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Foreword

The authors believe that the future vitality and effectiveness of hospitals, the Blue Cross organization and, in fact, the entire range of health care service activities in the United States will be greatly influenced by the relationship between hospitals and Blue Cross Plans during the decade ahead. In particular, the balance between governmental and non-governmental decision-making in health services will largely reflect the extent to which hospital-Blue Cross Plan relationships serve the community interest. Constructive interaction by Blue Cross Plans and individual hospitals in response to public pressure for cost containment, reform and increased effectiveness of medical care will be crucial.

The basic facts are that Blue Cross Plans have contracts with almost all hospitals; that over 90 percent of the nation's hospitals selected Blue Cross Plans as the Medicare intermediary; that over 20 billion dollars flows annually between Blue Cross Plans and hospitals (well over half the total income of community hospitals); and finally, that these relationships are all subject to governmental regulation, inspection, public hearings and approval. This report does not question whether there should be a hospital-Blue Cross Plan relationship. Rather it concentrates on how to increase its value in order that both can operate more efficiently and more effectively, thereby providing quality services to their patients, subscribers and communities at a lower cost than might otherwise obtain.

Some readers will be disappointed that this report does not attempt to provide answers to some of the difficult substantive questions at issue between Blue Cross Plans and hospitals, such as:

- What are the best tools available to Blue Cross Plans in helping hospitals to control costs?
- Has the Blue Cross organization done enough in providing ambulatory care and other alternative benefits?
- Is differential payment justified?
- How should Blue Cross Plans pay hospitals?
- Should Blue Cross Plans move strongly to deductibles and co-insurance to control costs and utilization?
- What should be the Blue Cross organization role under National Health Insurance?

These issues are of crucial importance and, while we do have views, for the most part we do not discuss them in this report. Our study concentrates on defining the framework and processes of Blue Cross Plan-hospital interactions in which substantive issues can be addressed most constructively.

The goals of the study were to:

1. Analyze the current status of hospital-Blue Cross Plan relationships locally and nationally.
2. Identify the external forces at work in the next decade and project how they will influence the content and nature of the relationship.
3. Suggest specific steps that the Blue Cross Association and individual Plans should take to improve the effectiveness of their relationships with hospitals in serving the public.

We knew from the beginning that no simple universal prescriptions are available to strengthen hospital-Blue Cross Plan relationships throughout the country. Hospitals and Blue Cross Plans and their relationships vary widely across the nation in many important respects, especially as they relate to physicians, Blue Shield and government. Throughout our work, we became ever more aware of this wide diversity, and of the strengths as well as the weaknesses associated with it. We attempt to identify common themes and mechanisms that can be adapted to fit a variety of local situations.

The entire study had to be completed in a few months because of other commitments of the authors. All of the work (involving visits to ten Blue Cross Plan areas, review of detailed information requested from all Plans, many sessions at the Blue Cross Association and the American Hospital Association and review of their files, and many interviews with knowledgeable people in government, academia and public life) took place during the first six months of 1976.

In focusing sharply on Blue Cross Plan-hospital relationships, we necessarily neglected other important relationships that should be examined in detail to give a complete picture of the potential value of the interaction of Blue Cross Plans and hospitals. Of special importance is the potential for joint action by Blue Cross and Blue Shield Plans in working with hospitals and physicians in a variety of medical staff and other professional settings. We also would have liked to examine in more detail the interaction of such programs as Medicare with the Blue Cross Plan-hospital relationship.

The report is not a piece of research, or even an example of disciplined gathering and organizing of systematic information. Rather, it takes the form of a consultant's report, providing impressions, insights and judgment. We hope that this report will stimulate a wide variety of more scientific studies.

We gratefully acknowledge the help of those in all of the Plans who responded so fully and frankly to our questionnaires; of everyone in the Blue Cross Plan areas we visited, including the executives of member hospitals and hospital associations; of the staffs of the Blue Cross Association and the American Hospital Association who gave so generously of their knowledge and insight; and of all the others who helped us to gain perspective on an important subject. We were fortunate to have the wise counsel of C. Rufus Rorem. Special recognition goes to the president of the Blue Cross Association for supporting this project. At the same time, the authors alone are responsible for the final product.

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I. The Hospital-Blue Cross Plan Relationship: The Options

A special relationship with hospitals is one of the important characteristics of a Blue Cross Plan. From the beginning, a contract between the parties reflected a common commitment to more accessible community hospital service at monthly premiums that the public could afford. Nationally and in many Plan areas, a variety of forces is currently exerting strong pressures on this relationship. Rising hospital costs, increased federal and state governmental responsibilities for financing and regulation of hospital care and concern about the impact of "third party" payments on managerial efficiency or quality of care have all led to questioning—within the Blue Cross organization, among hospitals and by the public—the effectiveness of the relationship.

Some hospital spokesmen see the relationship in terms of imposition of rigid and unfair fiscal limitations which threaten standards of patient service and managerial flexibility. Some public spokesmen see the relationship in terms of a "coziness" that interferes with a disciplined buyer-seller interaction. The capacity of the relationship to serve the broad public interest is not as clearly articulated or understood as in the past.

