AFFIDAVIT OF ROBERT CUNNINGHAM III

1.

My name is Robert Cunningham III. I am a Maryland resident currently employed as editor of Medicine & Health Perspectives, a weekly newsletter on health policy based in Washington D.C.

2.

I am the principal author of *The Blues: A History of the Blue Cross & Blue Shield System*, published in September, 1997 by Northern Illinois University Press in De Kalb, IL. This history was commissioned by the Blue Cross and Blue Shield Association (BCBSA) in Chicago and was begun by my father, Robert M. Cunningham Jr., in 1988. I took over the project from my father in 1990, after he was incapacitated by illness. At the time he began the history, my father had retired as longtime editor and publisher of The *Modern Hospital* magazine (now Modern Healthcare) and was working part-time as a consultant to BCBSA. He died in 1992. My work on the history was subject to an agreement that BCBSA would not interfere with the content of the history, and that our mutual goal was to seek publication by a trade publisher or university press as a validation of the work's objectivity. The text was peer-reviewed by three academic experts before publication, according to the usual procedure for university presses.

3.

Sources for The Blues include archival records of BCBSA and the Empire Blue Cross and Blue Shield archives in New York City, including minutes and transcripts of various BCBSA proceedings, published and duplicated studies and reports produced internally by BCBSA, documents collected in the BCBSA archives from Blue Cross and Blue Shield plans, a large collection of audiotaped and transcribed interviews with early Blue Cross and Blue Shield leaders, and an unpublished history of Blue Cross by James Stuart. Other sources included published materials, news reports, and interviews.

4.

This affadavit summarizes information from the book describing some aspects of the roles and relationships filled by Blue Cross and Blue Shield plans in the communities they serve. All of the information in the book and this affadavit is based on personal knowledge that I acquired by study of the sources named above..

5.

The first Blue Cross plan began in 1929 in Texas as an experiment to provide hospitalization insurance to members of the community at an affordable rate. That year, Baylor University hired Justin Ford Kimball, formerly a superintendent of schools in Dallas, to provide oversight of the University's medical education and help shore up the shaky finances of Baylor's hospital. With occupancy rates falling and patients unable to pay their own bills, Mr. Kimball set out to establish a plan that would help hospital patients pay their bills and keep the hospital alive.

6.

Having previously established a sick benefit for the Dallas teachers ten years earlier, Mr. Kimball used this same teacher organization to initially explore prepaid hospital coverage. Kimball's proposal virtually coincided with the October 1929 stock market crash, which added urgency to the teachers' worries about economic security and increased their interest in Kimball's hospital prepayment plan.

7.

The Baylor prepaid hospital plan was created to be distinct from traditional commercial insurance. An early brochure announced that, "Baylor uses no sales agency or middlemen, but prefers to deal directly with each group so that all group hospitalization fees paid may be used only for hospital care of members and not for any personal profit." (Texas Blue Cross and Blue Shield, Advance, June 1989 at page 6). The original Baylor plan gave Dallas teachers twenty-one days of hospital care for $6 per year. The Texas Department of Insurance determined that the Baylor plan was not in the business of providing insurance. Described by Kimball's assistant Brice Twitty as a "godsend to thousands," the plan attracted more than 1,300 teachers initially and within five years, more than 408 employee groups with more than twenty-three thousand members were covered by this new type of plan.

8.

It did not take long for the concept of prepaid, nonprofit health care coverage as envisioned in Texas to take root in other parts of the country. As the 1930s began, gaps in health care coverage were widening. Families and individuals were faced with hard choices and hospitals were increasingly facing financial difficulties. As a hospital executive and future Blue Cross executive stated,

I could remember the difficulties we had then, trying to keep our doors open. . . . People brought chickens in and meat to pay their bills. They would paint or do work around the hospital of some kind. . . . Nurses would come in and beg us to give them a job without pay, for room and board, because they were starving.

(Fritz Lattner, interview with Odin Anderson, page 4).

9.

