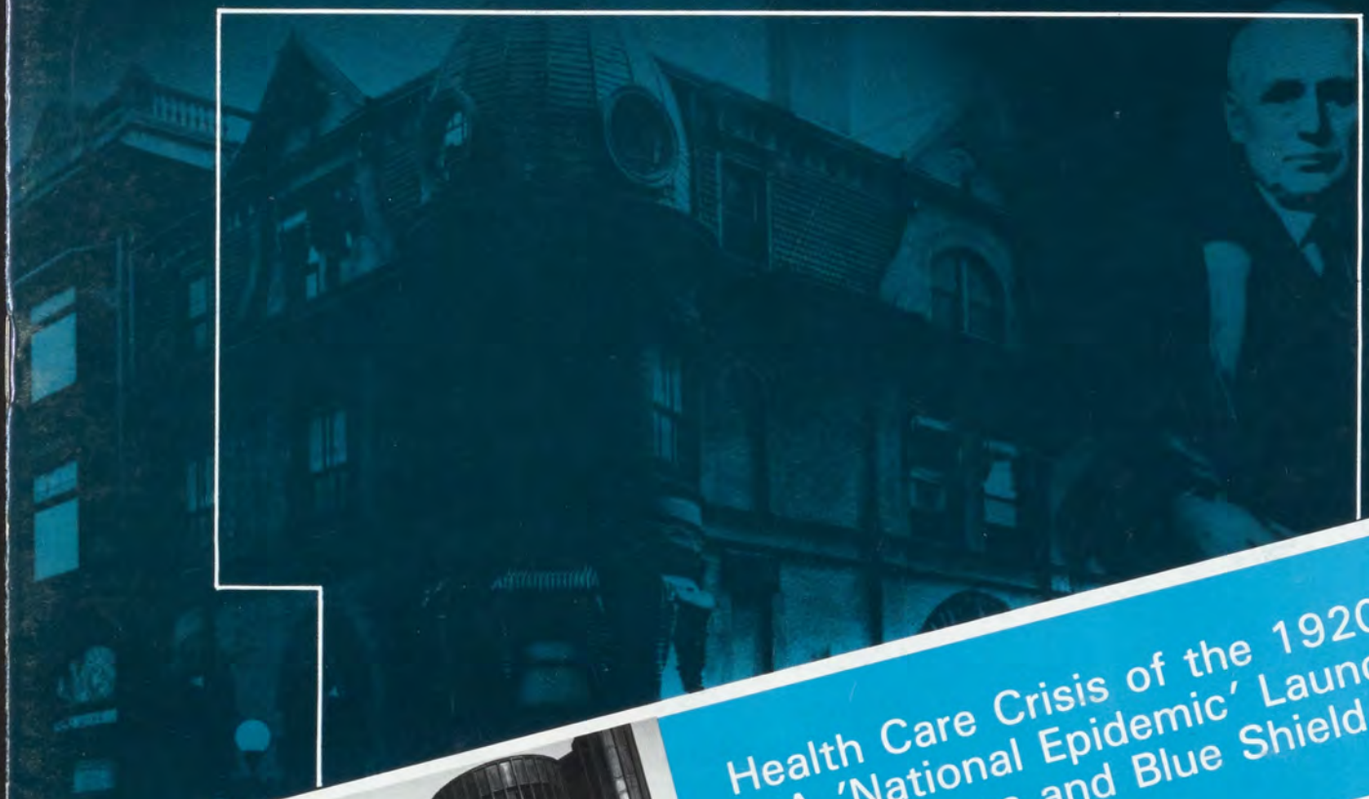
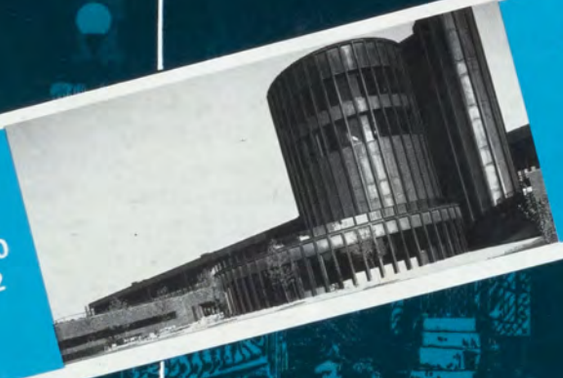
RAMSEY COUNTY HISTORY

Ramsey County Historical Society

3.00



Health Care Crisis of the 1920s-- A 'National Epidemic' Launches Blue Cross and Blue Shield



Volume 20
Number 2

Ramsey County History

Published by the
RAMSEY COUNTY HISTORICAL SOCIETY
Editor: Virginia Brainard Kunz

Contents

Volume 20
Number 2

ACKNOWLEDGEMENTS: All photographs used in this issue of Ramsey County History *are from the files of Blue Cross/Blue Shield of Minnesota.*

Health Care Crisis of the 1920s-- A 'National Epidemic' Launches Blue Cross and Blue Shield

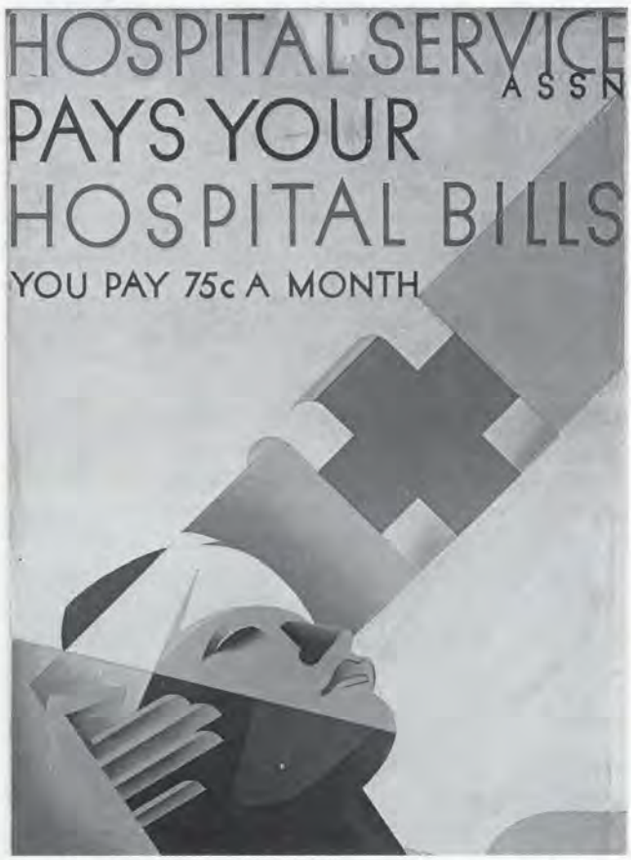
By Gary Phelps

The story of Blue Cross and Blue Shield of Minnesota (BCBSM), which has just marked its fiftieth year in Minnesota, represents one of the most amazing developments in non-profit public health care in the United States. Today, few people know that Minnesota Blue Cross was the second of such plans to organize in the country, that it became a model for other states to follow, and that the Blue Cross symbol originated in St. Paul.

Established originally to help people pay their hospital bills, the movement that began in the depths of the Depression of the early 1930s counted *40 million* enrollees by the early 1950s.[1] In Minnesota, public acceptance was no less startling; between 1933 and 1950 enrollment went from zero to more than one million members.[2] However, the history of Blue Cross and Blue Shield in Minnesota is not a tale of static maintenance after the onslaught of public acceptance. Rather, it is a history of internal and external challenges — internal when Blue Cross and Blue Shield divisiveness caused their split in 1959, and external as a result of the changes and competition in health care over the past five decades.

