. Steel. For most of them, Blue Cross covers 95 to 100 per cent of their employees.

Its nationwide capability has also enabled Blue Cross to provide health care protection to federal employees (under the Federal Employees Health Benefits Program, or FEP), the world's biggest voluntary health coverage group.

Originated in 1960, FEP makes available four different kinds of plans to government workers, one of which — the Service Benefit plan — is offered by Blue Cross and Blue Shield.

Of the federal employees who enrolled when FEP began, 54 per cent (2,800,000 employees and their dependents) chose Blue Cross and Blue Shield protection. In 1971, 61 per cent of a much larger enrollment was protected by Blue Cross and Blue Shield — representing 5,100,000 federal employees and their families. For 1971, Blue Cross Plans paid an estimated $755,000,000 in benefits to federal employees under FEP.
government health programs

As big as that program is, however, it is not the largest single enterprise served by Blue Cross Plans through the Blue Cross Association.

What is? A total of 23,000,000 beneficiaries of Medicare and Medicaid.

Title 18 of the Social Security Amendments of 1965 established Medicare, the health program for persons 65 and older, financed through the Social Security Administration. Medicare went into effect July 1, 1966, and on June 16, 1966, representatives of the Department of Health, Education and Welfare and the Blue Cross Association signed a contract designating the Association as "administrative intermediary" between the government and almost all of the nation's voluntary hospitals. The contract called upon Blue Cross to perform a wide range of functions in communication, claims processing, utilization review, audit and other financial activities necessary for operation of the portion of Medicare providing institutional benefits—principally by hospitals, extended care facilities such as qualified nursing homes and home health agencies.

Under the contract, the Blue Cross Association supervises operations of a data processing center and nationwide telecommunications network. It coordinates the fiscal policies and procedures of the Plans and some 6,000 participating hospitals. It provides technical assistance to the Plans as well as to the Social Security Administration. And it helps to formulate and interpret Medicare policies, regulations and instructions.

Title 19 of the 1965 amendments provided for Medicaid, the state-initiated, state and federally financed program of medical assistance for the poor and near-poor. As states initiated Medicaid programs, beginning January 1, 1967, many of them contracted with Blue Cross Plans to validate eligibility, administer claims, maintain records and perform other administrative functions.

In addition, through the Blue Cross Association as prime contractor with the U.S. Department of Defense, Blue Cross Plans serve more than a million dependents and retirees of the armed forces through CHAMPUS—Civilian Health and Medical Program of the Uniformed Services. In 1971, Blue Cross Plans paid $120,000,000 in benefits to people covered by CHAMPUS.
the communications network

A major factor in Blue Cross' ability to handle national programs for employers, as well as fulfill its responsibilities for Medicare, Medicaid and other government programs, is the computer-based telecommunications center located in the Chicago headquarters of the Blue Cross Association.

One special service it makes possible for Blue Cross subscribers is the "Inter-Plan Service Benefits Bank." Because of the Bank, a Blue Cross cardholder can be admitted to any of the 6,500 Blue Cross member hospitals in the United States and receive health care benefits. If the hospital is outside of the area of the Blue Cross Plan to which the subscriber belongs, the Bank arranges with the Plan in the area where he is hospitalized to provide benefits. The local Plan pays the hospital. Then, through the Inter-Plan Bank, the local Plan is repaid by the hospitalized subscriber's home Plan.

Blue Cross pioneered in the use of computers in the health field. And by the time Medicare came along, Blue Cross was ready to take on the monumental task of handling data covering the hospital claims and records of some 20,000,000 beneficiaries of the federal program.

The telecommunications network links Blue Cross Plans with the Social Security Administration's computer headquarters at Baltimore where Medicare records are kept. In 1968 Blue Cross developed a "tape to tape" system to speed claims and reduce or eliminate errors in record keeping. Under the system, Medicare claim payments are recorded on magnetic tape, which is sent to the Baltimore center and fed directly into the Social Security computer, automatically updating Medicare patient records in the master file.

The system has reduced the number of days required to process Medicare hospital claims from 18 to two, and saves more than a million dollars a year in processing costs.

Blue Cross computers also aid member hospitals and their patients. Many Plans offer data processing services to member hospitals and extended care facilities to make billing, accounting, payroll and other business operations more economical. In one state, hospitals use Blue Cross and Blue Shield computers in cooperation with an "eye bank" for instant identification of donors for corneal transplants. In another, a Blue Cross computer keeps track of a statewide inventory of blood for participating hospitals.
hospital costs and efficiency

Over the years, Blue Cross subscription rates have gone up. And people paying for Blue Cross protection often wonder why.