As plans developed in other states, improvements were made to the Baylor model, the most basic being an expansion of coverage to most or all hospitals in a community rather than just one. he first multi-hospital plan began in New Jersey in 1931. Frank Van Dyk was hired as the executive director of the Essex County Hospital Council to collect overdue bills from patients at the seventeen hospitals affiliated with the council. In the early 1930s, Mr. Van Dyk's job was difficult as

families needed every penny to keep warm, dry and fed. They did not have the money to pay hospital bills. 'It occurred to me what a wonderful thing it would be if you could remove the cashier's window from the hospital. . . . There ought to be a better method of doing things¼. Everywhere in the state people had to put off going to the hospital because of inability to pay.'

(Frank Van Dyk, interview with Odin Anderson, page 2).

10.

Like its counterpart in Texas, the New Jersey plan was formed as a nonprofit corporation. It offered up to twenty-one days of semiprivate hospitalization for $10 a year, not including maternity or dependent care. Soon after, the plan added dependent care and, within a year, six thousand people were covered and thirty hospitals were participating.

11.

Support from leaders in the community and community engagement were characteristic of the early Blue Cross plans. The Cleveland Plan was started with a special city welfare

federation grant of $7,500. By the mid 1930's the Cleveland plan had engaged people and organizations from throughout the area to assist in promotion.

Wherever the Plan secured and kept such public identification, the membership growth was rapid and beyond the dreams of the most optimistic manager. In these areas, governors and mayors proclaimed Blue Cross enrollment periods, service clubs took part in promotion, Boy Scouts delivered enrollment material to prospects, and clergymen from the pulpit urged people to enroll in this community enterprise. Such promotion could not be bought at any price.

(James E. Stuart, "Blue Cross Story: An Informal Biography of the Voluntary Nonprofit Prepayment Plan for Hospital Care").

12.

One of the early leaders in the Blue Cross organization stated, "[i]t soon became obvious . . . that a general community need could not be met through single-hospital service Plans." (Stuart, "Blue Cross Story"). In 1934 the American Hospital Association (AHA) formally approved the concept of group hospitalization plans. C. Rufus Rorem, who led the AHA's efforts to provide support and guidance to the plans, identified the common principles desirable for the fledgling plans as nonprofit ownership, free choice of hospital and physician, appointment of doctors and community leaders to governing boards, financial integrity, and "dignified promotion." Rorem stated that the

pioneers in the voluntary hospitalization movement were not philosophers. They were not social reformers. They were social organizers. The voluntary Plans were an attempt to organize the public buying power on a voluntary basis, without the disadvantage of political control, a means by which an employed group of people could finance medical care for itself. They were dealing with a practical problem in a practical way.

(C. Rufus Rorem as cited in Margaret Albert, A Practical Vision, 1987, a history of Blue Cross of Western Pennsylvania).

13.

With hospitals acting in loco parentis in the 1930s, the early Blue Cross plans received a value system in the tradition of the private, not-for-profit hospital that then dominated the American health system. The voluntary spirit was reflected in the fundamental differences between the plans' approach to paying for care and conventional underwriting practice. The keys to this approach were the concepts of the service benefit and of a single, community wide premium rate.

14.

Throughout the country, most of the plans offered the same rates to all subscriber groups regardless of age, sex, occupation, or other characteristics that might affect hospital utilization. It was not until the for-profit commercial insurers began to move into the health insurance market did the Blues plans begin to question whether their efforts to provide community rating should continue. Blue Cross plans did not begin to set rates based on the claims experience of employee groups until the 1950s.

15.

As more local communities initiated plans, the AHA's Committee on Hospital Service, created in 1936, determined that it would offer "associate institutional membership" to any nonprofit organization that met specific standards. The committee's initial role involved issuing approval certificates for nonprofit plans which met the standards.

16.

Among the standards first instituted in 1937 were the requirements that: membership plans be nonprofit; the board of each plan include representatives from local hospitals, the medical profession, and the general public; all hospitals in a community be given the opportunity to participate in the plan; plan employees receive salaries rather than commissions; and hospitals be reimbursed based on costs in order to get the best coverage to the largest possible number of people at the lowest possible cost. The standard requiring reimbursement based on costs was difficult to agree on.. Too low a price would break the hospitals and too high a price would break the plan, so rates had to be decided by good faith negotiations. In the nonprofit environment, rate negotiations were not seen just as a game of winners and losers.