It is also a history that has its roots in a national health care crisis, a grave problem that in the late 1920s confronted millions of American families and received intense scrutiny from the medical profession, the press and the citizenry. A long ago echo of a situation painfully familiar today, the problem concerned the staggering cost of illness that required hospitalization and devastated the budgets of middle-income families. As Olin West, secretary of the American Medical Association in 1928, described it, the most outstanding question before the medical profession was, "the delivery of adequate, scientific medical service to all people, rich and poor, at a cost which can be reasonably met by them in their respective stations in life."[3]

ABOUT THE AUTHOR: Gary Phelps, a 1975 graduate of the University of Minnesota where he majored in physical anthropology, is a researcher and writer who was a Ramsey County Historical Society staff member from 1978 to 1981. He worked on the Historic Sites survey co-sponsored by the RCHS and the St. Paul Heritage Preservation Commission. He has contributed a number of articles to Ramsey County History *and to* Minnesota History, *published by the Minnesota Historical Society.*



Reproduction of an original poster commemorates the first official public use of the Blue Cross symbol. In 1934, E.A. van Steenwyk commissioned a Viennese artist, Joseph Binder, to paint a poster with the Blue Cross symbol on it. In 1939, it became the accepted trademark of all Blue Cross plans in the country.

IN 1928, AS AN OUTGROWTH of this concern, six major foundations created the Committee on the Cost of Medical Care which, over the next five years, published twenty-seven studies on health services, treatment, medical economics, and group medical practice. An early committee publication, *Hospital Service for Patients of Moderate Means*,[4] addressed the issue that confronted the 55 percent of working Americans (26 million people) who earned from $1,500 to $5,000 a year[5] and who bore the brunt of medical costs.

Minnesota Blue Cross's second home, 2388 University Avenue, 1951. This Midway location was chosen in 1935 after the Minneapolis prepaid hospital plan merged with the St. Paul Hospital Association.

Minnesota Blue Cross and Blue Shield building at 2619 University Avenue seen here shortly after its construction in 1951. Blue Cross's first office was located in the Guardian building in downtown St. Paul.

The director of a large New England hospital summed it up:

"What of the man of small or moderate income? He cannot afford the private ward of the hospital, or the doctor's fees there charged. He cannot enter the charity ward because he can pay his doctor something and medical services there are gratuitous. He is self respecting and wishes to pay his own way as he can. What is the result?. . . The fear of illness hangs over the heads of parents like the sword of Damocles . . .If the bread winner is the one to be ill the disaster may be even greater than in the case of the child."[6]

The human response was to avoid hospital care at all costs. The resulting impact on the hospitals themselves was sadly predictable. Too many beds in non-governmental hospitals were empty and by 1929 those hospitals needed help. Twenty years earlier, in 1909, the average number of beds for all hospitals in the United States had been 97; by 1927 it was 125.[7] In 1927, bed capacity stood at 308,149 for non-governmental controlled hospitals; by 1931 it was 332,591. As the number of beds increased, the percentage of occupancy decreased. In 1931, patients occupied only 62 percent of the beds in non-governmental hospitals, compared to 89 percent in governmental hospitals.[8] Some hospitals folded; others operated at a loss.

The health crisis had become a national epidemic by the early 1930s. As the situation stood, hospitalization insurance was inadequate, sick Americans avoided hospitals, independent hospitals faced economic disaster, and the worst depression in the country's history had just begun.

As James Flavin, who was vice president of government programs for Blue Cross and Blue Shield of Minnesota, commented in a recent interview with the author, "A system that allowed people to pay in advance for their hospitalization, medical and surgical needs was a slick idea. In my own family history we had a rainy day bank account. Blue Cross simply offered a formalized approach to saving for a rainy day. You're always going to get sick and you're always going to need money to get well and that was a good way to do it."

IT IS TRUE THAT commercial accident and health insurance policies existing at this time provided cash benefits to pay the costs of medical care, but many policies had broad cancellation provisions, women and persons with hazardous occupations were frequently excluded, and coverage was restricted on certain types of injuries and illnesses. Trade union-sponsored insurance and coverage among fraternal orders also carried restrictions. For twenty years prior to 1930, special associations scattered throughout the United States provided payment for hospital costs, but they issued plans to individuals rather than to a group as a whole, and most proved unsuccessful due to administrative expenses, the high cost of selling policies, and the inclusion of high risk or chronically ill patients.[9]

A reapplication of the group insurance idea, however, proved to be the origin of the Blue Cross movement. In the late 1920s hospital prepayment plans evolved in a few American towns where hospitals and groups of employees contracted for hospitalization insurance. The contract covered the entire group and members paid a monthly or annual fee. The most famous of these plans began in Dallas, Texas, in 1929 under the guidance of Justin F. Kimball, an attorney who once worked for an insurance company. An educational administrator as well, he was superintendent of the Dallas public

schools before becoming vice president of Baylor University. Kimball had pioneered a teachers' sick benefit fund after the influenza epidemic of 1918, and in 1929, using the benefit fund records and other data, he calculated the group's average monthly hospital bills at 15 cents a month.

AFTER ENTERING INTO an agreement with Baylor Hospital on a prepayment plan, Kimball circulated an announcement to the Dallas teachers which asked for 75 percent teacher participation at 50 cents a month, or $6 a year. This covered up to twenty-one days of care at Baylor and included operating room service, anesthetics, and laboratory fees.[10] Between the time school began and the end of the year, 1,000 Dallas teachers enrolled, well over the 75 percent minimum. The plan proved beneficial not only to the teachers, but to the hospital as well.

In 1931, Kimball's hospital plan was reported at the annual meeting of the American Hospital Association (AHA). The following year St. Paul hospital administrators, Dr. Peter Ward from Miller Hospital and Arthur Calvin from Midway and Mounds Park Hospitals, learned more about the Baylor plan at the annual AHA meeting in New Orleans.[11] On their return, they encouraged administrators of independent, non-profit hospitals in St. Paul to adopt something similar. They had a listening audience. Some area hospitals were operating at a loss with up to 50 percent of their beds vacant.[12]

In September, 1932, seven St. Paul hospital administrators assembled to hear Calvin and Ward outline the Baylor plan and a similar plan at the Touro Infirmary in New Orleans. Calvin and Ward then spent the next three months designing a prepayment plan for a group of St. Paul hospitals, rather than just one hospital, as Kimball had done. In December, 1932, they announced the formation of the St. Paul prepaid hospitalization plan in the periodical, *Minnesota Medicine*.

THE ORIGINAL MEMBERS of the Hospital Service Association of St. Paul, as it called itself, were Bethesda, Midway, Miller, Mounds Park, St. John's, St. Luke's and West Side General Hospital. Attorneys on their boards of directors drafted the association's original papers and submitted them to the secretary of state, the attorney general, and the insurance commissioner of Minnesota, incorporating the association as a non-profit corporation under Minnesota law.[13]

The current headquarters of Blue Cross and Blue Shield of Minnesota at 3535 Blue Cross Road in Eagan. Cerny Associates designed the building which opened in 1970.

