APPENDIX K

*Excerpts from the Testimony of C. Rufus Rorem before the Senate Committee on Education and Labor, 1946**

We are here to present the facts about the 21,400,000 members of Blue Cross plans for hospital care, a program which has enrolled more participants in less time than any voluntary movement in the history of the world. We are directly concerned with the administration of voluntary health services, and its management and achievements. We are anxious to expand its virtues and remove its defects and thus increase its services to our nation. We believe it should not disappear from the American scene as a noble experiment.

We participated 17 years ago in establishing many of the estimates which have been submitted as evidence that no one can tell either when he will be sick or what his sickness will cost him. It is now generally recognized that the costs of severe illness weigh heavily upon a small number of people, whereas the larger proportion are faced with only small annual expenditures for necessary health services. The burden of sickness costs thus can be most effectively carried by application of the law of averages to the payment of hospital bills. The basic question before your committee is the method and degree of such application at the present time.

What Is Blue Cross?

A Blue Cross plan for hospital services is a nonprofit corporation, a community organization which accepts regular and equal payments from groups of members, the combined funds being used to pay hospital bills for those members requiring care. The hospital protection may be supplemented by a medically sponsored plan for medical and surgical care. The cost for hospital plan membership is approximately seventy-five cents a month per person or two dollars per family. Subscription rates for doctors' services in hospitalized cases are about the same.

The governing body of a Blue Cross plan is a board of directors (which includes

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*From Rorem's A *Quest for Certainty: Essays on Health Care Economics, 1930-1970* (Ann Arbor: Health Administration Press, 1982), pp. 99-113. At the time of this testimony, a national health insurance

leaders from industry, medicine, labor, welfare, hospitals, agriculture, government) who serve without pay, just as do the trustees of a church, social agency, or educational institution. These persons have no financial interest in the success of the Blue Cross plans, yet they devote many hours to professional and administrative policies. Their only reward is participation in a program of community service.

Benefits are available as hospital service rather than cash allowances. The services to subscribers are guaranteed by contracts with more than 3,500 community hospitals throughout the United States. Benefits are usually provided in semi-private accommodations and include the special services necessary for diagnosis and treatment. Benefits are available for each family member, usually for three to four weeks of "full coverage," with extended periods at discounts from regular hospital charges.

Blue Cross plans are supervised through an approval program conducted by the trustees of the American Hospital Association, and in the various states are regulated and supervised by the insurance department or other appropriate body. The American Hospital Association's requirements for approval include nonprofit organization, free choice of hospital and physician, hospital guarantee of service benefits, and representation of subscriber interests in control. The standards also provide for the establishment and maintenance of contingency financial reserves to protect the interests of subscribers and member hospitals.

It is not, accidental that protection for hospital bills has expanded so rapidly throughout the nation. The hospitals of America belong to the people, and hospital service is generally recognized as a community responsibility. Hospitals have assumed a moral, and sometimes legal, obligation to accept emergency cases, regardless of their ability to pay. Instances where a patient is refused emergency care are so unusual as to make headlines or be the subject of editorial comment.

Blue Cross Enrollment Growth Rapid

Enrollment in Blue Cross has accelerated during the past few years, and particularly the last few months. Growth during the war years was not entirely due to increased employment and high wages. The three-month period ending March 31, 1946, witnessed the largest total net increase in the history of the movement; nearly 1,400,000 persons joined during that period. This growth occurred in spite of conversion from war to peacetime industry, and in spite of many strikes in certain industries where Blue Cross protection had been especially well accepted.

The percentage of population enrolled under Blue Cross has been highest in the

eastern and northern states, where large portions of the population are engaged in industry. Yet, of the twelve states which show a total of more than 20 percent of their population now protected under Blue Cross, four may definitely be said to be rural in character.

Recent Developments in Blue Cross

We now turn to a set of affirmative statements which are presented to explain the progress and prospectives of voluntary health programs. Frankly, we are doing much better than many of us had ever expected. Eight years ago, we were congratulated for having reached 1,000,000 subscribers. Now we are criticized for merely exceeding 21,000,000 participants. Friends and critics alike are emphasizing the unfinished task rather than the work already done.

Most of the American population is now eligible for participation in a nonprofit prepayment plan for hospital care. Nonprofit Blue Cross plans now serve 43 states and the District of Columbia, and it is expected that the number will reach 47 by the end of the year. Residents of small towns are being protected through community enrollment; farm groups are being served through the activities of the farm bureaus, granges, and unions and the establishment of special organized county health improvement associations. Rural producers and consumers co-operatives also have served as enrollment and collection agencies. In many urban areas, enrollment privileges for self-employed persons are being introduced, and Blue Cross is giving increased attention to those groups.