Any Blue Cross Plan-hospital relationship can be viewed as having two basic dimensions reflecting the extent to which the parties are (1) *getting along* and (2) *getting something accomplished* in the public interest. The fundamental concern of this report is with the second dimension. Benefits of an improved relationship between hospitals and Blue Cross Plans should accrue to patients, to subscribers and to the communities served.

Currently, these two dimensions are not necessarily related in any simple way; all possible configurations are found among the 69 Plans, and within each Plan in its relationships with individual hospitals.

Although little of value is usually accomplished among parties which do not get along, there are important exceptions in some Plan areas. By the same token, in some areas where parties do get along well, clear-cut benefits to patients and subscribers are not easily identified. Assessment of the capacity of a Blue Cross Plan-hospital relationship to respond responsibly to a wide variety of community, public, professional and institutional demands involves careful ex-

amination of both dimensions of the relationship. Accordingly, the concern of this report is with the full range of Blue Cross Plan interactions with individual hospitals, rather than with the hospital contract, reimbursement, the activities of the provider relations staff or any other specific facet.

Throughout, the fundamental search was for answers to this question: How can the Blue Cross Plan-hospital relationship be shaped to contribute to more efficient and effective health care service to the public during a period of strong pressures to contain rising costs and to reform the health care system?

Blue Cross Plan-hospital relationships are extremely complex. The relationship in fact encompasses uncounted millions of interactions related to a majority of all hospital patients. Thousands of Blue Cross Plan and hospital employees at various levels work with each other on money and data flow; budget, rate and utilization review; health planning; and many other functions. The relationship varies widely—as Plans and hospitals and their community settings vary.

In general, an individual Blue Cross Plan's approach to its hospital relationship over the years has been determined by the Plan's primary emphasis on eliminating financial uncertainty associated with hospital service. In an earlier period, when Blue Cross Plans were attracting initial subscribers to a new idea, hospital relationships were secondary to marketing efforts, reflecting a visible community partnership committed to low premiums and easy access to hospital care. Later, as volume increased, as hospital costs rose, as technological gains proliferated and were absorbed, and as commercial competition exerted strong pressure, emphasis shifted to improved efficiency of processing claims and more businesslike hospital relationships.

Currently, with government moving to mandate universal entitlement to health insurance benefits and with strong public pressure for hospital cost containment, some Plans find themselves in adversary relationships with some hospitals. Some Plans are working closely with individual hospitals in joint innovative programs to contain hospital costs. Pressures and priorities are changing and are affecting Blue Cross Plan-hospital relationships.

But few Plans have as yet systematically reassessed the goals and objectives of their hospital relationships to develop a coordinated program in response to new forces and new public requirements.

The current importance of the Blue Cross Plan-hospital relationship lies in its great potential to respond constructively to pressures for change in the health care system. Public spokesmen are insisting on reform to control costs, eliminate or upgrade substandard quality service, broaden access to primary care, harness technology, avoid unnecessary duplication of services and advance health maintenance through alternative delivery systems and health education programs.

Unfortunately, there are still few tested and proven practical techniques to achieve these important objectives anywhere in the world. There are no easy answers available to government, Blue Cross Plans or hospitals. Complex changes in the behavior of professionals, patients and the public are involved. Any change imposed on health care institutions, with strong built-in resistance to disturbance of long-standing professional working relationships, runs the risks of unexpected side effects. At the same time, much can be accomplished by testing and demonstrating the value of new approaches in appropriate hospital settings. Blue Cross Plans have a unique capacity to work with individual hospitals, and should, in conjunction with Blue Shield, help to bring about productive change during this complex period in health service history. The disciplined public service orientation that such Blue Cross Plan-hospital interaction requires can influence the nation in its search for an effective balance of voluntary and government responsibilities in the U.S. health care system which is emerging.

For an individual Blue Cross Plan, organizing hospital relationships to help in improving community health service effectiveness requires a strategy that reflects understanding of the wide variation in hospitals. The typical Plan works with about 50 to 75 hospitals that vary widely not only in size and scope of service programs, communities served and physical facilities, but also in governance capability, managerial and financial resources, involvement of physicians in management and capacity to innovate. Common exploration of the public interest by a Blue Cross Plan and individual hospitals can lead to a variety of working arrangements.

Three Basic Options. In relating to an individual hospital, a Blue Cross Plan appears to have three basic options, depending upon its own capabilities, characteristics of the individual hospital and the community setting and external forces impacting on the hospital and the Plan.

1. A primary focus on *systems efficiency,* so that the Blue Cross Plan can keep its own operating costs down, provide prompt and accurate claims processing services to the participating hospital and the subscribers it serves, and be competitive. Systems efficiency must be a key element of any Blue Cross Plan-hospital relationship, without which little more can be expected. This approach is necessary but not sufficient to meet the challenges that lie ahead.

Improvement in basic processing systems may be all that is currently possible with hospitals which are not yet prepared to face up — with their medical staffs — to the realities of increasing public pressures for reform and to the continuing erosion of institutional self-determination that is the inevitable consequence of insensitivity to the public. With such hospitals, Blue Cross can only focus on increased efficiency of mechanical systems while it seeks some basis for more dynamic interaction in the future.

In other hospital situations, a basic systems efficiency approach may be all that is immediately achievable because the hospital management team — often in a key hospital with demonstrated interest in new directions — lacks confidence in the Plan's capability to interact in terms of health care services innovation. Some Blue Cross Plans lack trained personnel with sufficient understanding of the health care setting to be able to participate effectively in working out extremely sensitive institutional and professional change processes.