The earliest photograph documenting the Blue Cross organization, then known as the Hospital Service Association. From right to left: a young E.A. van Steenwyk, Dr. Peter Ward, and Arthur Calvin, both seated, ca 1933. The three men standing are unknown.

The attorneys, with Ira Oehler as chairman, faced the novel task of preparing contracts to be signed by each hospital that agreed to provide the care covered by the contracts issued to subscriber groups. Abbott Fletcher, a Minneapolis attorney who became general counsel for Blue Cross, wrote:

"Great care was taken in preparing these contracts . . .There was no actual experience to guide those framing the subscriber's contract. For all practical purposes, insurance companies were not then in this field and they did not seriously come into the field until after Blue Cross proved that such a plan could be successful."[14]

The state insurance commissioner at first maintained that the contracts were insurance contracts but approved them after the attorney general ruled that they were for service, not for insurance.

The hospital administrator and one trustee from each of the seven hospitals made up the association's original governing body. They hired a manager, E.A. van Steenwyk, who would become a "giant" in the Blue Cross movement in the United States.[15] John E. Stuart, first president of the national Blue Cross Association, said of van Steenwyk: "Probably more than anyone else [he] had the vision of what voluntary, non-profit prepayment could do for the private hospitals and for the people of the country. . .[He was] an unquestioned leader in the Blue Cross nationally."[16]

THE SON OF AN IOWA boot and harness maker, van Steenwyk received a two-year teaching degree in history and economics at the University of Minnesota in 1928. After a brief teaching career he joined the staff of Bruce Publishing Company in St. Paul, where he sold magazine advertising. Bruce Publishing was the business manager for *Minnesota Medicine* and van Steenwyk became acquainted with many local hospital administrators, including Ward and Calvin. He also became interested in prepaid health care and studied the Baylor plan, believing it would work on a city-wide basis. Then, a seemingly non-propitious event occurred. Van Steenwyk's son, John, tells the story:

"My father did well at Bruce Publishing — too well, in fact. He made too much money! In the depths of the Depression, Mr. Bruce took him off commission and put him on salary. That amounted to a big cut in pay. Pa was offended and quit. So he needed a job."[17]

Van Steenwyk apparently sat in on meetings with Ward and Calvin late in 1932, drawing up plans for the hospital organization before he was made manager. Since he went from an advertising salesman to manager of the fledgling association, he must have made a positive impression on the trustees.[18]

He took over the post in the summer of 1933, and on July 1 began taking applications for the new hospitalization plan from a one-room office in the Guardian Building in downtown St. Paul. Contracts

were issued to groups of five or more employees although 50 percent of any group was the desired number.[19] The contract provided twenty-one days of hospital care for the subscriber, including operating room service, anesthetics, general nursing, surgical dressing, and all other routine hospital services. Twenty-five percent discounts applied to serums, special drugs, X-rays and other special services. Contracts covered 50 percent of maternity care if the subscriber had been a member for at least ten months.

Dependents received 25 percent coverage for an additional $1 a year. Exclusions included mental diseases and pulmonary tuberculosis (except for hospital diagnosis), as well as doctors' fees. Subscribers paid 75 cents a month or $9 a year. The sponsoring hospitals provided initial capital of $1 per bed with a minimum of $100 and a maximum of $200 each. This amounted to $857 — the investment that started Blue Cross of Minnesota.[20]

In July, 1933, the employees from the St. Paul Union Stockyards Company became the first to enroll in the new plan, and Thomas E. Good, the company's president, held contract 1, group 1, in the Hospital Service Association. A year later enrollment in St. Paul had reached 1,812.[21] Two problems became apparent early on — the first being contractual. Under the association's contracts, the hospitals were reimbursed a flat sum of $5 per patient day. However, inequities existed. Some stays were short and involved surgery (tonsillectomies, for example), and the hospitals lost money. Some stays were long, required no surgery, and exceeded the necessary operating capital for the hospital. So contracts needed to be adjusted as a new situation arose.[22]

MARKETING WAS ANOTHER CONCERN. Initially, van Steenwyk asked employers to spread the news to their employees about the group plan. However, in 1934, he wrote, ". . .we have since found that if the request for the plan can be aroused from the employees themselves rather than the employer the appeal is more effective. . .Mail advertising is not practical when the money for sales is so low. For that reason we have used bulletin boards almost exclusively."[23] Employee participation was crucial in another way. Payroll deductions were not commonly used until after the passage of the Social Security Act in 1936, so employees collected payments from other employees.

In St. Paul, word began to spread about the Hospital Service Association. In 1934, when van Steenwyk sent out a questionnaire to enrollees, 80 percent who received care said they were more than satisfied. A total of 150 members had been hospitalized for an average of 9.5 days. Average savings per patient were $39.90, and average payment for hospital "extras" was $10.20, including private rooms, X-rays, special perscriptions, telephone and radio.[24]

The Blue Cross staff in front of the building at 2388 University, August 1939. E.A. van Steenwyk at left front in dark suit, Bert O'Leary behind him to the left.

Guiding forces of Blue Cross confer. From left to right: Donald Condon, Arthur Calvin, and Richard Crist, ca. 1954. At left, Governor Harold Stassen signs the enabling legislation for Blue Cross on March 10, 1941. To his right stands James McNee, administrator of St. Lukes Hospital, Duluth; on his left is Arthur Calvin.

Soon van Steenwyk, the one-time advertising salesman, began to conduct his own advertising campaign on radio stations that gave him free time to explain the new plan. He later noted:

"In those days, we didn't have an opportunity to advertise because we had no money, but radio was just starting and offered all kinds of help. I remember one characteristic duty of that time was going on to the radio station and telling my little story about prepayment over the air, telling people the phone number of the association and then running back to my office [in the Guardian Building] to intercept the phone calls that came in."[25]

He also searched for a symbol "who will speak to the groups from the bulletin boards about the advantages of membership from month to month." He liked the character from the streetcar company, "Bill, the Motorman," and adopted his own spokesperson, "Sally the Student Nurse," dressed in blue and white.

For a logo to identify the association's literature, he adopted, in 1934, a blue Greek or Geneva cross, a symbol of relief for those struck by disaster. By 1939 the blue cross had become the national symbol of prepaid multi-hospital plans.[26]

THE HOSPITAL SERVICE ASSOCIATION of St. Paul incurred a deficit of $2,175 in its first year of operation, but van Steenwyk remained confident. The association had hired no solicitors, leaving this and all other chores to van Steenwyk but sales were not an outstanding problem. Van Steenwyk saw the prepayment plan selling itself: "The point of the matter is this, the full weight of the community is being forced by the practical demonstration of the plan's value to the community."[27] But he realized that the association had yet to acquire a track record and to do so, he wrote:

". . .the hospital must steadily produce the goods. When this has been done for a time regularly and consistently, with the community being advised of its progress. . .the community will supply the kind of support the movement needs without much coaxing. This takes time and the matter of getting it over, as we have said, is not a simple task."[28]

The association's deficit did not dissuade others around the country from starting their own plans. A national spokesman arose. He was Rufus Rorem, who served with the Rosenwald Foundation (a benefactor to the Committee on the Cost of Hospital Care) and as consultant for the American Hospital Association Council on Community Relations and

Administrative Practice, formed in 1933. In 1934, he visited van Steenwyk, and after hearing a summary of the first year's experience, asked him, "Well, are you a bull or a bear on group hospitalization now?" Van Steenwyk responded, "The answer is an emphatic 'bull.'"[29]

Around this time, seven Minneapolis hospitals began to organize their own prepayment plan. They included Abbott, Asbury, Fairview, Northwestern, St. Andrews, St. Barnabas, and Swedish. Then the Minneapolis plan and the St. Paul Hospital Service Association formed a committee to negotiate a merger. With Rufus Rorem assisting, the committee resolved a number of differences between the plans, including the assumption of the St. Paul Association's deficit which, by the summer of 1935, had reached $4,000. The Minneapolis plan's system, known as an inter-hospital agency contract, was adopted, with the new association reimbursing member hospitals $10 for the first patient day, and $5 for each day thereafter. Hospitals received $10 for tonsillectomies.[30] The two organizations, called the Minnesota Hospital Service Association, merged on May 27, 1935, and chose a site in the Midway area, at 2388 University Avenue (now home of Film in the Cities) for their offices. Van Steenwyk remained as executive director, like an astronaut at the controls of a rocket about to take off.

