Don,
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HISTORY

OF

BLUE CROSS AND BLUE SHIELD

From: Blue Cross
Blue Shield
Association

HISTORY OF THE BLUE CROSS AND BLUE SHIELD ORGANIZATION

"Blue Cross" and "Blue Shield" have become household words in the United States. The familiar symbols are instantly recognized as representing protection from the costs of hospital and medical bills for millions of Americans.

The Blue Cross and Blue Shield organization is not a single company. Rather, it is a nationwide federation of 79 locally governed, autonomous corporations, each operating under state law as a non-profit service organization. (Each local corporation is known as a Plan.)

The pre-payment movement now known as the Blue Cross and Blue Shield organization grew up in local communities, gradually spreading to other communities, joining together at a regional or state level, and eventually forming a national organization to coordinate the activities of the local Plans.

The Blue Cross Plans were founded primarily to cover hospital expenses, though they have expanded their coverage into out-patient care, other institutional services and even home care. The Blue Shield Plans were established primarily to cover physician's services, though they too have expanded into other benefits, such as dental and vision care. In most areas, Blue Cross and Blue Shield Plans cooperate closely and many, a single management. Or they may share office space, conduct joint enrollment and billing functions. In other areas, they are separate organizations which overlap in the benefits they offer, or even compete with each other.

How did this pre-payment movement come about?

The Blue Cross Idea

During the 1920's, hospitals in several states offered their communities a new method of paying for hospital care in advance of need. The most successful of the Plans was at the Baylor University Hospital in Dallas, Texas, under the leadership of Justin Ford Kimball, Ph.D., Executive Vice-president of Baylor University. In 1920, a group of Dallas school teachers worked out an agreement with the University Hospital. For a monthly sum of $.50 per teacher, each was assured of receiving 21 days of care in a semi-private hospital room when needed.

Other groups of employees in the Dallas area joined the group. The Baylor program was described at the annual meeting of the American Hospital Association in 1931. The idea soon attracted nationwide attention and similar arrangements spread throughout the country. The deepening Depression gave impetus to the movement as millions of persons recognized the need to protect themselves from the devastating cost of illness.

At first, each plan involved only an individual hospital, but by 1932, community-wide agreements offering subscribers a choice of hospitals began to emerge. Among the first communities to have programs of this sort were Sacramento, California; Newark, New Jersey; and New York City.

In 1933, E.A. van Steenwyk, first executive of the Hospital Service Association of St. Paul, Minnesota, used a blue cross to identify his program on stationery, folders, and other printed material. The idea caught on, and other programs started using the same symbol. In 1939, the Blue Cross symbol was officially adopted by a commission of the American Hospital Association, which also developed membership standards which the Plans had to meet. Plan dues supported the commission from 1941 on.

In 1960, the Blue Cross Commission was replaced by the Blue Cross Association, which had been operating independently of the AHA since 1948, and was supported by dues from the Blue Cross Plans. In 1972, formal ties with the American Hospital Association were severed.

The design in the center of the Blue Cross symbol was revised in 1972 when the Blue Cross name, service mark, and approval program were transferred from the AHA to the Blue Cross Association. The stylized human figure in the center of the cross symbolizes all mankind and the role of the Plans in serving human needs.

Origins of the Blue Shield Concept

In the lumbering and mining camps of the Pacific Northwest at the turn of the century, employers contracted for medical services for their workers with individual physicians who were paid a monthly fee. That arrangement led to establishing "medical service bureaus" composed of groups of physicians contracting their services to employers. The workers then had the freedom to choose their doctor from among the participating physicians. The first of the county service bureaus in the Northwest was organized in Tacoma, Washington by Pierce County physicians in 1917. Numerous such bureaus were founded and many including the Pierce County bureaus are still in operation today as Blue Shield Plans.

In 1938, the American Medical Association's house of delegates endorsed the principle of voluntary health insurance, a move that encouraged physician cooperation in pre-payment programs. A year later, a Blue Shield Plan was begun in California as California Physicians Service. It provided physician services to employee group members of $1.70 per month and was limited to those earning less than $3,000 per year.

During the next few years, a number of similar Plans were established throughout the country. Although they were not affiliated, they had in common some elements that were to become basic to the Blue Shield movement.

The Blue Shield Plans were sometimes subsidized by physicians. They were founded around a nucleus of participation doctors who agreed to accept payment from the Plans as full payment for services rendered to subscribers. If the Plan ran out of money it would be the doctors who stood the losses. Most of the Plans worked closely with Blue Cross Plans for joint enrollment and fee collection.

The Blue Shield name and symbol were first used by a pre-paid plan in Buffalo, New York, known today as Blue Shield of Western New York. The name and symbol were informally adopted by the Associated Medical Care Plans in 1948, and registered officially in 1951 for Blue Shield Plans.

The need for a national organization was recognized early. Nine of the non-profit pre-payment plans joined together in 1946 to form Associated Medical Care Plans. Other Plans soon joined. Later, the organization became the National Association of Blue Shield Plans and eventually in 1976 the Blue Shield Association.

The two national organizations, consolidated staffs in 1978, and formally merged in 1982 to form the Blue Cross and Blue Shield Association.