Efforts to go beyond a systems relationship in the absence of mutual confidence between the Plan and the hospital is likely to result only in friction, tension and lack of results for any investment involved.

2. A primary focus on an *interdependent relationship,* recognizing that the Blue Cross Plan must represent consumer-subscribers, but can do so best when it is able to work constructively with a community-focused hospital in common efforts to balance cost containment, quality and access issues in the broad public interest.

With such hospitals, Blue Cross Plans can strengthen and expand mutually supportive activities, and increase their visibility in the community. In developing this approach with an individual hospital, the Blue Cross Plan will build on its own systems capacity, hospital management expertise and Blue Shield relationships to help hospital management and medical staff leadership to attack cost containment problems and other hospital effectiveness issues vigorously and constructively in the public interest.

3. A primary focus on a "get tough" *adversary relationship* with any hospital providers which are aggressively resisting public pressures for reform. In some Plan areas, the adversary posture of some hospitals permits no other option for a Blue Cross Plan with commitment to the public interest. Some insurance commissioners, various unions and large corporations are highly concerned about the cost of health fringe benefits; they expect Blue Cross Plans to face up to any hospitals which want to explain away rising costs rather than attack real problems.

With "adversary" hospitals, a Blue Cross Plan has little alternative but to negotiate more strongly at arm's length and demand improved performance. Sensitivity to individual hospital problems, implicit in the interdependent Blue Cross Plan relationship, is not productive in relations with such hospitals. In fairness to their millions of subscribers, Blue Cross Plans must demand performance. As hospital performance standards are tightented, some of these hospitals may be expected to shift to non-participating status.

No One Option Fits All Situations. To be effective, an individual Plan's approach to its hospital relationships cannot be based on exclusive commitment to any one of these three options, by itself. The first option, the systems approach, is superficially attractive because it correctly stresses the importance of efficient service elements which are basic to any Blue Cross Plan role and can avoid much tension and friction with hospitals. Each of the three options must involve efficient systems, but this approach, by itself, is not sufficient because it ignores the opportunities inherent in the wide diversity of hospital and physician responsiveness to public pressures. Given the magnitude of current health care service problems, an agency with only a systems superiority has a weak claim to continued existence.

The second option, the interdependent approach, also cannot be effective if applied to all hospitals. This approach requires a degree of responsiveness on the part of the relating hospital that cannot be expected across-the-board in the foreseeable future.

The third option, the adversary approach, is also not feasible in relation to all hospitals. A Blue Cross Plan can no longer be partners with all hospitals, especially those with no visible dedication to the public interest. But little innovation will come from hostile relations with all. Such an approach assumes that the Blue Cross Plan has public support and that hospitals do not; in fact, Blue Cross Plans do not

have a monopoly in the pursuit of the public interest. There are outstanding examples of public-spirited trustees and hospital executives working hard to control costs, support community planning, improve utilization and test alternate delivery systems. Furthermore, despite clear evidence of consumer dissatisfaction, subscribers and public agencies at the local level are not united in any determination to achieve massive reform of hospital service; often quite the reverse is true when parochial interests are involved. Confrontation between "bad" institutions and "good" consumers most frequently reflects an oversimplified view of a complex situation.

Matching Options and Hospitals. These three options suggest vastly different behavior patterns for a Blue Cross Plan. Some Blue Cross Plans appear to have already made the choice, consciously or not, and are already following one or another of the three options outlined above — not always adequately tuned to the realities at each hospital. Each Blue Cross Plan should be prepared to exercise all three options in relating to different hospitals at different times. The key question is not "Which option?" but "Which option for which hospital at this stage of development?".

Different Blue Cross Plans can expect to have different mixes of hospitals in the three options, depending on the characteristics of (1) each hospital's leadership and medical staff, (2) the community served and (3) the capabilities of the Plan. Each Plan should strengthen its capacity to pursue each of the three options effectively at the same time and to make wise decisions in matching options and hospitals.

Nevertheless, Blue Cross Plans should have a preference for one of the three options which Plan spokesmen can articulate, and which consumers, the public and hospitals can identify as inherent in Blue Cross Plan-hospital relationships throughout the country.

Movement Toward More Interdependent Relationships. The thrust of this report is that each Blue Cross Plan develop the second option, the interdependent approach, with as many hospitals as possible. In some Plan areas, this might involve only a handful of hospitals at first. In other Plan areas, a much larger number of hospitals might respond more quickly.

Relations with most other hospitals can reflect the first option, an increasingly disciplined "systems efficiency" approach. With some hospitals, when necessary, the Plan must be prepared to adopt the third option, the adversary approach.

Adopting the second approach as the goal — broader interaction with hospitals based on interdependent responsiveness to community interest — has much to commend it to Blue Cross Plans, hospitals and the public. The relationship between Blue Cross Plans and hospitals is the main interface between money and health programs in the U.S., and effective interaction between money and programs is the key to solution of the nation's health care problems. The hospital-Blue Cross Plan relationship has accomplished much and is in place to be built upon; society does not have to create some new instrument for the purpose. Blue Cross Plan computer and data systems and skilled hospital relations staff form an essential base for a more dynamic relationship that can influence cost, access, quality and productivity of health care services. Many Blue Cross Plan officials have understanding of hospital problems and how they can be solved, and confidence of hospital officials and public representatives. Only 69 Plans are involved; much good leadership exists; and much strength is present. Each Plan can proceed at its own pace with each hospital, reflecting the degree of innovation, tension and competence in the local culture. Each Plan should accept the challenge, but all do not have to be leaders for national impact to be demonstrated.