BY THE END OF 1936, the Minnesota Hospital Service Association had 12,037 members, plus another 12,000 dependents. A $5,400 surplus replaced the $4,000 deficit. Promotion began in earnest when in December, 1935, Blue Cross (by now the association's popular name) distributed 30,000 copies of a newsletter called *The Hospital Service News* to members and prospective customers. The names of the 477 member groups filled most of the newsletter. American Hoist and Derrick, Buckbee-Mears, First National Bank of St. Paul, Minnesota Mutual Life Insurance, Great Northern Railroad Shops, St. Paul Fire and Marine, and Webb Publishing were among the members.

Bert O'Leary, manager of hospital relations.

Radio broadcasts continued over KSTP, WCCO, and WTCN, which all donated three one-minute announcements each week plus one five-minute discussion period. In his report for 1935, van Steenwyk noted that in November and December "we have not had one broadcast that had produced less than forty direct telephone inquiries, in addition to numerous requests for further information through the mail."[31]

In January, 1937, van Steenwyk issued the first annual report covering a full year, January through December, 1936. Surplus cash, according to the report, totaled $55,000, ten times greater than the previous year's. Membership had nearly tripled, reaching 33,090, plus an additional 33,000 dependents; 2,359 members were hospitalized for 17,948 days with bills of $188,300. The average hospital bill per patient was $50, of which Blue Cross paid an average of 77 percent. A total of 1,850 dependents were hospitalized for 13,450 days at an average cost of $49 per patient, of which Blue Cross paid 24 percent. The staff consisted of twenty-two full-time employees. Trustee committees included an actuarial, administrative, auditing, public relations, investment, and special services committee.[32]

BLUE CROSS ALSO WAS ADDING new member hospitals in the Twin Cities. Shortly after the 1935 merger, Children's Hospital of St. Paul joined, followed by St. Joseph's, Eitel, Northwestern, and St. Mary's. Bert O'Leary, who was hospital consultant on health affairs for Blue Cross, went to work as a salesman in 1935. He was number three on the force, hired "because I was interested and had a car, I guess," and remembers that hospital superintendents would write in for information and the salesmen would follow up.

"We were selling hospital care for 75 cents a month. The sales pitch was 'the rich are taken care of, the poor are taken care of - here's an opportunity.' St. Barnabas Hospital thought that if they could get $5 a day for steady income, it would be wonderful." The value of Blue Cross to struggling hospitals was proving itself. As one trustee observed many years later, "it was a marvelous way to keep hospitals solvent."

In 1935 a problem arose that van Steenwyk and

Dorothy Hunt in 1960. She became the first woman vice president in a Blue Cross plan. A crack statistician, she ascended in the organization from a statistical clerk to vp of actuarial research in 1965.

the trustees took very seriously. Two subscribers injured in an automobile accident near St. Cloud asked to be driven to their Mineapolis hospital where they were covered by Blue Cross. One of the subscribers lost so much blood on the trip to Minneapolis that his life was in jeopardy. The result was that Blue Cross adopted emergency coverage for members outside the Twin Cities without additional premiums. The board of trustees believed that subscribers would not abuse such coverage, and they were right. In 1938, out of a total payment to all hospitals of $585,339, only $6,584, or 1.1 percent was paid to non-member hospitals.[33]

THE SUCCESS OF BLUE CROSS in the Twin Cities encouraged other communities to request participation. Duluth became the first to enter, when Blue Cross drew up contracts with St. Luke's and St. Mary's Hospital in 1938. To van Steenwyk, the move proved the trustees' commitment to the health care movement. Since many of these hospitals had unequal service rates, reimbursement contracts proved to be a problem. Van Steenwyk later wrote, "At great expense and at no inconsiderable effort Duluth was enrolled and has since become a strengthening factor in association affairs. The Twin Cities hospitals might have adopted a provincial attitude denying other communities the advantages which a going concern offered."[34]

By the late 1930s, Minnesota Blue Cross had become a model for other Blue Cross plans forming throughout the nation. In 1938, a Philadelphia group invited van Steenwyk for consultation and later offered him the position of executive director. He accepted, and left Minnesota in June, 1939. (Bert O'Leary later noted that Rufus Rorem persuaded van Steenwyk to move east to guide the Blue Cross movement in that region.)

The previous November, van Steenwyk had written the Minnesota trustees from Philadelphia: "Our organization [Minnesota Blue Cross] is regarded as 'hot stuff' everywhere. There is no longer any question in my mind that the Minnesota approach is the most realistic of any in the country."[35]

VAN STEENWYK REMAINED in high regard in Minnesota. The board of trustees expressed their thanks to him in the 1939 Annual Report that is a testimony to his success. Through 1939, Minnesota Blue Cross had 133,750 employed subscribers and 175,464 dependents, for a total membership of 309,216. Thirty-two percent of the Twin Cities population was enrolled. Total hospitalization cases for 1939 reached 68,740, with payment of benefits just shy of $2 million. The surplus for epidemics and other contingencies totaled $516,000. Twenty hospitals in the state were members, including six in such other communities as Duluth, Fergus Falls, St. Cloud and Stillwater. Minnesota Blue Cross had eighty-three employees. In 1958, van Steenwyk became the first winner of the Justin Ford Kimball award "for outstanding encouragement given to the concept of prepaid voluntary health care plans."[36] He died in 1962.

Marcella Connolly, who was senior personnel administrator, remembers him as "nice-looking, gentle. He was hard-working but never seemed to be under stress. He would come through the departments, ask how we were doing. We liked and respected him. Everybody who worked for Blue Cross in those days felt that there was such a good opportunity for people in all walks of life to gain something for little money."

In 1939, the trustees appointed Arthur Calvin, the board's secretary, to the position of executive director. A founder of the old Hospital Service Association of St. Paul, he had been an accountant before becoming a hospital administrator. During his first year as executive director, he and the board of trustees confronted a challenge inherent to the formation of Blue Cross itself.

The first Blue Cross "baby", Ronald Gower, 12, poses in 1945 with Arthur Calvin, right, and Dr. Peter Ward, Miller Hospital administrator.