Growth of Pre-payment

The health insurance concept was stimulated by the Depression, when millions of Americans found it difficult to meet day-to-day expenses, let alone the costs of an illness or accident. With the introduction of legislation like the 1935 Social Security Act, unemployment compensation, and old age assistance programs, the concept was given additional emphasis. With the onset of World War II, the fringe benefits concept began to develop and take hold within the United States. Employers, unable to raise wages because of the wage freeze laws, began to offer employees fringe benefits in lieu of wage increases. Because of the basic need which health insurance filled for Americans of all economic levels, health coverage was a much sought-after benefit.

The health insurance concept was further stimulated by the experience of returning servicemen. Accustomed to having their medical needs provided by the military, veterans heartily endorsed the pre-payment idea for themselves and their dependents. As American industry began to convert from a wartime economy to peacetime production, unions assumed strong positions in their negotiations for employee benefits. Employer tax exemptions for health and welfare contributions

further enhanced the movement. A favorable climate for union fringe benefit demands was thus created. As a final measure, when the U. S. Supreme court late in 1949 ruled that as part of the Taft-Hartley Act, employers had to bargain on welfare issues, the pre-payment concept caught on throughout the nation, sweeping every aspect of American industry. The Blue Cross and Blue Shield Plans grew rapidly.

Emergence of Competition

Up until now, the commercial insurance companies ahead been largely indifferent to the potential of health insurance. Seeing that it worked, the commercial companies were quick to include health insurance in their insurance packages offered to large groups. By 1963, more than 900 insurance companies were actively writhing health insurance.

The impact of the commercial insurers' practices was to significantly change the environment in which the Blue Cross and Blue Shield Plans operated. In the early years, for example, the Plans followed the practice of "community rating," meaning that the risk was spread over the entire subscriber population. The Plans offered everyone in the community the same benefits at the same price, regardless of their age, health status or employment. The commercial insurance companies entered the market with a different system known as "experience rating," which in its simplest form means that rates are based upon the amount of services the group uses and the risk represented by that particular group. The effect of this change was that the commercial insures could offer lower rates to groups with younger and healthier employees. The Blue Cross and Blue Shield Plans were forced to modify their practices by adopting experience rating in order to compete.

The Plans did not abandon the smaller groups and individuals who constitute higher risks, however. They still cover individuals and small groups whom the commercials avoid. They do not cancel coverage because of high use or poor health.
The Plans differ from commercial insurers also in their strong hospital and physician relations; they contract with hospitals and physicians to provide services, and they pay contracting providers directly, whereas the commercial companies simply pay the policy-holder a stated number of dollars. The Plans return a greater percentage of premium payments to subscribers in the form of benefits. Governed by boards of directors consisting of a majority of public representatives, they have a strong obligation to their communities and their subscribers which the commercial companies do not necessarily share.

The Changing Environment

Costs of hospital and medical care increased steadily and rapidly, especially after the advent of Medicare and Medicaid in 1966. Spurred by the economy, inflation, the infusion of money through government programs, the development of new technology, and the availability of insurance to cover medical advances, costs increased each year, sometimes as much as 15% per year. Cost containment became of paramount importance. The Blue Cross and Blue Shield Plans led the way in cost containment efforts, being first to support area-wide planning, for example, and encouraging the shift from in-patient to out-patient care.

Another example is the Medical Necessity Program to define and apply good standards of practice to the utilization of services. The Plans were in the lead in the development of "managed care'" including utilization review, second opinion and pre-admission certification programs. They developed new ways of paying hospitals. They developed health maintenance organizations and, more recently, preferred provider arrangements.

The early 1980's witnessed a revolution in the way health care is delivered and financed in the United States. Old partnerships and relationships evaporated as competition became the order of the day. For-profit hospital chains emerged, as did a wide variety of ambulatory care facilities, both hospital-affiliated and freestanding. Both providers and insurers began developing health maintenance organizations and preferred provider organizations. Hybrids of there are beginning to appear. Pressure from cutbacks in Medicare and Medicaid have forced providers to seek other sources of income at a time when they cannot turn to privately insured patients to make up the difference. Even non-profit hospitals are establishing multi-hospital systems in order to compete, and hospital corporations are getting into insurance. The trend among large employers has been toward self-insurance, and this has created a variety of administrative service arrangements.

While all these competitive pressures and complex relationships have changed the structure of the organization and the way the Plans operate, they have not changed the basic philosophy of the Blue Cross and Blue Shield Plans, that of serving the community by providing payment for quality, affordable health care coverage on a non-profit basis.

Move Toward National Unity: The Blue Cross Association

1937 -- The American Hospital Association established the Commission on Hospital Service -- a forerunner of both the Blue Cross Commission and the Blue Cross Association. The Commission, located in Chicago, provided information and advice for developing non-profit, voluntary health plans, served as a clearinghouse for ideas; and studied hospital and pre-payment plan financing.

1939 -- The Blue Cross symbol -- designed by E. A. van Steenwyk, President of the St. Paul, Minnesota Plan -- officially was adopted by AHA as the national emblem for the Plans which met AHA guidelines.

1941 -- The AHA dissolved the Commission on Hospital Service and replaced it with the Hospital Services Plan Commission (HSPC). The HSPC was financed with dues from the Plans rather than through AHA, and it took on responsibilities for research and Plan coordination.