Working together on an interdependent basis, a Blue Cross Plan and individual hospitals dedicated to the public interest can provide local demonstrations of a new approach to health care cost containment and reform that can enrich national public policy debates and suggest a new balance of constructive voluntary-public sector interaction at national, state and community levels.

Interdependent action between Blue Cross Plans and hospitals in the public interest cannot, of course, solve all of the problems acting in isolation from other national and community forces. Health Systems Agencies, PSROs, HMOs, Blue Shield Plans, hospital associations, state regulatory agencies and a host of other public, private and voluntary organizations have key roles to play in health care reform. All other forces for change will be handicapped in achieving results in the absence of interdependent Blue Cross Plan-hospital relationships, energetically supporting and underpinning their efforts. Any realistic approach must recognize that hospitals are where the action is — the professionals, the support personnel, the patients, the facilities, the money flow, traditional community leadership and emerging new community forces. Reform requires behavioral changes in this institutional setting.

Envisioned here is a true intermediary role for the Blue Cross organization: working with committed hospitals, consumers and government in the public interest, helping each to understand the other and maintaining confidence and effective communications with each. Is this possible or is there a conflict of interest? Many suggest that a Blue Cross Plan must decide whether it is provider or consumer oriented and believe it cannot be both. This is a wrong formulation of the problem; it is inherent in the Blue Cross concept to maintain strong bonds with the public and with public-spirited professionals and officials in hospitals as well. This has always been a keystone of Blue Cross philosophy and practice, and can be adapted to solve current problems.

The interdependent approach envisioned here rests on the belief that a Blue Cross Plan and a hospital can find much common interest in working together energetically to serve the community. However, there will inevitably be instances of conflict and friction. Blue Cross Plans will tend to be advocates for the well population and the entire community, whereas hospitals will quite appropriately focus on the needs of sick patients. Total agreement is not seen; there will be disputes with individual institutions at various times. However, the imperatives of providing consumers with quality care at reasonable cost with little paperwork through service benefits require constant interactions, effective working relationships and tested mechanisms for channelling and resolving conflict constructively.

In the environment of the seventies, a Blue Cross Plan must represent the consumer interest, but it can best do so by working closely with any hospitals that wish to identify with common public interest goals and by influencing all hospitals to face the realities of public service. The remainder of this report will attempt to outline ways that each Blue Cross Plan can strengthen its capacity to relate to hospitals in the public interest, develop more of a presence in health care delivery developments and shift more of its individual hospital relationships into the interdependent option. New attitudes and policies are involved, as well as new evaluation techniques, some reorganization and possibly allocation of more resources to this effort in most Plans. Hospital associations, Blue Shield, individual hospitals and their medical staffs as well as consumer and public agencies must necessarily be deeply involved; maximum success will depend on a common effort.

II. Elements of the Interdependent Blue Cross Plan-Hospital Relationship

Implementation of the interdependent approach will require that most Blue Cross Plans work at hospital relationships with renewed intensity. Current capabilities may have to be increased; new talent and new systems developed. Frequently, some reorganization of internal and external staff activities will be called for. The Plan's conception of its role in the community will typically be enlarged to encompass new programs aimed at aiding and influencing hospitals and their medical staffs wherever possible. Greater involvement with Blue Shield and other professional and public agencies will almost certainly occur. New ideas must be developed, tested and implemented.

This chapter attempts to lay out a structured framework for analysis of all facets of a Plan's hospital relationships, with special emphasis on transitional steps in moving toward a larger number of interdependent hospital relationships.

The heart of the relationship lies at the level of the Blue Cross Plan working with the individual hospital on a day-to-day basis in common service to the public. A well planned program, involving the following ten elements, should be productive:

1. Candor and credibility.
2. Interaction mechanisms.
3. Common philosophic framework.
4. Plan performance.
5. Hospital performance.
6. Joint programs.
7. Blue Cross Plan organization of its hospital relationship.
8. Hospital organization of its Blue Cross Plan relationship.
9. Blue Cross Plan involvement with agencies impacting on hospitals.
10. Visibility.

Candor and Credibility. A sense of mutual candor and credibility is certainly a key to an effective interdependent relationship. Unless there is a sense of understanding of and responsiveness to the other party's problems and pressures, the relationship is likely to be unproductive and probably harmful to the effort of both hospitals and Blue Cross Plans

to identify with the community. In the absence of this element, response to anticipated external forces will be, at best, unpredictable and, at worst, self-destructive.

A sound relationship recognizes the right — even the obligation — of both parties to criticize the other, not only in private, but also under appropriate circumstances in public. The relationship is one of candor and credibility between the parties and with the public. It is a relationship of shared goals and interdependence, but is not a partnership that precludes differences, private or public, about the community interest.