THREE ST. PAUL ATTORNEYS representing subscribers sued Minnesota Blue Cross alleging that it insured members against hospital expense and that instead of being a benevolent institution, it operated for gain — the gain benefitting both members who received hospital care and hospitals which enjoyed better business through the plan. Thus they contended that Minnesota Blue Cross was an illegal insurance business. Representing the association, Abbott Fletcher and Wilfred E. Rumble, St. Paul attorney, demurred to the complaint.[37]

Petitions carrying more than 13,000 signatures gathered within thirty-six hours from Blue Cross subscribers informed the court that the plaintiffs did not represent them.[38] The case was dismissed as moot because the subscribers who brought the suit were no longer Blue Cross contract holders. Blue Cross already had asked the state legislature to pass an act authorizing non-profit hospital service corporations — essentially legalizing the current status of the association. Governor Harold Stassen signed the bill into law on March 10, 1941.

Before the bill passed, the association had launched a campaign to increase the number of member hospitals throughout the state. In 1940, forty-six hospitals in thirty-eight Minnesota cities were added, bringing the total to seventy-five hospitals. Of the 380,937 subscribers, including dependents, 87,245 lived outside the Twin Cities area. Each member hospital had to meet strict criteria regarding its non-profit status, equipment, personnel, and physical plant, and have approval of its medical societies.*[39]

Minnesota Blue Cross's explosive growth and the complexities created by the multitude of contracts with scores of new member hospitals prompted the association, during 1941, to hire an actuarial consulting firm which surveyed its financial and underwriting procedures and pronounced them sound, even though the association had no established pattern as a guide. By the end of 1941, 437,000 Minnesotans were covered by Blue Cross under seven

**The Minnesota Farm Bureau Federation was one of the most important organizations in enrolling new members in rural communities. Organized in each Minnesota county, the Farm Bureau provided a structure, both on the county and the township level, accommodating Blue Cross salespeople in local meetings. The mining unions in the northeast part of the state also were extremely important to Blue Cross' state-wide development.*

different contracts issued to individuals, dependents, and families. Family contracts represented the highest amount of income and expenditures for hospital care, as coverage was increasingly extended beyond the bread-winner to dependents.[40]

BY THE BEGINNING OF WORLD WAR II, dependents' benefits were at 50 percent of hospitalization expenses. Throughout the war years, Blue Cross allowed subscribers to waive their own benefits while in service, but to continue their dependents' benefits for $8 a year. After leaving service, subscribers could have their original contracts reinstated based on the charge of current similar contracts. In 1943, the trustees increased dependent coverage to 100 percent for an additional 50 cents a month.[41] In 1942, Blue Cross enrollment in Minnesota reached a half million, including dependents, although more than 7,639 had suspended their contracts to enter service. Throughout the war, in fact, Blue Cross enrollment increased, primarily because war-related jobs increased. For example, in December 1943, an estimated 35,000 war workers in the Twin Cities were covered under Blue Cross. The complications caused by these temporary jobs were extensive, however. During one month in 1943, there were approximately 3,000 contract and record changes because one war plant decreased its personnel. All these contracts were dealt with on an individual basis.[42]

Dorothy Hunt, who was vice president of actuarial research, remembers those years. "When I started in 1944," she said, "our contracts provided a $3- to $5-a-day room allowance. At one time we had a ten-day restriction on obstetrical cases and a thirty-day restriction on mental illnesses. Over the years those restrictions went off." (Some, however, are now coming back.)

James Regnier, a man who wore many hats in the Blue Cross organization. He became chief executive officer in 1976.

Richard Crist, head of Blue Cross from 1957 to 1973.

Calvin and the board of trustees were concerned that enrollment would drop considerably when the war ended, industry slowed and workers were laid off before regearing to peace-time activities. To their surprise, their fears did not come true. Each year throughout the war showed an increase, and in 1946, the first complete calendar year without hostilities, enrollment exceeded 122,000, bringing the total to 754,489. Fifty-five employees were added to the staff in 1946 alone, for a total of 210.[43]

The association had outgrown its building at 2388 University Avenue, and was renting 11,000 square feet in the Chittenden and Eastman Building two doors down. The trustees purchased a new site at 2610 University Avenue and established a building committee. Some of the sales techniques that helped spur the growth during the late 1940s and early 1950s are described by James Flavin:

"We'd go to a hospital when we got into town and ask if some group had expressed an interest in

coverage, perhaps because an employee had been hospitalized and had no coverage. Hospitals were a great source of referrals. When we began to market Blue Shield, we used doctors and clinics in the same fashion. The service organizations — Rotary, Lions, Kiwanis, Chambers of Commerce — were always looking for speakers and we would talk to these groups. Another marketing technique was the movies. We had trailers for use in local theaters. We involved school children in writing 'Why I Like Blue Cross and Blue Shield' in twenty-five words or less. We had the local physicians give bicycles away to kids during a theater matinee when all of the little guys were in there watching Roy Rogers. We probably couldn't use these techniques today but at that time they were successful."

Dorothy Hunt describes some of the pressures of work during these years of expansion.

"There was a board meeting coming up," she said, "and for some reason the billing and accounting departments couldn't get the monthly report together. I just got home one Friday night when I was called back to work, along with about five other women in my department and some of the men. We worked like dogs all week-end going through the billing records. I even had my three children over there filing because they could recognize A's and B's and C's. Our husbands were there doing the leg-work. By Monday we had the figures."

WITH SOME IRONY ATTACHED, a group of Minnesota doctors organized, in 1945, a group plan for prepaying medical expenses to complement the coverage of hospital expenses that Blue Cross had proven to be so successful. As Ben Stephens, who was director of utilization audit for Blue Shield, explains it,

"A prepayment plan would ease the burden on the patients and the family pocketbook. One of the greatest elements I have known in the field of medicine was that the medical profession has, repeatedly down through the years, cared for their patients regardless of economic circumstances, and that's true today."

The irony was that many doctors had opposed the formation of Blue Cross, fearing that it was a step toward socialized medicine.[44] This threat was unfounded; in fact, Blue Cross leaders opposed socialized medicine in place of voluntary coverage. In the late 1930s and 1940s, many doctors felt threatened again when supporters of national health insurance drafted a bill in Congress that failed to reach either floor for debate. In response, state medical societies began to sponsor prepaid physicians service plans.[45]

Andrew Czajkowski, current chief executive officer of Blue Cross and Blue Shield of Minnesota.

Dr. I.O. Sohlberg in St. Paul and Dr. Richard Cranmer in Minneapolis investigated such plans before presenting their ideas to the Minnesota Medical Association. Along with Sohlberg and Cranmer stood a figure many saw as the guiding force behind the Blue Shield movement in Minnesota — Twin Cities attorney, Francis Manley Brist. Brist wrote the enabling legal documents for Blue Shield which the state legislature passed in 1945. In 1946 the House of Delegates of the Minnesota Medical Association recommended the Blue Shield organization in preference to socialized medicine and contract carriers.[46]

Ben Stephens knew Manley Brist well for many years.

"He could be irascible," Stephens remembers, "but he usually was right. For years he represented the medical profession in Minnesota. He represented doctors individually, he represented Blue Shield, the State Board of Medical Examiners, the American College of Clinical Pathology, the American College of Radiology. He was nationally known as an authority on legal medical practices."