1946 -- The Blue Cross Commission was created by AHA to replace HSPC. The Commission, also financed by Plan dues, help formulate and establish national Plan policies, as directed by the Plans at their annual meetings.

1948 -- The AHA incorporated the Blue Cross Association in Chicago to begin a subsidiary organization called Health Service, Inc. (HSI).
Through voluntary contributions by the Plans, HSI was organized as a Plan-owned insurance company to write uniform national health contracts.

1949 -- The Inter-Plan Service Benefit Bank was created as a clearinghouse to serve Blue Cross members who happened to be hospitalized or receive health care outside their local Plan areas, and the Blue Cross Commission in chicago took overs its administration.

1951 -- The Inter-Plan Transfer Agreement, which provides for transfer of membership between Plans without loss of benefit continuity, became operative and was administered by the Blue Cross Commission in Chicago.

1956 -- The Blue Cross Association was thoroughly reorganized and set up in New York City with responsibilities for national enrollment, advertising and federal government relations. It also assumed responsibility for administering the federal Military Dependents Coverage program, known as CHAMPUS.

1957 -- The Blue Cross Association established Inter-Plan private telecommunications wire service to streamline Inter-Plan claims and transfer communications. At this point, the Inter-Plan Bank and Inter-Plan Transfer administrative work was transferred from the Blue Cross Commission to the Association in New York.

1960 -- The Blue Cross Association assumed administrative and coordinating duties for the Federal Employee Health Benefits Program (FEP).

1962 -- The AHA dissolved the Blue Cross Commission, and the Blue Cross Association moved out of its subsidiary role and into a partnership role with AHA. This charge created a single, strong national association to represent the Plans, rather than two weaker national organizations in New York and Chicago. Under the new organization, the Blue Cross Association was directed by a twenty-five member Board of Governors consisting of 11 District Governors and 11 Members-at-Large, elected by the Plans, and three AHA Governors, nominated by AHA.

1962 -- Walter J. McNerney became the President of the Blue Cross Association, succeeding James E. Stuart.

1964 -- The Blue Cross Association established a Washington office and hired a Washington representative in anticipation of increased government interest in health pre-payment.

1965 -- The National Labor Office was begun in Washington by the Blue Cross Association to improve liaison between Blue Cross and national labor union leaders.

1966 -- Blue Cross contracted with the federal government as principal Medicare intermediary for hospital and other institutional stays by the elderly. The Blue Cross telecommunications system at Association headquarters in Chicago began handling all claims communication between the Plans and the Social Security record center in Baltimore.

1972 -- Formal ties with the American Hospital Association were severed. The name, trademark and Plan approval program were transferred from AHA to Blue Cross Association. A new stylized blue cross symbol was introduced.

History of the Blue Shield Association

1946 -- Nine Blue Shield Plans formed the Associated Medical Care Plans, forerunner of the National Association of Blue Shield Plans. The nine Plans were located in California; DesMoines, Iowa; Detroit, Michigan; Kansas City, Missouri; Omaha, Nebraska; Newark, New Jersey; Columbus, Ohio; Portland Oregon; and Camp Hill Pennsylvania.

1946 -- Frank E. Smith was named director, and served until 1954.

1947 -- During the first year of operation, the number of affiliated Plans jumped from the original nine to 45 Blue Shield Plans. Subscriber enrollment tripled to nearly 6 million.

1948 -- Blue Shield symbol was adopted by the Association and Plans.

1950 -- By 1950, there were 72 Blue Shield Plans with over 19 million enrolled.

1950 -- The blue shield symbol was officially adopted as reflected in the change of the name to Blue Shield Medical Care Plans, later (1960) to National Association of Blue Shield Plans, and (in 1976) to Blue Shield Association.

1950 -- A national service agency was established as a subsidiary of the Association, originally called Blue Shield Service,Inc., later changed to Medical Indemnity of America (MIA). The new organization functioned as a working arm of the Blue Shield system in writing coverage for national account groups under certain circumstances. MIA was able to underwrite gaps in coverage in national accounts caused by lack of uniformity among Plans created by different state laws and regulations.

1955 -- John W. Castellucci was named Executive Director (later named President). He served until 1971.

1971 -- Ned Parish served as President from 1971 to 1976.

1976 -- William E. Ryan served as President from 1976 until BSA's consolidation with Blue Cross Association in 1978.

National Merger

1978 -- The staffs of Blue Cross Association and Blue Shield Association were consolidated under one president, though each association retained its own board. Walter J. McNerney became President and William E. Ryan, Senior Executive Vice-President of both organizations.

1980 -- The associations moved to 676 N. St. Clair Street, Chicago.

1981 -- Bernard R. Tresnowski was appointed President, succeeding Walter J. McNerney.

1982 -- Blue Cross Association and Blue Shield Association were merged into one corporation with one board effective 7/1/82.

1982 -- HSI and MIA merged to become BCS Financial Corporation, the parent corporation for the BCS Insurance Company.

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QUESTIONS AND ANSWERS

ABOUT

THE BLUE CROSS AND BLUE SHIELD ORGANIZATION

YEAR END, 1990

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QUESTIONS AND ANSWERS

ABOUT THE BLUE CROSS AND BLUE SHIELD ORGANIZATION

WHAT IS BLUE CROSS? BLUE SHIELD?