A productive sense of mutual trust depends upon the ability of Plan and hospital representatives to exchange information and to discuss problems in a framework in which the shared information will not be used for embarrassment. At the same time, the general rule of openness and public interest can never be forgotten. In general, the more the community knows, the better for all parties involved in community affairs. Few Plans feel sufficient obligation to share data that are valuable by-products of their hospital relationships. Fear of helping the "competition" frequently exceeds the obligation to let the public — or any part of it — know.

Interaction Mechanisms. Mechanisms for regular communication between Blue Cross Plan and hospital officials are crucial. In recent years, there has been a marked trend to reduce or remove hospital representatives from the board of Blue Cross Plans. A reduction or elimination of opportunity to participate at this level requires the sensitive organization of machinery operating at other levels to obtain hospital input.

A host of instruments is available as interaction mechanisms. During the visits made to Blue Cross Plans, we found the following used successfully:

Hospital Affairs Committees - At the board level with high level staff participation.

Hospital Advisory Committees - Created by the Plan and reporting to the board of the Plan, or to the Plan's chief executive officer.

Technical Advisory Committees - In addition to general hospital advisory committees, much can be gained from technical advisory committees' providing for input of fiscal officers, physicians, medical record librarians, outpatient staff, utilization review specialists, etc.

Blue Cross Plan Relations Committee of Hospital Associations - Plans usually are members of hospital associa-

tions and participate at the board and committee level, as well as at "district" levels of some associations. In addition, many hospital associations—both state and metropolitan—have special committees and councils concerned with the Blue Cross Plan relationship.

Appeal Mechanisms - Carefully designed appeal mechanisms which have the confidence of all concerned are important. Disagreements will inevitably occur and there should be remedies short of litigation.

Structured Agenda Liaison Meetings with Each Hospital - At least one Plan carries out a formal liaison meeting with each hospital at least once annually. In moving toward interdependent relationships, a Plan is well advised to develop this particular mechanism fully.

A Common Philosophic Framework. As Rufus Rorem, a pioneer in prepayment programs, once said, "What is the essence of the hospital-Blue Cross Plan relationship? Seller or buyer? Partners in public service? Producer and consumer? Brothers in the human family? Master and servant? Producer and/or consumer cooperatives?".

Historically, the strength of Blue Cross Plans, of hospitals and of their relationship has been deeply rooted in a common philosophic framework. Sharing a few basic concepts permitted subscribers to receive care at hospitals with little financial effort at the time of illness.

Little energy was expended by individual Blue Cross Plans or hospitals in the early, busy days in formulating precise statements of the common purposes and sense of mission on which the operating relationships were based. In many Plan areas, there is evidence that a few courageous, hard working, devoted leaders with a sense of mission and public interest shaped the relationship and carried the day with energy and results rather than with rhetoric or consensus exercises.

In more complex times, there are dangers in this approach. Lack of clearly stated concepts and basic principles can result in erosion of apparently strong ties. Too often, there is an apparent lack of vision. Managers are schooled in technical disciplines and quantitative techniques and can become preoccupied with them. The advice of lawyers and accountants may dominate the outlook of the chief executive officer. These viewpoints must be tempered by a community point of view of the broad public interest. Where is the field going? What does it believe in?

Although almost forgotten in some Plan areas and not clearly articulated in most, the philosophical fundamentals of a sound interdependent relationship have not changed:

- -A belief in pluralism in organization and financing of services the public requires.
- -Support of a flexible non-profit voluntary sector.
- -A commitment to community.
- -Concern with costs and efficiency.
- -Service benefits.
- -Commitment to the hospital as a continuing evolving institution with the potential to serve as a major organizing focus for comprehensive health care services and for balancing community and professional interests and aspirations.

A joint statement of philosophy, describing goals and working relationships, can be a source of strength to Blue Cross Plans and hospitals. As a public statement, such a document can be used over time to assess behavior against the spirit it contains.

Basic Plan Performance. There is no substitute for good performance. In its interactions with hospitals, a Blue Cross Plan must master computer and related technology and operate effective EDP systems. A Plan must get and maintain subscribers, process claims, answer the phone, etc. A good hospital relationship requires smoothly running Plan functions as they relate to hospitals. Money must flow in the right amount at the right time with a sensitivity to the extraordinary cash flow problems of hospitals. Audits must be done on time and with a sensitive interaction about exceptions. When operational problems develop, there must be ways to get after them quickly.

Several Plans have handled basic hospital services with great effectiveness through well trained provider representatives, special phone numbers and other devices. Plans are experimenting with direct hospital access to Plan files to permit eligibility verification. Blue Cross Plans and hospitals can work together on many more imaginative ways of using new technology; a few Plans are well along in developing paperless claims processing. But it is easy for a Blue Cross Plan to become too rigid and preoccupied with internal operational systems requirements and unresponsive to hospital problems.

Blue Cross Plans have yet to develop and publish reports of statistics which illuminate Plan performance from the

hospital point of view, similar to the performance standards designed for Medicare. Some of the performance standards in use within the Blue Cross organization go far in this direction. Those on eligibility response times and claims processing are directly relevant.

In the absence of systematic effort by a Blue Cross Plan to market its basic services to hospitals and their medical staffs, as it markets services to governmental and subscriber groups, there is frequently a lack of appreciation among hospitals of the effectiveness of Blue Cross Plan services. In many instances, Plans have a record of solid performance which is not documented and is further obscured by the tendency of some hospital fiscal officers to distort operating procedures and magnify the importance of isolated unfortunate events.