They know that when a member of the family was hospitalized 10 years ago, Blue Cross covered nearly everything. And when another member was in the hospital this year, the same thing happened. It seems to them they are getting the same thing they got 10 years ago, but are paying a lot more for it.

What they need to realize is that hospital costs have risen rapidly and are continuing to go up. As they increase, Blue Cross obviously has to pay more for every day of service for its subscribers.

Premiums for commercial health insurance might not have gone up at all. The reason is that the insurance company usually pays benefits in fixed dollar amounts, not hospital services. As hospital charges go up the insurance dollar benefit is worth less toward paying the bill.

In the mid-60s, an average day of semiprivate hospital care cost $55. An insurance policy that paid $40 a day left the patient $15 a day to pay himself. Today the policyholder might be paying the same premium and getting the same $40 a day, but hospital care now costs an average of more than $80 a day. Out of his own pocket, he now has to pay a much larger difference.

By contrast, most Blue Cross coverage still provides the benefit of a day's care in a semiprivate room.

Then and now, the average Blue Cross subscriber's basic services are provided. He pays more for his Blue Cross protection, yes; but its value has risen dramatically.
Why have hospital costs gone up so fast and so far? Part of the answer is inflation that has affected the whole economy. Like families, hospitals have to pay more for everything. Their food, fuel, building materials, furnishings, medical equipment and supplies have been rising in price just like the individual citizen's expenses. Some authorities say inflation accounts for half or more of the rise in hospital costs in recent years.

What about the other half? Two main things account for it. One is that salaries and wages paid to hospital workers (nurses, orderlies, aids, janitors, cooks, maids and everyone else) account for 63 percent of the average hospital's budget. And those wages and salaries have gone up faster than in other industries.

Today, hospitals must compete vigorously with all other industry for people at all levels of skill.

And since 1967 hospitals have been required to pay the federal minimum wage.

The other principal factor in rising hospital costs has been the extraordinary advances in medical science and technology. Walk down a hospital corridor anywhere, and you will be amazed by the complexity of equipment and instrumentation. The equipment is necessary to give care that couldn't even be given just a few years ago. And the equipment must be operated by highly skilled people.

In much of industry, technological advances increase productivity while reducing the work force. Not so in a hospital. Technological advances mean installing new equipment, plus hiring new people to operate it.

Not long ago, a hospital needed 400 to 500 square feet of space per patient bed to house all of the services, supplies and people required to give what was then good care. Today the minimum is 800 square feet per bed, and runs to 1,100 or 1,200 in hospitals with research and teaching functions — still just to house the people and equipment needed to do what a hospital is expected to do.

Another measurement is today's standard of 2.7 employees — not counting doctors — for each hospital patient. A few years ago the standard was 1.5.

The complexity of technology may vary with the size and location of the hospital and the community. A small hospital in a rural community doesn't have the degree of automation and level of instrumentation found in the metropolitan medical center.

But the difference is not as great as it used to be. For example, outlying hospitals may be linked to medical centers by communications networks over which laboratory, radiologic and other data are transmitted for interpretation and guidance. A small hospital and its patients must carry part of the cost of that network, but patients are the beneficiaries.

Moreover, small hospitals are upgrading their facilities. Some of them today have intensive care units, with special equipment and services for critically ill patients. Until recently, only the largest and most advanced hospitals had them.

Some recent bills paid by Blue Cross Plans show how expensive good medical care can be. A basic Blue Cross program paid $42,495 of $43,724 charged a patient suffering from both a heart condition and emphysema. Blue Cross paid $25,000 for the kidney transplant of a 13-year-old girl in New England, and $110,000 for treatment of a man on the west coast afflicted with a urinary and kidney disease.
controlling costs

The Social Security Administration estimates that total expenditures for medical care will nearly double by 1975, compared with 1968, rising to 111 billion dollars. By 1980, the SSA estimates that expenditures will reach 156 billion dollars. According to those projections, expenditures for care in the hospital will increase more rapidly than any other element of overall health care. While 36 per cent of all medical expenditures went for hospital care in 1968, the share of hospital expenditures is expected to be nearly 50 per cent by 1980.

Fortunately, the Blue Cross system is already deeply concerned with the rising costs of health care. That concern is being translated into action in a wide variety of ways.

The activity is not new. Blue Cross has always sought to control and reduce hospital costs, mainly by establishing uniform accounting and cost-finding and cost-control methods for hospitals. In addition, Blue Cross has helped many local and regional hospital councils establish uniform principles of pricing, and has encouraged and stimulated joint purchasing and shared use of services by hospitals.