"Blue Cross" and Blue Shield" are the names and symbols used by the 73 local, non-profit community service organizations (called Blue Cross and Blue Shield Plans) which contract with hospitals, physicians and other health care providers to provide pre-paid health care services to their subscribers.

The Blue Cross and Blue Shield organization is not a single company. Rather, it is a nationwide federation of locally governed, autonomous corporations, each operating under state law as a non-profit service organization. A few Plans are organized as non-profit mutual insurance companies.

WHEN AND HOW DID THE BLUE CROSS IDEA ORIGINATE?

The Blue Cross idea originated in Dallas, Texas, in 1929. Under the leadership of Justin Ford Kimball, PH.D., executive vice-president of Baylor University, a group of school teaches worked out an agreement with the university hospital. For the annual sum of $6.00 per teacher, each was assured of receiving 21 days of care in a semi-private hospital room.

Other groups of employees in the Dallas area then joined the group. The idea soon attracted nationwide attention and similar arrangements spread throughout the country.

At first, each one involved only an individual hospital, but by 1932, community-wide agreements offering subscribers a choice of hospitals began to emerge. Among the first communities to have programs of that sort were Sacramento, California; Newark, New Jersey; and New York City.

in 1933, E. A. van Steenwyk, first executive of the Hospital Service Association of St. Paul, Minnesota, conceived the idea of using a blue cross to identify his program on stationery, folders and other printed material. The idea caught on and other programs started using the same symbol. In 1939, the Blue Cross symbol was officially adopted. The design in the center of the cross was revised in 1972 when the name and mark were transferred from the American Hospital Association to the Blue Cross Association.

WHEN AND HOW DID THE BLUE SHIELD IDEA GET STARTED?

The origin of the Blue Shield organization can be traced to a number of county medical pre-payment bureaus which came into existence shortly before the turn of the century in the northwestern United States. These pioneer programs provided experience for the first Blue Shield-type plan founded in California in 1939, called California Physicians Service.

WHAT IS THE DIFFERENCE BETWEEN BLUE CROSS AND BLUE SHIELD PLANS?

The Blue Cross Plans were founded primarily to cover hospital expenses, though they have expanded their coverage into out-patient care, other institutional services and even home care. The Blue Shield Plans were established primarily to cover physicians' services, though they too have expanded into other benefits, such as dental, vision and out-patient.

In most areas, Blue Cross and Blue Shield Plans cooperate closely and many, in fact, are joint corporations. Often, they are two corporations under a single management. Or they may share office space, conduct joint enrollment and billing. In other areas, they are separate organizations which may overlap in the benefits they offer, or even compete with each other.

On the national level, the Blue Cross and Blue Shield Association is a single corporation.

HOW MANY BLUE CROSS AND BLUE SHIELD PLANS ARE THERE?

There are 60 Blue Cross Plans in the United States and Puerto Rico. There are 65 Blue Shield Plans in the United States and Puerto Rico. Some of the local Blue Cross and Blue Shield Plans are joint, making a total of 73 local Plans.

In addition, there are affiliated Plans in Canada, Jamaica and England.

WHAT IS THE BLUE CROSS AND BLUE SHIELD ASSOCIATION?

The Blue Cross and Blue Shield Association is a coordinating agency of the Plans. The Association serves as a spokesman for the Plans in matters of national concern. It initiates and coordinates programs of public education and professional relations. It works with Plans on cost containment efforts. It provides research, statistical, actuarial, marketing and other services to the Plans. It administers membership standards which the Plans must meet. It maintains a computerized telecommunications system linking all the Plans.

One important job of the Association is to help coordinate health care coverage for large national employers with plants and offices in more than one region. The Association is the prime contractor for the Blue Cross organization's administration of the institutional (Part A) benefits under Medicare. The Association also serves as coordinator for other federal and state health programs.

The forerunner of the Blue Shield Association was formed in 1946 to coordinate activities of the Blue Shield Plans. The Blue Cross Association was formed in 1948 to serve as the national coordinating agency for the Blue Cross Plans. BSA and BCA became a joint corporation in 1982, after operating under one management since 1978.

ARE BLUE CROSS AND BLUE SHIELD REALLY NON-PROFIT?

YES. Blue Cross and Blue Shield Plans are non-profit organizations which operate, for the post part, under special state legislation subjecting them to stringent regulation. Virtually all of the money Blue Cross and Blue Shield Plans take in -- on the average about 90 cents of every dollar -- goes to provide benefits for their subscribers. The remainder, about 10 cents, is used for operating expenses and the reserve funds which the Plans are required by law to maintain. The average operating costs for the organizations as a whole amount to about 9 cents of each dollar.

In 1989, Blue Cross and Blue Shield Plans paid a total of $120.8 billion for health care on behalf of the people they serve. Of this, $50.7 billion was paid for care received by their subscribers, and $70.1 billion was paid for persons under Medicare.

HOW MANY PEOPLE DO THE BLUE CROSS AND BLUE SHIELD PLANS SERVE?

The Blue Cross and Blue Shield Plans serve almost 100 million people in the United States.