Thus far, we have not heard of any effort by Plans to develop techniques for evaluating Plan performance with active participation of contracting hospitals. However, a variety of technical hospital advisory committees does exist in many Plans which can be used for this purpose. A desirable by-product of such an effort might be the opportunity for hospitals to make accurate comparisons of Blue Cross Plans with other carriers.

Basic Hospital Performance. Hospital performance is at least as important as Plan performance to the public being served. In an effective relationship, the Blue Cross Plan can play an important part in a joint effort to define and measure effective hospital performance. The goal is that a subscriber-patient receive good service from both, at reasonable cost, with value added by the relationship.

At this time in the history of hospital-Blue Cross Plan relationships throughout the country, this is the weakest, least understood, most controversial and probably the most important of the elements.

Many hospital representatives appear to believe that basic hospital performance is none of the Plan's business. Some Blue Cross Plan executives seem to accept this point of view. Other Blue Cross Plan representatives appear to believe that a Plan can take major hospital cost containment initiatives without active top level hospital support or participation. The fact that some Plans do have some success under such circumstances clearly indicates the inherent power of the relationship and the amazing unused potential of a more dynamic relationship.

The public increasingly understands that 90 to 96 percent of Blue Cross premiums reflects hospital performance and medical staff decisions; less than 10 percent reflects direct Blue Cross Plan activity. Concern at Blue Cross Plan rate increase hearings may zero in on Plan executive salaries, reserves and overhead, but increasing attention focuses on the payments for hospital and medical performance — and what subscribers get for what they pay.

Rising expenditures for hospital service cannot be adequately explained in the absence of performance standards and clear-cut efforts to raise performance levels and standards with active involvement of the medical profession. Greater Blue Cross Plan initiative is called for in this type of activity.

To date, the hospital field has not developed systematic cost effective performance standards or programs designed to administer them, although the AHA's Hospital Administrative Services Program and some planning agency guidelines represent a good beginning. The standards of the Joint Commission on Accreditation of Hospitals offer a useful model, but have not yet addressed the issue. The AHA has come much closer to the basic questions in development of its Quality Assurance Program and Blue Cross Plans have developed imaginative joint programs with hospitals around Quality Assurance Programs. Much the same kind of thing can be done by Blue Cross Plans and hospitals with the current AHA initiative in promoting cost containment committees at individual hospitals.

Joint Programs. Given all of the above interactions between Blue Cross Plans and hospitals, joint programs are an inevitable consequence of an effective relationship. Good works, conducted together, demonstrate the validity of Blue Cross Plan-hospital relationships. In many areas, talented and aggressive hospital associations can be a source of energy and ideas.

The communities' institutions for providing care and the community institution for financing care may be independent of each other, but this does not preclude overlap and sharing of activity. Efforts to put the organization and financing functions in separate compartments can lead to sterility of relationship, missed opportunities and loss of public support. Blue Cross Plans can engage in a variety of joint programs with hospitals, over and above those functions that characterize a basic commercial insurance operation.

There are many examples of good joint programs — the CASH program in California, shared computer programs in Pittsburgh and many other Plans, prospective rate and incentive reimbursement experiments in several Plans, uniform billing forms, in-service training programs, HMO developments, shared methods engineering services and others.

But because this is a difficult area and can only come out of a relationship that is good in many other ways, there are few persistent patterns here and success tends to be isolated. Joint programs have probably not been regarded as an important goal of Blue Cross Plans or hospitals. But tremendous opportunities await the ambitious. Existing ideas can be elaborated and replicated. Innovation seems possible since little systematic attention has been given to this. With many Plans handling 50 or 60, even 80 percent of hospital money, can business operations be more coordinated with paperless claims processing and the resulting economies achieved? This could favorably affect a Blue Cross Plan's administrative costs and competitive position. Can hospitals and Plans and planning agencies get together and be forces of reason in support of coordinated public and private sector health development, as contrasted to massive government intervention? Can Plans and hospitals work together to develop health education for subscribers in the community, as well as for sick patients with particular disease problems? Can research be conducted jointly to learn more about the effectiveness of given delivery patterns?

Because organization, financing and administration of health care services are so bound up together, new ways will be found to link these various elements outside of Blue Cross Plans if the Plans do not take more initiative in demonstrating the value of joint programs with interdependent hospitals. There is already some tendency for functions which might stay wholly or partially within the relationship to move outside of it. New corporations to gather data are one example; PSRO is another; hospital planning is another; the rate setting commission is another. As planning agencies continue to evolve slowly or fail completely in some areas, a dynamic Blue Cross Plan-hospital relationship might find opportunities for renewed planning initiatives.

Destructive competition with active state and metropolitan hospital associations is to be avoided. Rather, hospital associations which wish to develop cost effective programs should be given assistance and support. But the ability of Blue Cross Plans to work with individual hospitals makes it possible for them to develop a variety of joint programs that the hospital association might not be prepared to initiate.

Blue Cross Plan Organization of its Relationships with Hospitals. All of the activities involved in Blue Cross Plan relationships with an individual hospital should be organized within the Plan in the most effective manner for marketing to member hospitals and for constructive impact on each hospital. This seems so obvious that it is easy to overlook. There is a wide variety of implications, each of which may result in minor or major adjustments in the organization of the individual Blue Cross Plan.