Blue Cross favored the organization of Blue Shield because commercial carriers of hospital/medical coverage were proving very competitive. The next year Blue Cross helped Blue Shield (or Minnesota Medical Service, as it was officially called) get started. Originally, the two agreed that Blue Shield would pay

Blue Cross $11,500 for handling all Blue Shield's start-up costs, including administrative and overhead. This agreement ended when Blue Shield's first subscriber contract became effective. Blue Cross, however, maintained the responsibility for selling Blue Shield contracts to Blue Cross subscribers and sending the bills to Blue Shield for payment. Also, Blue Cross maintained the general accounts for the two plans as well as necessary statistical reports.[47]

IN 1947 BLUE SHIELD issued its first contracts in Minnesota to the Minneapolis Gas Company, the Minnesota Farm Bureau and the South St. Paul Stockyards Company. These early contracts provided surgical, obstetrical, some out-of-hospital diagnostic X-ray coverage, and benefits for twenty-one days of routine in-hospital medical care. Individual coverage was $12 and family coverage $27 annually.[48] Blue Cross marketed a combined Blue Shield/Blue Cross benefit package at $27 a year for individuals and $60 a year for families.[49]

Initially, public support for prepaid medical coverage was even greater than prepaid hospitalization coverage had been. After 1947, subscribers numbered 1,203; after 1948, 100,666; through 1952, 554,961.[50] Blue Cross had 964,000 subscribers in Minnesota through 1952, slightly below the one million mark it set in 1950 and 1951.[51] This figure topped the million mark in 1954 when Blue Cross offered non-group subscriber contracts with a $25 deductible.[52]

The system for dividing expenses between Blue Cross and Blue Shield proved troublesome, because it soon was observed that Blue Shield's expenses were related to the number of contracts, and not to the dollar volume.[53] An attorney hired by Blue Cross determined that Blue Shield had underpaid Blue Cross $73,000 for the year that ended February 21, 1951, leading to the conclusion that "a contract basis would be much fairer than the income basis for determining payment for service by Blue Cross to Blue Shield."[54] Throughout 1952 negotiations proceeded and these were tied to Blue Shield's occupancy of Blue Cross's new building completed in 1951 at 2610 University Avenue. Blue Shield's trustees wished to purchase a half-interest in the building, but in a July 25, 1952, board meeting Blue Cross trustees declined to sell and stated that payment of expenses should be settled without delay. By December, 1952, Blue Cross and Blue Shield finally agreed upon the contract-in-effect system, but by this time their relationship had undergone definite stress.[55]

FURTHER STRESS arose in 1953. By this time commercial carriers were offering a variety of hospital and medical contracts. "When Blue Cross started, there was no competition," Dorothy Hunt explains. "But as the movement grew, and unions began negotiating for health benefits in their contracts, the insurance companies became interested in entering the field, and they did. We watched the number of contracts decrease, especially among the employed population segment. We were losing groups we'd carried for years. When employers went to employers' contribution they often would go to a commercial company, rather than staying with Blue Cross. Our losses were strongest in the very large accounts that were the favorites of our marketing people."

To remain competitive, Blue Cross had to adopt different types of coverage to meet employers' demands. However, they found Blue Shield inflexible, which was alarming to the Blue Cross sales force attempting to sell Blue Cross/Blue Shield packages. Donald Condon, at that time enrollment director for Blue Cross, considered the drastic effects this inflexibility would have on selling big group contracts to businesses and stated it simply: "Blue Cross cannot get along without a companion medical-surgical plan. . ."[56]

Ben Stephens explains the discord this way: "Blue Cross was much more liberal but was having financial problems. Blue Shield was conservative but was not having financial problems. Blue Shield wanted something to say about the sales policies and some authority over its own business."

Blue Cross then drafted articles of incorporation and by-laws for a new corporation which would provide medical-surgical and obstetrical coverage. Known as Minnesota Indemnity, Inc., the corporation was on file in the Minnesota secretary of state's office as of August 4, 1954. Blue Shield, needless to say, found the creation of Minnesota Indemnity threatening, and the relationship between the boards underwent further strain before concessions in the spring of 1955 brought the two organizations back into accord.[57]

THE NEXT FIVE YEARS were stable years in the Blue Cross/Blue Shield relationship and relatively stable years within the organizations themselves. Blue Cross had 1.03 million subscribers in 1950, and 1.02 million in 1960. Claims, however, nearly quadrupled, rising from $10 million to $40 million over the same period and indicating the rising cost of hospitalization. In 1957 subscribers set a record. Approximately 202,700 members were hospitalized in Minnesota, 26,808 of them receiving maternity benefits — the largest annual maternity rate in Blue Cross' history to that time.[58]

Blue Shield, like Blue Cross, had a stable decade, with 411,733 subscribers in 1950 (only three years

Freelance photographer, Nick Burkowski, shot this descriptive photo in 1959.

after its inception) and nearly 900,000 by the end of the decade. Claims rose from under $2.2 million in 1950 to over $9.5 million in 1960.[59] Handling claims could be complicated, Ben Stephens recalls, because doctors around the state did not always have the same fee schedule. He established a network of physicians who would offer advice as to fees and this grew, by 1955, into a claims review committee composed of doctors from each specialty.

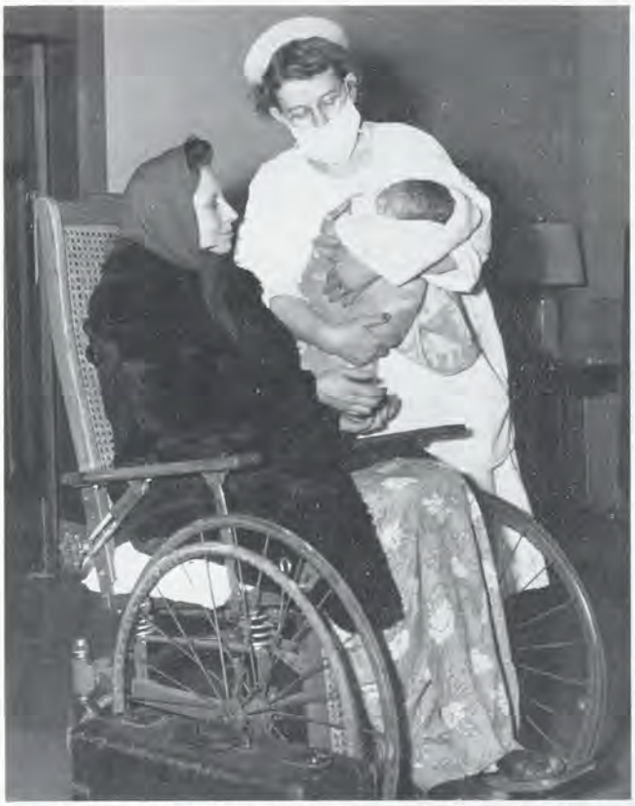
"We had twenty-three members," he said, "and they were of great value. They met once a month to review fees that were in question."

In 1957, Arthur Calvin died. A national pioneer in prepaid health care, he had guided Blue Cross since van Steenwyk's departure in 1939. During his years as executive director, Blue Cross subscribers rose from 381,000 to 1.4 million, and benefits and coverage increased. He served on numerous national health organizations and as executive director of Blue Shield from 1947 to 1954, during its period of greatest enrollment. Under his leadership Blue Cross and Blue Shield worked out complex operating agreements that mended the divisiveness threatening their cooperation. Richard Crist succeeded Calvin, who had persuaded Crist to leave his job as accountant for the *Minneapolis Star and Tribune* newspapers in 1948 and join Blue Cross when it encountered fiscal management problems.