Of those, about 72.5 million are regular Blue Cross and/or Blue Shield Plan subscribers. This figure includes subscribers under the Federal Employee Program and coverage supplementing Medicare. Approximately 30 million Americans are served by Blue Cross and Blue Shield Plans in their roles as intermediary for Medicare Part A, and as carriers for Part B of Medicare, Medicaid, and CHAMPUS (military dependents). Eliminating duplications between programs, the total number of people is almost 100 million.

HOW DOES PRE-PAYMENT WORK?

Like insurance, Blue Cross and Blue Shield coverage is based on probabilities -- the predictability of illness and injury among large numbers of people. While no one knows when a member of any one family will need hospital or physician care, statistics can predict with near certainty how many cases will occur in a group of a thousand families. The amount paid by all the subscribers covers the bills of the ones who need care.

However, if the Blue Cross and Blue Shield concept 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. The Blue Cross and Blue Shield Plans' differences lie in their contracting relationship with hospitals and physicians who serve Blue Cross and Blue Shield subscribers, guaranteeing them the care they need when they need it. They offer "service benefits" rather that "indemnity benefits."

Blue Cross coverage traditionally provides a semi-private room in full, rather than so many dollars a day toward a hospital room. It typically provides nursing service, rather than a certain sum toward the cost.

The costs of services provided to Blue Cross subscribers by the hospital are then paid for under separate contracts between Blue Cross Plans and their approximately 5700 member hospitals. While Blue Cross programs have varying rates and benefits, the basic principle of coverage for service is characteristic. Since billing is handled between the hospital and the Blue Cross Plan, the patient is relieved of that burden and need only be concerned with any deductibles or co-payments his policy may require.

Similarly, Blue Shield Plans have special agreements with physicians to provide services to their subscribers.

HOW ARE BLUE CROSS AND BLUE SHIELD PLANS DIFFERENT FROM INSURANCE COMPANIES?

The most important difference is that the Blue Cross and Blue Shield Plans are non-profit. This means that almost all the money they take in as premiums is paid out in benefits for their subscribers.

The next most important difference is the unique contract relationship with providers. Unlike commercial insurance companies, which generally pay policy holders a certain sum against what they must pay the hospital or physician, most Blue Cross and Blue Shield Plans have contracts with hospitals and doctors. Because of these contracts, participating hospitals will admit a Blue Cross Plan subscriber without a deposit or other financial assurance. The provider bills the Blue Cross and Blue Shield Plans directly, in most cases.

Another distinctive feature of Blue Cross and Blue Shield coverage is its broad availability, regardless of age or health. Blue Cross and Blue Shield Plans take the "poor risks" and they do not cancel coverage because of change in health status or for high utilization of benefits. They allow conversion from group to individual coverage and guarantee the transfer of membership from one local Plan to another in case of a residency change.

Through the negotiated provider contracts, Blue Cross and Blue Shield Plans can work with hospitals and other providers to control cost and assure quality. Under these contracts, the Plans have responsibilities for auditing hospitals, and for prompt payment to hold down operating expenses. Commercial insurance companies do not have these obligations.

By offering the broadest possible coverage to as many people as possible, and by paying a greater percentage of the bill, the Plans help relieve hospitals and other providers of the burden of bad debts and "charity care" write-offs. Most insurance companies avoid these high risk groups.

Commercial insurance companies can usually raise their rates at any time, while the Plans must get approval from the state insurance department before they can raise their rates or change their coverage, often after public hearings.

WHAT ARE THE ADVANTAGES OF LOCAL AUTONOMY?

Since Blue Cross and Blue Shield Plans are organized locally, they are better able to meet local needs. Maintaining close contact with providers and recipients of health care gives the Plan unique flexibility in predicting and planning for changes in health care delivery. The Plans are able to study utilization and cost patterns because they are thoroughly familiar with the local conditions. And they are able to cooperate with hospitals and physicians in experimenting with new methods of delivering and paying for care.

HOW ARE BLUE CROSS AND BLUE SHIELD PLANS REGULATED?

Almost all Blue Cross and Blue Shield Plans are subject to a stringent regulation by the insurance departments of their home states. Generally a Plan's subscriber rates, benefits, payments to health care providers, and other contractual details must be approved by the state agency which conducts regular examinations to assure Plan operation in the public interest under sound financial conditions.

In most cases, the enabling legislation providing for insurance department jurisdiction over non-profit service benefit plans was passed in the 1930's. Early Plans themselves sponsored the legislation. A few Plans are regulated as non-profit mutual insurance companies.

In addition to state regulation, Plans are audited by the federal agencies responsible for various government programs, such as Medicare, Medicaid,Military dependents and the Federal Employee Program.

WHAT ARE SERVICE BENEFITS, FIRST DOLLAR COVERAGE?

Blue Cross and Blue Shield Plans have traditionally provided "service benefits" for their subscribers, rather than fixed dollar amounts ("indemnity benefits"). That is, they provide the service in full, rather than a certain number of dollars toward the cost. When the cost goes up so does the payment.

In recent years, there has been a trend toward deductibles and co-insurance, rather than "first dollar coverage." While Blue Cross and Blue Shield Plans will continue to emphasize service benefits, the marketplace demands such cost sharing features as deductibles and co-payments.

WHY ARE BENEFITS AND RATES NOT THE SAME IN ALL PLANS?