In recent years, however, Blue Cross activities to control hospital costs have greatly broadened.

An example that goes back to 1963 is the Commission on Administrative Services for Hospitals (CASH), formed by the Los Angeles Blue Cross Plan and the Hospital Council of Southern California.

With 189 subscribing hospitals, representing approximately 40 per cent of the short-term general hospitals and 60 per cent of the hospital beds in the state, CASH...
works with hospital management to lower hospital costs by improving the utilization of their resources through the application of modern management techniques.

As CASH stated in its annual report for fiscal 1971, "The benefits of scientific management to improve personnel utilization and to provide quality controls are now recognized in most subscribing hospitals. In addition, CASH has been called upon to provide counsel and at times to actively participate in matters of concern to the hospital industry of California."

In the area of paying hospitals or other providers of health care, the recently developed idea of "prospective reimbursement" shows promise. Prospective reimbursement is a method of reviewing and negotiating the level of expenditures before they are made. It puts the hospital or other health care providers at risk to a greater extent than other methods. The risk factor is obvious: if the provider's costs go above the budget agreed on in advance, it has to absorb the loss itself. If its costs can be kept below the agreed level, it keeps part of the difference, sharing the total savings with Blue Cross.

Blue Cross also has taken an active part in encouraging and helping utilization review committees and medical societies to develop and use review techniques that are concerned with the assessment of both the quality and the cost of the care any given patient receives.

One way Blue Cross helps is to provide data to utilization review committees so that comparative studies can be made. Data "profiles" allow similar sized hospitals in a given community or area to be compared as to the average length of patient stay and other variables which significantly influence costs. Profiles of physicians' activities can indicate how their handling of selected diagnoses compares with norms and standards. Wide deviations from usual patterns by individual physicians can be investigated.

Utilization review is carried out not only under Medicare, but in the private Blue Cross business as well. About 70 Blue Cross Plans have the utilization review data of individual hospitals on file. And more and more frequently, the presence of an active utilization review committee is becoming a Blue Cross requirement for participating hospitals.
Money can be saved and better use can be made of health resources by planning health facilities and care on an area or regional basis.

Areawide planning discourages building more hospitals in a community than it needs. In cities where overbuilding has happened, beds stay empty and the cost of the ones in use goes up. Hospitals hire personnel and install equipment to care for the number of patients made possible by the number of beds. Consequently, it costs two-thirds as much to maintain an empty bed, in effect, as it does a full one.

Areawide planning can avoid the duplication and higher cost that result when several hospitals in the same area provide such complex and expensive services as open-heart surgery and kidney dialysis, where one or two might handle the entire load.

In addition, areawide planning might assign services so that one of two hospitals would handle all obstetrics, another pediatrics, another rehabilitation care, and so on.

The advantages of areawide planning are so clearly recognized that a federal law was passed in 1966 to encourage formation of planning agencies. Amendments to Medicare, Medicaid and other federal health programs have been proposed that would require the facilities and services of participating hospitals to conform to recommendations of planning authorities.

The Blue Cross Association and its Member Plans have been active supporters of community health planning since the beginning of the movement. In 1971, 69 Plans were involved in areawide planning. Several Plans require their member hospitals to prove the need for expansion of facilities, and most other Plans are working toward requiring conformity with planning recommendations.

Blue Cross participation in planning is varied. Some Plans have provided a percentage of the planning budget. Others furnish such services as electronic data processing, statistical information, manpower and shared office space.

In most cases, Blue Cross has representatives on planning boards at either the state or regional level.
Looking for ways to control the cost of services is not enough. Another big part of the answer is to find new, less expensive ways of providing the services.

Nearly all Blue Cross Plans now offer benefits not only for patients who are hospitalized, but also for those who can be cared for at lower cost in hospital outpatient departments. Expansion of outpatient benefits has been so great, in fact, that since 1969 the rate of claims for outpatient benefits for Blue Cross subscribers has exceeded the rate of their admissions for inpatient benefits.

An important innovation has been the addition of "preadmission testing" to benefits offered by Blue Cross Plans. Under this benefit, many Plans pay for tests given to persons before they are admitted to the hospital, saving the cost of "room and board" for one or more days of testing after admission.

Outpatient diagnostic coverage also helps avoid unnecessary hospitalization, where tests show that no inpatient care is required.