Over half of the 80 U.S. Blue Cross plans offer complete protection for catastrophic illness through co-ordination with plans for medical or surgical protection. This coverage does not meet the full need of the American people, but it removes most of the economic burden of sickness from the shoulders of the individual.

The Blue Cross program has proved adequate for the mobile population of recent years. Blue Cross plans permit convenient transfers of memberships from one Blue Cross plan to another, and they allow continuance of membership when a subscriber leaves his place of original enrollment. Liberal out-of-town benefits are provided. These privileges have been achieved through formal agreements among the various Blue Cross plans.

Blue Cross plans are representative of the entire community: employers, employees, agriculture, hospitals, the medical profession, welfare groups, and others. The social significance of this voluntary sponsorship and guidance cannot be overemphasized. It is consistent with human values derived from permitting individuals to act voluntarily in removing the uncertainty of their sickness costs. The economic and social foundation of a

community hospital is as broad as the population itself. And the combined resources and support of a group of hospitals in a community of a state may be said to represent the combined resources and support of the entire public.

Hospital administrators and trustees regard themselves as administrators and trustees of public funds. The primary purpose of both Blue Cross plans and hospitals is to maximize service for the people who have built the hospitals, who use them, and who support them. Critics of Blue Cross plans have sometimes described them as "producer co-operatives," implying that their trustees were concerned only with maintaining the status quo of hospital operations and finance. The analogy is something less than complete. For, although the hospitals sponsor and guarantee the Blue Cross plans which enroll potential patients, the net savings are distributable only to the subscribers as increased benefits or reduced subscription rates.

The proof of the pudding is not in the recipe. Blue Cross plan trustees have typically been able to strike a balance between the interests of subscribers, who provide the money, and the hospitals, which provide the service. They have used the subscribers' funds economically, having regard for the necessity of maintaining professional standards through adequate payments.

Wage agreements between labor unions and management are often written to provide partial or full payment of prepaid health benefits by the employer. Blue Cross has been specially popular in such agreements because of their nonprofit service-benefit features and the policy of permitting continuance of membership when employment is interrupted by strike, layoff, or change to another firm. The advantage of protection has been demonstrated by a number of organizations during recent strikes. Some of the larger corporations in the country have permitted employees to authorize advances during a strike or temporary layoff. Conversely, Blue Cross plans have often permitted protection to continue, with the idea that payments would be made upon return to work.

The largest employer in the United States (the federal government) does not yet permit the privilege of voluntary payroll deduction. The Blue Cross Commission office receives letters daily from units of the United States government asking for the privilege of protection. Yet there are only 300,000 federal employees and their dependents participating in voluntary plans because of the difficulties involved in handling organization and payment details through voluntary group leaders who are employees of the federal government. Mutually satisfactory arrangements are not possible without the privileges of payroll deduction. Undoubtedly the existing makeshift enrollment and collection procedures have in many instances proved to be inefficient for the government departments involved as well as for the plan.

Overhead costs have been remarkably low, considering the rapid rate of growth. The average operating expense for the entire country, for all Blue Cross plans, was approximately 12 percent of the total income during the year 1945. In some of the larger organizations with established memberships, the operating expenses are less than 10 percent of the total subscribers' payments. On the average, about three cents of the subscriber's dollar has been used for consumer education and enrollment activities. About nine cents has been required for accounting and billing procedures and the payment of benefits. The expenses for general administration are being reduced. Plans are now using streamlined methods for maintenance of enrollment records, authorization of hospital admissions, and other administrative economies consistent with good business practice and efficient public service.

Many of the Blue Cross plans have increased their benefits during their period of operation without corresponding increase in subscription rates to the beneficiary. The increased benefits have been made possible through better "selection" among subscribers and [the] decision to apply reserves to provision of immediate benefits. Blue Cross plans are, of course, concerned with providing protection for all costs of hospitalized illness. In some cases, increased costs for labor and supplies in hospitals have necessitated increased rates to the subscribers. Usually, however, this has also been accompanied by increased benefits. But the problem of inflation and its effects upon increased costs of hospital care still face Blue Cross and any program of health service, voluntary or governmental, if the quality of availability of care is to be increased and assured.

Voluntary plans have been accepted by many veterans as a genuine opportunity for family protection. Even though veterans are entitled to care under existing GI legislation, they recognize that at least three-fourths of the care in their families is received by wife and children. Moreover, Blue Cross benefits permit free choice of hospital and doctor, which are not available at the present time for nonservice-connected disabilities. Blue Cross plans have exempted returning veterans from the group requirements imposed upon members of the general public, and thousands are being added daily to the Blue Cross rolls.