17.

A formal process for plan approval by the AHA began in 1938, and only those plans that received approved could use the Blue Cross symbol and name.

18.

With the growing public reliance on prepaid hospital plans, there also arose a demand for coverage for medical services. Physicians were more resistant than hospitals to the concept of prepaid plans, fearing among other things a violation of the physician and patient relationship. But doctors were experiencing difficulties getting their bills paid and the public continued to feel the financial burdens of paying for medical care. In response to growing public pressure throughout the country, doctors and state and local medical societies began to develop group and individual prepayment arrangements.

19.

The first successful prepaid medical plan began in California in an effort to cover five thousand workers building an aqueduct. Soon thereafter, under the guidance of Henry J. Kaiser, whose construction company was involved in the aqueduct project, a successor plan began that was open to other employee groups -- and still exists as Kaiser Permanente Health Plan. Not far behind Kaiser, the California Medical Association (CMA) launched its own voluntary prepayment plan in 1939 and the American Medical Association (AMA) began to seriously consider, rather than simply resist, the concept of prepaid medical care.

20.

Also during the 1930s, President Roosevelt, in conjunction with development of the social security program, established a committee to investigate the establishment of a national health insurance plan. While these early efforts at national health insurance by the Roosevelt administration were abandoned, the medical establishment's steadfast resistance to prepaid health care coverage evolved into a more tolerant posture. In California, the CMA offered a nonprofit service-oriented prepayment plan for voluntary private coverage, partly to bolster doctors' incomes and partly to hold back the attempt to institute compulsory insurance. The

state insurance department initially objected to the categorization of the CMA plan as a "nonprofit" instead of an insurance company. After seven years of litigation, the U.S. Supreme Court held that that the plan was appropriately categorized as "nonprofit" and should be exempt from state insurance laws.

21.

Local autonomy was the guiding principle governing the development of the Blue Cross and Blue Shield system.. The plans gradually became more financially independent from the hospitals and medical societies that helped found them and maintained a commitment to strong public representation on their governing boards. The Blues plans saw themselves as the "intermediary" between the needs of the community and the needs of the hospital networks. The 1947 report on Blue Cross Blue Shield plans by the Federal Security Agency of the US Public Health Service discusses the evolution of public involvement in the Blue Cross plans:

A new Plan which the hospitals have started and which they underwrite is in a very real sense a creature of the hospitals. However, as the Plan grows it stands more and more on its own feet. . . . After a certain stage it would seem that dominant control should shift to the public. . . . When the children have grown, when they support themselves, then parental control is no longer desirable or possible.

(Louis Reed, Blue Cross and Medical Service Plans, 1947.)

On the sometimes misunderstood question of who contolled the plans, Reed found in a survey of 39 plans that for the most part, 'provider interests' did not necessarily dominate. In general, 60 percent of hospital representatives [on Blue Cross governing boards] were trustees rather than administrators. The were civic leaders who were successful men of affairs in business, banding, or law:

In any conflict of interest between the two, such as might arise over remuneration, he [the trustee representative] will generally try to weigh the interests and the needs of both [hospital and subscriber...(Reed)

Reed calculated that 57 percent of the Plan directors surveyed could be classified as representatives of the public.

22.

During the 1940s, there was a growing effort -- despite the actuarial hazards involved -- to offer direct enrollment to individuals as well as groups, recognizing "that their social purpose and public relations require that the opportunity of enrollment should be available to all." (Reed) Plans began to use yearly community enrollment drives, providing an enrollment window opened to the general public. This proved to be a successful tactic for increasing enrollment both in the cities and in rural areas. Media and civic organizations promoted the enrollment campaign, treating the plans as a public service. The techniques varied by state but essentially included a limited period of time during which individuals could sign up for coverage and promotion of the full support of the medical community. In small communities, local civic organizations such as farm bureaus, women's clubs and the Red Cross would help sponsor and carry out the campaign on behalf of the plan.

23.