This is because benefits are negotiated locally, often with the employer, who purchases coverage for the employees. The purchaser may choose from a wide range and level of benefits. The Matrix Contract offers flexibility to meet the needs of the group.

Rates differ also geographically, depending upon hospital costs and physicians' fees in that area. Or they may be based upon the experience of the group.

WHAT IS THE MATRIX CONTRACT

Under the matrix contract, employers can choose from an almost endless combination of benefits to suit the needs of the employee group and the amount of money available for health care coverage. These benefit packages range from the standard paid-in-full program with supplemental major medical coverage to cost-sharing packages with deductible, co-insurance and stop-loss feature.

In other words, each benefit package is tailor-made for that particular group. The packages may differ from one group to another in the number of days covered, the amount of the deductible when there is one, the range of services covered, and the inclusion of such extras as dental, prescription drug and vision care. All these choices explain why there is no "typical" coverage or average rate.

HOW ARE LARGE NATIONAL ACCOUNTS HANDLED?

Companies which have employees in more than one Plan area are called national accounts. Coordination is achieved through the Blue Cross and Blue Shield Association, which maintains a national computerized central telecommunications system linking the Plans.

DO ALL SUBSCRIBERS BELONG TO GROUPS?

Most, but not all. Approximately 93.2% of all regular (under age 65) Blue Cross and Blue Shield subscribers in the United Sates are enrolled through groups. An additional 5.4% have enrolled either as individuals or individual families, and pay their premiums directly. Of Medicare complementary enrollees, about 31% are group and 69% are non-group. Overall, the ratio is 87% group and 13% non-group. The advantage of group enrollment is economy of administration, especially in collecting premiums.

CAN A SUBSCRIBER GET BENEFITS AWAY FROM HOME?

YES. A special service made possible by Blue Cross and Blue Shield Association's computerized telecommunications network is the "Inter-Plan Service Benefit Bank." Because of the Bank, a Blue Cross card-holder can be admitted to any of the 5700 Blue Cross Plan member hospitals in the United States and receive health care benefits.

If the hospital is outside the area of the Blue Cross Plan to which the subscriber belongs, the Bank arranges with the Plan in the area where the patient is hospitalized to provide benefits. The local Plan pays the hospital. Then, through the Inter-Plan Bank, the host Plan collects from the subscriber's home Plan.

In some areas, payment for Blue Shield Plan subscribers needing physician services out-of-area is handled through the Reciprocity System, which permits the physician to receive payment without billing the subscriber.

CAN COVERAGE BE CANCELED BY THE PLAN?

Only for on-payment of premiums or for fraud. To assure continuous coverage, the Plans have a policy that no subscriber's coverage may be canceled because of poor health, frequent use of benefits, or for any other such reason. Furthermore, group subscribers may convert to individual coverage when they leave their jobs; and subscribers moving from one Plan area to another may transfer to the new Plan.

WHY DO RATES GO UP?

In a period of rapidly rising health care costs, Blue Cross and Blue Shield Plans have had to increase their payments to hospitals and physicians for services received by subscribers. Because Plans provide benefits in the form of services, rather than fixed dollar indemnities, the rates charged to subscribers have also had to go up. More expensive technology, an aging population and increased use of out-patient services also contribute to increased costs. However, cost containment efforts have resulted in declining utilization of expensive in-patient services.

WHAT KINDS OF HOSPITAL SERVICES DOES BLUE CROSS COVERAGE PAY FOR?

Although Blue Cross contracts vary from group to group, they generally provide subscribers with hospital care in a semi-private room for a certain number of days in any given benefit period, plus other needed hospital services such as X-rays, laboratory services, operating room and medication. Benefits are provided for all conditions commonly cared for in a general hospital, as an in-patient when medically necessary, or as an out-patient.

THEN YOU DON'T HAVE TO BE HOSPITALIZED TO RECEIVE BENEFITS?

Not necessarily, Out-patient benefits are available under almost all contracts. A concerted effort is being made to shift care away from the more expensive in-patient treatment to ambulatory care where appropriate. These efforts include ambulatory surgery, pre-admission certification, pre-admission testing and early discharge. In addition, Plans contract with a variety of institutions other than hospitals, including extended care facilities, home health agencies, ambulatory care facilities, and hospices.

The Blue Cross Plans have been paying more out-patient claims than in-patient claims since 1969. There has been a dramatic decline in in-patient utilization, largely as a result of cost containment efforts such as ambulatory surgery, pre-admission certification and concurrent review. In the past five years, the number of admissions has declined at a rate of 15.8% t 83.89 admissions per 1000 Blue Cross subscribers in 1989. The number of in-patient days per 1000 declined 16.7% to 502.44 days. The average length of stay for Blue Cross subscribers declined .99% from 6.05 days in 1984 to 5.99 days in 1989.

HOW DO THE PLANS REIMBURSE HOSPITALS?

There are a number of ways. The method of payment is determined locally through negotiations with participating institutions and is spelled out in the Plan/hospital contract. Billing is often done by computer directly to the Plan without need for paperwork.