Often the quest for internal efficiency of Blue Cross organization elements can result in neglect of effective coordination of activities with individual hospitals. No short-term payoffs are seen and, in an effort to keep administrative costs down, the budgets for hospital relations suffer. Thus while the Plan's own administrative costs may look good, dollars represented by the share of the Blue Cross Plan premium going to hospitals may be rising rapidly, and with little restraint or influence from any Blue Cross Plan-hospital interaction.

We attempted to learn how many Plan employees and dollars are devoted to "hospital relations." However, there are few data available, and definitions which would permit comparisons do not yet exist. Better manpower and financial data are highly desirable, but an updated conceptual frame of reference will be required before the hospital relationship effort can be measured. The Blue Cross Plan dollar should be divided into three pieces rather than two. Instead of the traditional two-way split of the premium dollar between hospitals (95 cents) and the Blue Cross Plan (5 cents), there should also be separate identification of a quite thin third slice (a fraction of a cent). This slice would reflect Blue Cross Plan expenditures directly influencing hospital operations beyond what is necessary for basic insurance management. Identification of some fraction of a percent of premiums for this purpose can be sold to public and private markets when the potential impact can be seen in relation to the total expenditure.

A thoroughly developed hospital relations function will require change in most Blue Cross Plans; more personnel with hospital and health care service education and experience may have to be brought into the Plan structure. Often this will strain existing salary structures, since hospital salaries have been rising recently. But personnel employed can be counterproductive unless they command the respect of hospital leadership and are able to work with and understand their problems. Envisioned here is not a group of professional glad-handers spreading good will, but rather an active and energetic management of the hospital-Blue Cross Plan interrelationship. A large influx of expensive new people is not envisioned, but rather a few well qualified individuals who can help to coordinate and organize the activities of all Plan personnel involved in any way in hospital interactions.

Each Plan's approach to an interdependent hospital should involve an individualized plan for coordinating and expanding activities and furthering mutual public service goals, plus designation of a well qualified liaison representative for coordinating all Plan activities relating to each interdependent hospital.

Movement toward this kind of arrangement within a Blue Cross Plan inevitably creates certain pressures and tensions within the Plan which will require close attention by top level Plan management. The hospital relations specialists often become ombudsmen or advocates for the point of view of interdependent hospitals. As a result, there may be abrasiveness with other Plan personnel with a more internal focus and inability to distinguish among adversary, interdependent and uncommitted hospitals. But with appropriate balance provided by the Plan president, benefits of better organization of the Plan's hospital relationships can be significant, with improved performance from both hospital and Plan points of view of the public interest.

Relationships with hospitals and hospital associations, and the effort to maintain a Blue Cross Plan presence in the health community must be closely coordinated within the Blue Cross Plan. Usually one organization unit within the Plan will be the main focus of this effort, but functions will necessarily be spread among other divisions. There is no best way to organize a provider relations function; indeed a consciousness of provider affairs widely spread through the Plan is essential.

Hospital Organization of its Blue Cross Plan Relationship. The Blue Cross Plan is important to virtually all hospitals, even in low penetration areas. Almost every hospital in the United States receives at least half its income through the Blue Cross Plan, including Medicare and Medicaid payments. Even where the plan is handling three-quarters or nine-tenths of the institution's money, there are virtually no indications that any hospital executive has thought deeply about all of the elements of the relationship and organized the hospital management team to take advantage of the full potential of Blue Cross Plan interactions. But neither Blue Cross Plans nor hospital associations have suggested this approach to date.

A hospital committee might be formed, involving medical staff and board as well as management, to review the relationship on a continuing basis, to analyze strengths, weaknesses and opportunities. Reimbursement levels could be reviewed; Medicare policies discussed; scope of service reviewed in relation to benefit patterns; controls identified; or eligibility determination and payment cycles reviewed. Contrasting and sometimes conflicting pressures of consumers and professionals can be brought into better focus. If key personnel understood Blue Cross Plans better, it might help overcome the often simplistic references to third parties and their controls. Blue Cross Plan staff might be invited to attend selected hospital committee meetings. Assignments for ongoing liaison with Blue Cross Plans should be made, involving at least the chief fiscal officer and the chief executive officer. Such an activist conception of the Blue Cross Plan relationship by the hospital should improve performance under current programs and identify new areas where coordination could be beneficial.

Blue Cross Plan Involvement with Agencies Impacting on Hospitals. A Blue Cross Plan with effective relationships with hospitals will feel an obligation to become involved with a wide variety of health agencies in support of the public utility of the relationship. The Plan will have an important health presence throughout its enrollment area. The Blue Cross Plan will be active with a variety of voluntary and governmental agencies which affect or are affected by the organization and financing of hospitals: United Funds, HSAs and other areawide planning agencies, Blue Shield and a variety of medical societies and other associations of professionals, health data system agencies, PSROs, state regulatory agencies, Medicare, Medicaid and other governmental programs, etc. Relationships with hospital

associations and participation in their affairs will be an area of special focus. In each instance, the Plan will be alert to assure that these health agencies know of the significant community interest dedication that a sound hospital-Blue Cross Plan relationship represents. In addition, the Blue Cross Plan will be alert to ways in which these health agencies can be supportive and make maximum use of the relationship in carrying out a wide variety of functions related to improved effectiveness of hospital service. By this means, the Plan can save individual hospitals a great deal of duplicate and unnecessary work with these agencies.