Amid efforts to strengthen their national organizations and compete more effectively with commercial insurers for the business of large, multi-state employers, the Blue Cross and Blue

Shield plans began contracting with the Dept. of Defense in 1956 to provide coverage for military dependents. In 1957, representatives of the Blue plans began negotiations with federal officials to design a program of health coverage for 5 million federal employees and dependents, culminating in the signing of legislation in 1959 creating the Federal Employees Health Benefits Program (FEHBP). The biggest difficulty for the negotiators representing the plans was that to participate in the FEHBP, the plans would have to be able to agree to a uniform structure of rates and benefits for federal employees all over the country, although the small negotiating team in Washington had no explicit authority to make commitments on behalf of the approximately 130 separate and independent Blue Cross and Blue Shield plans then in existence. But the volume of business involved and the prestige of entering a major business partnership with the government were powerful inducements to make the new arrangement work:

"It's bigger than both of us. We don't dare tell the government we can't respond," National Association of Blue Shield Plans representative Ed Werner said at one meeting. "There were some plans that would have preferred not to play but didn't want to be the ones to say, 'We can't do it,'" Werner said later. "It's a very big moment in the history of Blue Cross and Blue Shield."

(Werner, interview)

24.

As the private, primarily employment-based health insurance market began to mature in the 1960s, the limitations of the private coverage system for meeting the health costs of the aged, because of their reduced income and increased vulnerability to illness, became increasingly apparent. Discussion and debate on national health policy for the aged simmered through the 1950s, became a high-profile national issue in the 1960 presidential election, and continued to build as the decade progressed. The Blues plans recognized the problem of elderly uninsured but were extremely wary of the government's ability to respond to the problem effectively.

25.

In 1954, Congress asked the AHA for actuarial data on the costs of providing a prepaid plan to retirees. The AHA and the Blue Cross Commission then established a special Joint Committee to Draft Legislation for the Aged, Indigent, and Unemployed. The committee found that the cost of hospital care for the elderly was three to four times higher than the younger population. After collecting actuarial information, the Blue Cross Commission and the AHA drafted a legislative proposal creating a federal program that would provide prepaid coverage to elders and the poor through a federal matching program. While the proposal did not go forward, it was apparent that the Blue plans' relationship with Congress and the administration became increasingly more intimate and sophisticated.

26.

By the mid 1950s, many of the Blue plans had established relationships with county and municipal governments to work together in an effort to make care more available to the elderly and indigent. In Colorado, for example, the state created an "old age pension plan" whereby 85 percent of the state's excise taxes were used to fund a minimum monthly income for Coloradans over sixty five. By 1957 the surplus in the fund had swollen and voters approved a new constitutional amendment to use the surplus to fund a health care program for the aged. In partnership with the state, the Blue Cross and Blue Shield plans were responsible for administering the new state program, offering benefits that virtually mirrored the plans' benefit packages.

27.

In 1959, Congress attempted to fill many gaps in health care coverage by amending the Old Age Assistance ("OAA") program. The amendment sought to increase medical assistance for welfare recipients through federal and state matching funds. In addition, Congress added a proposal to create the Medical Assistance for the Aged ("MAA") program which would make health care available to people age 65 and over with low or moderate incomes. The MAA program also required state matching funds. By 1960, both proposals became law. Because many of the states did not have the resources to provide matching funds, not all states implemented these programs.

28.

Blue Cross and Blue Shield of Texas was one of a handful of Blue Cross plans that began to work with states to administer the MAA portion of the Old Age Assistance program. Ten percent of elders on OAA lived in Texas. In Texas, the Blue Cross plan worked with physicians, hospitals, and the state welfare department. Thinking that public opinion would not permit them to earn anything for themselves, Texas Blue Cross and Blue Shield underbid its commercial competitors by pledging to administer the program with overhead costs of 3 percent or less. Despite this tight administrative constraint, within the first two years the plan was doing well enough to expand benefits and return a surplus of $100,000 to the state. The program, funded with 75% federal funds and 25% of Texas state funds, offered comprehensive benefits that met the needs of elder consumers. As the head of the Texas Blue Cross plan said, "if every state could do what Texas has done, we wouldn't have any problem about the aged." (Walter McBee at the BCA annual meeting, 1963).

29.