In addition to preadmission testing and outpatient diagnostic services, other patient benefits now offered by a number of Blue Cross Plans include drugs that are prescribed outside of the hospital, ambulance service, rehabilitation services, care in extended care facilities or nursing homes and, in some cases, care that is provided in the patient's own home after hospitalization.
In further efforts to control costs and provide new kinds of care, Blue Cross for years has helped to develop—or has cooperated in supporting—prepaid group practices, offering their care as an alternative to traditional fee-for-service patterns of medical and health care.

Generally speaking, fee-for-service means that the patient pays a charged amount for each visit to his doctor, and for each service the doctor provides.

Under prepaid group practice—again speaking generally, since there are many forms—the patient enrolls with the group practice program, pays a set amount each month (as a prepayment) and receives whatever covered care he needs whenever the need arises.

Ordinarily a prepaid group practice accepts responsibility for organizing and providing health services to a certain group of people who enroll; it accepts prepayment by its enrollees; it has physicians in various specialties available to provide a broad range of medical services; and it offers comprehensive benefits, usually including hospitalization and complete physician services as well as diagnostic laboratory and x-ray services.

In the fall of 1971, seven Blue Cross Plans had operational prepaid group practice programs. Four others covered hospital care for group practice programs. And 15 more were in the planning and developmental stage of group practice.

Among other health problems facing the nation, there is a need to strengthen and reorganize the health care system to make services more readily accessible to the poor. That need is clearly recognized by Blue Cross.

In many cases—particularly in connection with the establishment of group practice programs—Blue Cross Plans have been involved in experimental programs to improve health care of the poor. Some programs have been undertaken in cooperation with the Model Cities program; others are involved with neighborhood health centers supported by the Office of Economic Opportunity; and still others are part of federally funded health projects for migrant workers.
Most health authorities agree that medical care in America reaches peaks of superb achievement in caring for the acutely ill and seriously injured, where most of the money, manpower and facilities are concentrated. But the nation lags behind in its attention to preventive medicine—finding means of keeping people well, or detecting problems early so they never develop into serious ones.

If more money and manpower were devoted to preventive measures and early detection, perhaps less would be needed to care for those who become seriously ill.

Blue Cross Plans are in the forefront of the movement to emphasize preventive measures through public education. Nearly all Plans devote public relations and advertising activities to public education in health. Activities cover a broad range of subjects—rubella vaccination, especially for women in the child-bearing years; “pap” tests to detect early signs of cervical cancer; a campaign to inform young people about the dangers—and available help—related to venereal disease. And many others.

In newspaper and magazine advertising, radio and television broadcasts, slide films, booklets and in public and professional meetings, Blue Cross Plans work to make people more aware of health problems and encourage them to seek competent medical advice early and regularly to avoid the complications that can follow when health is neglected.

Savings to individuals in hospital and doctors’ bills—and savings in hospital bed use and doctors’ time—can result from health education. But they are not its chief goal.

The main purpose is to relieve hardship, prevent suffering and—above all—improve the quality of life for millions of men, women and children who can have a longer, happier and healthier life because of education in good health.

That is the goal of the major health education program of the Blue Cross Association—its publication, “Blue Print for Health,” which is distributed to more than a million persons every year.

“Blue Print” is devoted to teaching people how to avoid health problems; how to lead healthier, more satisfying lives; and how to use health services more effectively.

Recent issues have covered the subjects of infant health, mental illness and the common physical and psychological problems of adolescence and middle age.
looking ahead

When Blue Cross began in 1929, the nation’s concern about health services was simply how to pay for them. In that economically depressed time it was a major worry, and Blue Cross was born because it could fill a need.

Today the nation’s concern is not just payment for health care, but making all health services better and more readily available to the whole population.

As medical science and technology become more complex and, inevitably, more expensive, Blue Cross continues its dedication to helping more people get the care they need—in new ways and in better ways.

Blue Cross spokesmen have testified before Congress on the need for increased government spending on research and development in health care delivery.

They have testified on ways to increase the effectiveness of the large number of federal programs now under way in the health care field.

They have called for specific, clearly enunciated national health goals, embodied in a national health policy which will guide both governmental and voluntary efforts to improve health, and thereby improve the quality of life for all Americans.

At the same time, the Blue Cross Association and the Blue Cross Plans have undertaken activities described in this booklet, proving that private, voluntary efforts can bring about improvement in access to care, in the quality of care and in the cost of care.

Everything that needs to be done cannot be done alone by Blue Cross. Nor can it be done by the government. Nor by consumers. Nor by health professionals and providers.

Instead, everyone who is involved in the health field—all of them—must work together to improve old ways while finding new ways to provide for all of the American people the level of health care which the nation needs. Blue Cross will do its part.
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