Payment may be made on the basis of the hospital's cost of providing services or on the basis of charges. Under either of these approaches, the Plan may require justification of any increased level of cost, or charge, through specific negotiation, comparison with peer institutions, audit, etc. The trend in recent years has been toward prospective payment requiring hospitals to submit and negotiate advance budgets to support their income requirements resulting, usually, in a firm commitment by hospitals to confine spending to the limits imposed through the contract. Numerous experiments are going on to find better ways of paying for services with incentives for cost containment. Some Plans have payment systems based on diagnosis-related groups (DRGs).

In some states, budget negotiations, approval of hospital cost levels and charge rates are under the jurisdiction of a state-appointed commission or agency. Blue Cross Plans in these areas pay for hospital services at rates established by the state.

Most Plans are now involved with preferred provider arrangements, under which subscribers are given financial incentives to use certain cost-effective hospitals under special contract with the Blue Cross Plan.

HOW DO BLUE SHIELD PLANS REIMBURSE PHYSICIANS?

There are several payment methods which a Plan may use to pay for medical services rendered by participating physicians. Among these, the dominant method is the Usual, Customary and Reasonable (UCR) payment method. Reimbursement under this program represents payment in full for covered services. It is based upon individual physician charge profiles and customary charge screens for similar groupings of physicians within a geographical area and with similar expertise. Within this system, various restraints may be implemented to curb the escalation of physicians' fees. Further, participating physicians agree not to bill subscribers for the difference between the actual charge and the payment level determined under the UCR concept.

There are a number of other methods of paying physicians. Some Blue Shield plans pay on the basis of a fee schedule. Health maintenance organizations are paid a captation amount for services of their physicians.

ARE THE PLANS INVOLVED IN HMOs AND PPOS?

Very much so. The Blue Cross and Blue Shield Plans have always been in the forefront in developing more effective ways of delivering and paying for health care.

As of 12/31/89, Blue Cross and Blue Shield Plans were operating 92 HMOs, enrolling 4.5 million people, in 40 states. The organization sponsors HMO-USA, a network of 76 HMO's in 40 states serving companies with employees in more than one location.

Preferred provider arrangements are rapidly gaining interest as another viable option. Usually, the subscriber is given financial incentives to use certain providers who have contracted with the Plan to provide cost-effective care. Fifty-seven Plans now offer a preferred provider product, enrolling 11 million persons.

WHAT IS THE ROLE OF THE ORGANIZATION IN THE FEDERAL EMPLOYEE PROGRAM?

Under the Federal Employee Health Benefit Program, more than nine million U.S. Government employees and their dependents receive a broad range of coverage for health care expense. It is a unique program, with the federal government in the role of employer negotiation for effective coverage for its workers and paying part of the cost. Private carriers underwrite the program, which is the largest voluntary employee group of its kind in the world.

One of the unique features is that employees have a choice of at lease four different kinds of health benefits, which are available from dozens of carriers, including the Blue Cross and Blue Shield Organization. All employees are free to change their carrier and type of coverage during periodic open enrollment periods. About 1.7 million employees have chosen Blue Cross and Blue Shield coverage (including dependents, over 3.8 million people.)

WHAT IS THE ROLE OF THE ORGANIZATION IN MEDICARE?

Title XVIII of the Social Security Amendment of 1965 established Medicare, the health care financing program for the elderly and disabled. The Blue Cross and Blue Shield organization serves as an administrative intermediary between the government and institutional providers participating in Part A of the Medicare program, including voluntary hospitals, extended care facilities and home health agencies.

Blue Cross and Blue Shield Association is prime contractor under Part A, and sub-contracts with Blue Cross Plans to perform a wide range of functions in claims processing, utilization review, audit and other financial activities necessary for the operation of the program. Under its prime contract, the Association monitors the performance of its sub-contracting Plans and provides technical assistance to Plans where necessary. In addition, the Association develops procedures, guidelines and program policy materials for use by the Plans, and operates a national telecommunications network for claims processing. As prime contractor, the Association negotiates contract changes, and consults with Health Care Financing Administration in the development of program policy, procedures and guidelines.

In fiscal year, 1989, the Blue Cross Plans processed 65 million institutional claims and paid out $53.1 billion in claims for Medicare patients.

Twenty-seven Blue Shield Plans serve as carriers for the medical insurance portion (Part B) of the Medicare program. The Association serves as a clearinghouse and offers operational assistance to these Plans.

In fiscal year 1989, Blue Shield Plans handled 262 million medical claims for Medicare patients, and paid out $17 billion in claims.

WHAT IS THE BLUE CROSS AND BLUE SHIELD ORGANIZATION DOING TO CONTROL COSTS?

Blue Cross and Blue Shield Plans use a variety of methods, aware that no single control is universally effective in controlling costs or influencing all of the variables affecting costs. Plans have formalized their commitment by adopting cost containment membership standards. They are active in local coalitions with business and consumer groups in efforts to control health care costs. The cost containment programs are based on support and co-operation of hospitals, physicians, consumers and major purchasers of care.

Reimbursement: One control is the way Blue Cross Plans pay hospitals. The Plans are engaged in programs and experiments that involve new methods of paying hospitals, aimed at rewarding greater efficiency and productivity without sacrificing the quality of care. Critical to their success is an understanding that Plans must be prudent purchasers on behalf of their subscribers in negotiating payment arrangements with hospitals. At the same time, Plans must pay a fair price that is the Plans' appropriate share of providers' costs for services provided to their subscribers. Negotiated reimbursement methods which require hospitals to operate within specified financial limits can, and do, have an effect on cost. Most Plans use some form of prospective payment. Approximately 30 percent of Plans base payment on diagnosis related groups (DRGs.) Other experiments are under way. Most Plans no w have preferred provider arrangements.