Lyndon Johnson's landslide 1964 presidential victory produced a Democratic majority in Congress strong enough to propel legislation forward that eventually took the form of a "three-layer cake" that combined a Social Security-based hospitalization insurance program for the aged (Part A of Medicare), premium and general fund-based medical coverage for the aged (Part B), and an enlarged state-federal program for the poor (Medicaid). The expertise and data possessed by the Blue plans were in constant demand. "We became a very integral part of the discussion in Congress," Blue Cross Association President Walter McNerney said later (McNerney, interview with Lewis Weeks). The Blues' representatives consistently urged that the existing, private payment system be used in the program Congress was designing, and and that legislators not reinvent the wheel by building a new public system from scratch.

30.

The imprint of the private sector model is apparent in the shape of the resulting federal Medicare program.. Replicating the Blue Cross and Blue Shield system, and medical insurance programs were bifurcated, with hospitals receiving cost-based reimbursement and doctors paid on a "usual and customary" charge basis similar to what leading Blue Shield began to develop in the 1960s. When the Social Security Administration gave hospitals the opportunity to choose their "intermediaries" – health plans responsible for administering and reviewing claims under the Medicare Part A program -- the hospitals chose Blue Cross plans as intermediaries in 31 states, representing 90% of the beds in all participating hospitals. Out of 49 "carriers" – the administrators chosen by the Secretary of Health, Education and Welfare for Medicare Part B -- 33 were Blue Shield plans, covering 60% of eligible beneficiaries. In the beginning, the Social Security Administration, which was delegated with the responsibility for overseeing the Medicare

program, ackowledged their need for Blue Cross and Blue Shield plans and other insurers to teach them. As a result, the role of the Blues as intermediaries in the development and administration of the Medicare program was very significant.

31.

Concern over rising health care costs deepened in the 1970s, and Blue plans in many states collaborated with state officials and others in seeking to rein them in. In 1972, for example, after negotiating a series of cost-control efforts with Blue Cross of Greater Philadelphia, Pennsylvania Insurance Commissioner Herbert Denenberg suggested that the public interest "might best be served by the federal government's granting a health insurance monopoly to Blue Cross and Blue Shield and other similar nonprofit insurers." (Saturday Review, 7/1/72) In response to public pressure, 35 Blue Cross plans claimed consumer majorities on their governing boards by 1972. In about a dozen states, Blue plans were among leading participants in voluntary efforts to control hospital cost increases in the 1960s and '70s with experiments in budget reviews and rate setting, or prospective payment, foreshadowing future development of Medicare's system of diagnosis related groups, or DRGs, in the 1980s.

32.

In the 1980s and 1990s, as concern about the affordability and accessibility of coverage continued to grow, Blue plans participated in further voluntary efforts in many states to control costs and enhance access with special products such as "bare bones" coverage and special programs for children. Blue plans still acted as "insurer of last resort" in 20 states in 1995, often being required by law to offer coverage to all comers.

33.

In 1986, Congress curtailed the tax-exempt status of BCBS plans. The national BCBS Association representatives argued to Congress that while they might have evolved into business corporations, they still retained the special character of a nonprofit plan, providing "a unique community service." (Interview with former Blue Cross and Blue Shield Association President Bernard Tresnowski). Despite the curtailment of federal tax-exempt status, most of the BCBS plans at that time continued to remain nonprofit and many often maintained tax exemptions under state and local laws. As Tresnowski stated,

We remain special, and thus essentially different from our competitors - as we always have been. The task now becomes one of converting this new circumstance to our competitive advantage by emphasizing the characteristics that distinguish Blue Cross and Blue Shield Plans from all others - community origins, community ties, small group recognition, unique hospital and physician relationships - along with strong name recognition.

(Tresnowski, "Report to the Plans, 1986," page 7.)

In 1994, after a vote by the member plans, the Blue Cross and Blue Shield Association eliminated the requirement that trademark licensees be nonprofit corporations.

Further affiant sayeth not.

Subscribed and sworn to (or affirmed) before me this 8th day of January, 1998, by

Signature of Document Signer
Robert Cunningham III

Name of Signer

Signature of Notary Public
My Commission Expires:

MY COMMISSION EXPIRES MARCH 14, 1999