CRIST HAS A COLORFUL account of his hiring. He recalls that when he first heard about the job at Blue Cross,

"I said there was no worse organization structurally in the whole state. We had just finished throwing Blue Cross out of the Minneapolis Star and Tribune Company and taken on Liberty Mutual. The only thing I ever had against Arthur Calvin is that he didn't tell me that the biggest management systems company in the country had been working for Blue Cross for a year-and-a-half and had been dismissed by the board two months earlier. He didn't tell me that the board had given him six months to find some answers to all their problems. But he made me an attractive offer, it looked like a challenge, and I took it.

"From the first day I had questions. I went home one night and told my wife, this place had got about three months to live, no more. Then your husband will be out looking for another job. Well, luck was



The post-war baby boom begins. Here Mrs. Herman Kluegel and her 6-day-old son leave Bethesda Hospital in 1946.

with me. Calvin turned all the responsibility over to me except contact with the board, which he handled. Cash hadn't been applied for six months. Correspondence wasn't answered. Salesmen were afraid to go on the road because of the questions they'd be asked. So I called the sales force off the road for a while and put them in the office answering phones and correspondence. We got that thing going again.

"The predicament Blue Cross found themselves in was comparable to a Ma and Pa grocery store where you didn't have to know much about business. Blue Cross just took the public by storm. The public needed and wanted the protection Blue Cross was offering at a very reasonable price and business was so good no one knew how to handle it.

"I changed the internal operating theory in the organization from what they had . . . I used the freedom that Mr. Calvin gave me. . .Without that backing, the whole organization would have gone down the chute about that time. . .he had the confidence and turned it [the fiscal management] over to me."

Under Crist, Blue Cross entered a new age marked by financially sound underwriting, computerization, and a gradual changeover from a community rating system to an experience rating system for group contracts. Crist's financial talent, complemented by that of statistician Dorothy Hunt, led Blue Cross until 1973. During his presidency, in 1959, Blue Cross and Blue Shield went their separate ways. Ten years later Blue Shield was insolvent.

In early 1959, Blue Cross and Blue Shield were working together to sell and administer hospital and medical coverage. By the end of 1959, they were competitors. Disagreement arose when Blue Shield adopted a mandatory clause containing diagnostic X-ray and laboratory benefits. Hospitals objected that the clause might affect their revenue and increase cost to patients. Blue Cross objected as well. When subscriber costs increased, Blue Cross administrators maintained, they could not compete with commercial carriers offering deductible contracts. As Richard Crist explains, "The flexibility of the insurance company was one of the big problems we had to face."

TO BLUE SHIELD and its doctors, mandatory coverage was sound and beneficial, providing outpatient medical X-ray and laboratory coverage for groups and individuals. To do this, the program had to be community rated so the risk could be shared equally and rate increases held down. Otherwise such services would mean higher rates, making the program unsaleable. Those acquainted with the situation who are still alive today readily admit that strong personalities clashed on this issue. The leading adversaries included Richard Crist and Donald Condon on the side of Blue Cross and Francis Manley Brist for Blue Shield. As Blue Cross's and Blue Shield's operating agreement neared its end it became apparent that neither organization would change its position.

As of November 30, 1959, Blue Cross and Blue Shield parted; but they maintained a short-term working agreement to allow Blue Shield to take over those operations carried out by Blue Cross. Almost immediately after the separation, Blue Cross activated Minnesota Indemnity, Inc. (MII), the medical plan that had been incorporated in 1954, and was off and running with its own medical coverage.

The transition for both organizations was not easy, but Blue Cross held the advantage in having its own building, sales force, accounting system, and new medical coverage. Blue Shield, on the other hand, had to move (to 2218 University Avenue), take over operations previously contracted for, and assemble a hospital plan. "We interviewed and hired salesmen," Ben Stephens remembers. "We brought in equipment, we asked people to work longer than they normally would."

"THE SPLIT CAUSED grave concern," Marcella Connolly adds. "We had to separate all the records

and it was a terrific job. We worked night and day at that. Then Blue Shield had to hire a new clerical staff." Blue Cross subscribers declined from 1.1 million after 1959 to 1.02 after 1960. As of May 1, 1960, however, MII had sold 44,500 contracts covering 125,000 individuals.[60] It would be another year before Blue Shield offered a hospital rider with its medical coverage.

The split behind them, Blue Cross and Blue Shield embarked on a decade that brought significant new developments for both. In 1962, Blue Cross's internal operations underwent a drastic change when it brought in a Honeywell 400 computer to supplant a punch card system of accounting that Richard Crist had initiated in the mid-1950s. Under Crist's leadership in 1966, Blue Cross and a number of member hospitals developed an on-line patient accounting system — the first on-line shared hospital system in the world.[61]

THE DEVELOPMENT OF an experience rated system proved to be another key transition for Blue Cross in the 1960s. Previously, it had relied almost entirely on a community rating system, that is, across-the-board premiums for all groups regardless of their hospital use. Crist recalled the situation:

"The commercial companies didn't do it that way. They attacked the rating of each individual group and they tried to become more selective in the groups and in the groups' experience so that they could take a very good group and charge it a lesser rate than a very bad group from an experience standpoint . . . In other words the good groups can see their experience at the end of the year, and if you are a bank [recognized generally as a good risk group] and you know you had an excellent experience, you see the dollars you have used and you will not stand for the fact that you are paying out twice as much as you are using up in care." The competitive and financial realities of health coverage had negated the community rating system.

The year 1966 had brought the greatest number of changes in Blue Cross up to that time, according to Crist in that year's annual report. Besides the accounting system, Medicare as of July 1 took over hospital coverage for people over 65 by paying ninety days of hospital care and all other essential services. To administer the program the Social Security Administration contracted with the national Blue Cross Association and the association subcontracted with member Blue Cross plans as financial and operating intermediaries for Medicare cases.

"Blue Cross had a wonderful telecommunications system," James Flavin explains. "If you were hospitalized in Florida, within an hour or so we knew about it in Minnesota. About a third of the people in the United States had Blue Cross and Blue Shield. We were the largest single carrier for hospitalization. The national association told its member Plans to create a coordinator within each Plan to administer the Medicare contracts and report only to the president of the corporation. That was my role and I worked directly for Dick Crist. The Medicare contracts, however, were negotiated by our national association for all Blue Cross Plans."

Blue Cross created supplemental coverage to Medicare for its over-65 subscribers whose contracts were cancelled at the time of Medicare's inception. In 1967, its first full calendar year as Medicare intermediary, Minnesota Blue Cross disbursed $74 million in Medicare payments to Minnesota hospitals.[62]

The introduction of MII and Medicare meant more staff and an increased operation that presented another office-space problem for Blue Cross less than fifteen years after they had constructed a new building. Blue Cross was renting space in five other buildings in the Midway district. Therefore, the board of trustees enlisted Cerny Associates, a Minneapolis architectural firm, to design a new building in Eagan on the Minnesota River. Richard T. Faricy, Blue Cross and Blue Shield of Minnesota board chairman from 1973 to 1977, recalls his experience with that project when he worked in the St. Paul office of Cerny Associates.

"Bob Cerny met with Dick Crist who was interested in buying a large piece of land out on Highway 13 in Eagan. Mr. Cerny asked me to draw up a master plan for that site. It included housing, as well as subdividing the site for other industrial projects. I drew it up and I remember driving in Mr. Cerny's big Lincoln to the Blue Cross building on University Avenue. I walked into the lobby with those large 30 x 40 boards illustrating my great efforts. Mr. Cerny thanked me and introduced me to the chairman of the board and Mr. Crist. Then I got on the bus and went back to the office."