Visibility. A healthy Blue Cross Plan-hospital relationship, in which separate accountabilities are preserved but interdependence is recognized, should be public information. Everyone should know how a Plan and a hospital are helping each other do the best possible job for patients, subscribers and the community.

The goal of the interdependent relationship is improved capacity of both parties to serve the public. Achievement of that goal requires that the public know the facts and be able to evaluate the results.

In addition, both the Plan and the hospital should publicly reflect their belief that interaction between the community's hospital service and financing agencies can serve the public interest and can help to improve the overall health care system locally and nationally.

Visibility of the interdependent relationship should be incorporated into all formats through which the hospital and Plan communicate with the public. Joint conferences of Plans and interdependent hospitals with representatives of important subscriber groups and public agencies are especially important.

An effort to concentrate on the goals and results of the interdependent relationship might move critics away from discussions of whether the relationship is too close or distant and toward consideration of how well it works for the people.

Conclusion

Taken together, these elements lay out a major new emphasis for Blue Cross Plans with far-reaching implications. Some specific recommendations to these ends are made in Chapter IV. The task will be difficult and tax the energy and vision of all Blue Cross Plans. Major work with hospitals is envisioned, carried out in a context of public accountability. Successes with interdependent hospitals will lead to policy shifts at previously uncommitted "systems oriented" hospitals and at "adversary" hospitals. As progress is made, subscribers, insurance commissioners, legislators and others must know about the effort and its implications. A few simple ideas are the core of it, but they have great potential for addressing almost every important issue in health care. Mistakes will be made but the time is right for new directions. An interdependent Blue Cross Plan-hospital relationship does not represent "the answer" to cost effectiveness problems, but offers an approach that is reasonable and that can be evaluated and measured over the years.

III. Views of the Blue Cross Plan-Hospital Relationship

In the course of our investigations, we encountered a variety of reactions to the concept of an interdependent Blue Cross Plan-hospital relationship designed to serve the public interest. Almost every reaction was closely related to personal viewpoint about (1) the nature of the nation's health care problems and feasible solutions, (2) the future role of the voluntary hospital, and (3) the future balance between the public and voluntary sectors of the nation's evolving health system. Efforts to enhance the effectiveness of interdependent Blue Cross Plan-hospital relationships must anticipate and prepare for these reactions.

Hospital Associations. The official position of the American Hospital Association, developed in conjunction with the BCA and adopted in 1972, is strongly supportive of interdependent Blue Cross Plan-hospital relationships designed for joint action in response to pressures for increased productivity and accessibility to care (see attachment at end of this chapter). The policy statement emphasizes that "the delivery of health care is basically a local matter and that service without financing and financing without service are both impossibilities. Meaningful solutions, therefore, can only be achieved through joint action at the local level . . . The future strength of the voluntary system of service and finance is dependent upon its ability to respond positively . . . and demonstrate significant progress . . . It is recommended that joint Blue Cross Plan/hospital mechanisms be developed for assisting, along with other appropriate community organizations, in defining problems and identifying, implementing and evaluating potential solutions."

The statement indicates that joint Blue Cross Plan-hospital action can serve "not only to resolve local problems . . . but also to integrate the service and financing arms of the private sector into a force capable of resolving complex issues of concern nationally."

This same official position was adopted by the BCA Board of Governors, as one follow-up to the 1971 joint memorandum on "AHA-BCA Organizational and Operational Relations".

Unfortunately, a series of distractions (national price controls, gap between leaders, etc.) interfered with implementation of the American Hospital Association's position, which has not yet been actively promoted through metropolitan and state hospital associations, or interpreted to association member hospitals in terms of operational implications for them. Many individuals associated with the AHA appear to support a purely systems approach and avoidance of any distinction between hospital relationships of community-based Blue Cross Plans and national commercial carriers. Implementation of the official position is long overdue, especially in view of the current initiatives of the American Hospital Association in hospital cost containment.

State and local hospital association executives tend to reflect a wide variety of reactions to the concept of an interdependent Blue Cross Plan-hospital relationship, based on their understanding of the AHA's direction as well as the pressures in their particular association area. Some newer association executives tend to be more committed to an expanded role for state government in direct controls rather than dynamic interaction with Blue Cross Plans in response to public pressures. Most recently, however, some disillusionment with the rigidities of government regulation seems to be setting in, which may open opportunities for reassessment of Blue Cross Plan relationships. In many areas, long-standing good relationships between Blue Cross Plans and hospital associations exist and have served the community well. A few of these, faced with tremendous social pressures, are experiencing difficulties in the absence of systematic assessment of interdependent goals by the hospital association and the Plan.

Hospital Executives. In our discussion with individual hospital executives, we observed tough-minded assessment of the Blue Cross Plan relationship based on the Plan's systems performance and its demonstrated understanding of and responsiveness to individual hospital problems. The extent of sensitivity of hospital managers to external pressures for change and recognition of the necessity to respond was greater than anticipated. Individual hospital executives typically viewed their Blue Cross Plan in a favorable light and, when stimulated to think about future health system developments, many readily accepted the idea that Blue Cross Plans should move into new roles in NHI, for example.