Managed Care: Blue Cross and Blue Shield Plans have pioneered in developing programs for the review of health care services to determine if the hospital and/or physician services provided to the patient are necessary, if they are appropriate to the patient's condition, and rendered in the appropriate setting. It has been found that reducing hospital stays can generate significant savings, so various efforts are aimed in that direction. Managed care programs typically include: pre-admission certification, whereby approval of the hospitalization must be obtained before admission to the hospital; concurrent review; discharge planning; and case management. Out-patient surgery for certain procedures and second opinion on elective surgery may also be required.

In addition, Plans provide statistical data to company accounts regarding utilization patterns for their employees, in order to pinpoint areas where utilization problems may exist.

Out-patient Care: To reduce the incentive for a patient to occupy a costly hospital bed unnecessarily, the Plans have broadened their benefits to cover more out-of-hospital and out-patient services such as pre-admission testing, home care, ambulatory surgery, and care in skilled nursing home facilities.

Home Care: The Plans have offered home care coverage for over 30 years, often reducing in-patient length of stay and enabling the patient to recover more quickly in the familiar surroundings of home. Some Plans have introduced early maternity discharge, with home nurse supervision. They also contract for hospice services to terminally ill patients at home.

Alternative Delivery Systems: As mentioned previously, the Plans are actively developing alternative systems such as health maintenance organizations and preferred provider arrangements.

Medical Necessity Program: In 1977, the Blue Cross and Blue Shield organization, in cooperation with several national medical specialty organizations, started the Medical Necessity Program, a cost-control effort related to utilization review. The first phase of the program ended routine payment for 85 surgical and diagnostic procedures which have been judged obsolete, outmoded or of unproven value. Under this program, it was also recommended that payment for routine diagnostic tests performed on admission to a hospital be made only when ordered by the physician specifically for that patient. Recent phases of the program established guidelines to eliminate unnecessary use of respiratory care therapies, diagnostic imaging, cardiac care procedures, and diagnostic testing.

Technology Evaluation & Coverage (TEC): The Blue Cross and Blue Shield Association's TEC program analyzes new, and often expensive, medical technologies. The program provides Plans with objective information on new technologies to facilitate reasonable, consistent coverage decisions that promote high-quality, cost-effective health care. Among the medical technologies that have been reviewed by the TEC program are: bone marrow transplantation, collagen implants, in vitro fertilization and serologic testing for AIDS.

Pre-admission Testing, Ambulatory Surgery, Second Opinion: In addition to the Medical Necessity Program, Plans have encouraged pre-admission testing for patients having surgery, often avoiding the expense of one or two days of hospitalization while tests are conducted prior to surgery. The Plans also encourage and pay for surgical procedures performed on an out-patient basis -- either in "same-day surgery" units at hospitals or in free-standing ambulatory surgical centers. Most Plans have initiated "second opinion" programs, under which the Plan will pay for consultations in advance of elective surgery as a means of reducing the incidence of surgery.

Anti-Fraud Programs: In addition to honest errors in billing and questionable medical

practice patterns, Plans often have to contend with outright fraud. Blue Cross and Blue Shield Plans have been among the leaders in anti-fraud activities. Many Plans have independent investigative units that have been able to detect cases when bills were submitted for testing, surgery and other health care procedures that were never performed. Anti-fraud programs not only recover millions of dollars each year from fraudulent claims, but also have a deterrent value, which can benefit the entire community, not merely Blue Cross and Blue Shield Customers.

WHAT ARE THE PLANS DOING TO PROMOTE HEALTH EDUCATION AND PREVENTATIVE CARE?

Studies have shown that the causes of most serious illness and injury lie outside the influence of the health care system, and that no matter how much money is spent on health care, the health of the nation will not be greatly improved. Factors such as lifestyle, safety, living conditions, income, nutrition and physical fitness can have a greater effect on overall health than do physicians and hospitals.

Recognizing this, the Blue Cross and Blue Shield organization is advocating a new approach to the problem of health care -- away from reliance on curing illness once it is a fact, and more toward preventing illness in the first place, or at least detecting illness in its early states.

To this end, Plans are targeting a variety of programs toward specific audiences: employee groups, schools, communities, health institutions and businesses. Program diversity reflects the community orientation of Plans as they develop programs most effective for their particular areas.

Working with schools and industry, Plans provide health materials such as educational films and pamphlets on particular diseases, nutrition and exercise in their efforts to promote healthier lifestyles. Plans conduct health fairs, sports and fitness events, immunization programs, health risk screening programs for hypertension, heart disease and cancer. A variety of health topics have been prominently brought to public awareness through advertising in newspaper, magazines, radio and television.

The national Association has developed a "Your Healthy Best" program consisting of audio-visual and printed materials for use in community or work-site health promotion efforts. The Blue Cross and Blue Shield system was an official sponsor of the 1988 Olympic games and will be a sponsor in 1992 as well.

These activities are representative of the organization's interest in improving the quality of life in communities served by the Plans and in controlling the cost of ill health.