THE BUILDING OPENED in 1970, and an addition was added in the mid-1970s, designed by the Architectural Alliance. In 1977, both firms received an award of excellence for their Blue Cross designs from the Minnesota Society of the American Institute of Architects.

For Blue Shield, the 1960s looked promising after enrollment leveled off in 1962 following the split. That year, Blue Shield brought in an IBM 1401 computer, issued the 20,000th hospital rider and introduced major medical coverage. In 1965, Blue Shield moved from the Midway to a stately building at 2344 Nicollet

Avenue in Minneapolis. In the years following, Blue Shield also administered Medicare medical payments, created its own supplemental coverage to Medicare and showed gains in subscribers and subscriber income, but suffered slight underwriting losses that reduced its contingency reserve in 1963 and 1965.[63]

Things began to go wrong for Blue Shield in February, 1969. An attempt to install a revised computer system proved unsuccessful. In October a Dallas data systems firm was brought in and made excellent progress in getting the billing and claims record back on track. By this time Blue Shield had operated nearly a year with inadequate data due to computer failure.

Late in the summer of 1969, the insurance department of Minnesota discovered during its regular triannual audit that Blue Shield's reserves were nearly depleted. The 1969 operating statement indicated that Blue Shield was in the red. Unwilling to let Blue Shield operate in an insolvent state, the insurance commissioner recommended that a debenture be obtained (it was secured), and that the financial conditions be reviewed after two months.

In April, a state auditor visited Blue Shield and reported more bad news. The computer system, which caused so much trouble, had been listed as an asset rather than an expense, and the claims reserve was understated. The total price tag on these items exceeded $1.5 million. An additional $500,000 in accounts receivable, also listed as an asset, was discounted by the insurance commissioner.

STATE OFFICIALS requested financial help to put the 1969 statement in the black. The National Association of Blue Shield sent in a team of financial and actuarial experts whose findings brought still more bad news. Blue Shield erred in figuring its 1968 surplus or contingency account — rather than $5 million, the figure should have been $3.2 million. The books after 1969 should have shown $1.2 million in the red. Furthermore, the team projected a total deficit of $2.6 million, not including the $1 million debenture.[64]

Blue Shield was insolvent and the state insurance commissioner wanted immediate action. State officials, in fact, ordered Blue Shield to obtain $1.5 million within a 24-hour period on April 22, 1970, or face receivership.[65] The Blue Shield board approached Blue Cross, who proved responsive, but a negotiating team did not think the Blue Cross board would approve an investment in Blue Shield. According to Abbott Fletcher, "Blue Cross felt that revised rating, contract revision and very careful management might be able to correct the problems of Blue Shield if given enough time.[66]

Richard Crist remembers the phone call from Attorney General Douglas Head:

"He said Blue Shield was in such a shape that they were going to close them up. Could we protect the policy holders? I said I would have to meet with our board. My feeling was that the public did not separate Blue Cross from Blue Shield and if we didn't take over we would do tremendous damage to our Blue Cross image. Walter Nelson was chairman of the board at that time. The board said, we will guarantee the Blue Shield contracts. I think that was a wonderful thing to do, although we didn't know it was going to be a very expensive undertaking."

Blue Cross guaranteed the obligations of Blue Shield to some 700,000 Minnesota subscribers. The two organizations entered into a contractual agreement on April 27, 1970, which was approved by state officials concerned about the subscribers' well-being.

What caused Blue Shield's plight? One leading factor, according to Blue Shield's actuarial chief, was "the failure to run parallel electronic data processing systems at the time of the conversion of the [new] system in February of 1969."[67] State insurance commissioner, Thomas Hunt, maintained that Blue Shield, in an effort to sell more contracts, wrote below-cost contracts and ultimately, benefits exceeded income.[68]

Ben Stephens puts it this way:

"Blue Shield's insolvency was caused by trying to underbid MII and Blue Cross. Blue Shield went into the hospital business and they thought they could sell $10 bills for $8. They had lacked the expertise in their actuarial departments that Blue Cross had."

And Marcella Connolly remembers the tension among employees: "Mr. Crist didn't want anybody to lose their jobs. He told them he would do everything in his power to protect them."

The agreement between Blue Shield and Blue Cross created quite a stir around the state capitol. Governor Harold Levander did not seek re-election and Lt. Governor James Goetz and Attorney General Douglas Head vied for the Republican nomination. Goetz charged that the Blue Cross and Blue Shield agreement was "ill advised" and "dangerous" because Blue Cross might be able to get out of its obligations by acting in a manner Blue Shield could not accept. Head and Levander backed the agreement. (Head was nominated but lost to Wendell Anderson.)

RESPONSIBILITY FOR the agreement fell on Crist, who assumed the position of chief executive officer for Blue Shield. The *Minneapolis Star* editorialized: . . ."Crist's track record at Blue Cross

BENEFITS FURNISHED IN HOSPITAL

1. **BOARD AND ROOM in a 3- or 4-bed room or ($3.75 a day toward more expensive accommodations in a participating acute hospital or $3.50 toward more expensive accommodations in other affiliated hospitals).**

   Note designations of hospitals on Page 8.

2. **GENERAL NURSING CARE.**
3. **UNLIMITED OPERATING ROOM SERVICE.**
4. **UNLIMITED ANESTHESIA when administered by a salaried employee of the hospital.**
5. **ALL SURGICAL DRESSINGS.**
6. **ALL DRUGS.**
7. **SERUMS, INTRAVENOUS SOLUTIONS AND LIVER EXTRACTS.....up to $8.00**
8. **LABORATORY SERVICE ....up to $8.00 and 25% of any additional.**
9. **X-RAY SERVICE, when necessary, for injuries due to each accident if subscriber is first admitted to the hospital within 24 hours after the accident.....up to $15.00**
10. **X-RAY SERVICE (except for accident cases covered in 9 above), electrocardiograms, basal metabolism studies.....25%**
11. **OXYGEN THERAPY, including all combinations of gases, diathermy, ultra violet and radiant heat treatments, and inhalations when administered by a salaried employee of the hospital.....up to $25.00**

Blue Cross leaflet, undated, lists benefits. This probably was issued during the 1940's.

is outstanding, and [insurance] Commissioner Hunt is justified, we think, in betting on him."[69] By the end of 1971, Blue Shield's deficit had reached $7.5 million, but for the first time in four years Blue Shield did not lose money. Crist noted:

"We do not plan that the effects of the Blue Shield deficit will fall on to the Blue Shield subscribers. We believe the deficit position can be repaired by Blue Shield through sound underwriting practices, without any substantial rate increases for that purpose. The financial audit for 1971 shows that we are making encouraging progress."[70]

In 1972, after the state passed new legislation for non-profit health service plans, Blue Cross and Blue Shield trustees agreed to merge, a proposal approved by the Minnesota insurance commissioner. The new corporation opened up its board to the public and thus was no longer governed only by hospital administrators and doctors. The thirty-three member board consisted of one-third public, one-third physician, and one-third hospital representation.

Richard Crist retired in 1973, and Robert Johnson, president of Utah's Blue Cross Plan, succeeded him. Unlike his predecessors, Johnson's stay was a short one. The trustees accepted his resignation in 1975 due to differences in management techniques and philosophy. During his stay, Blue Cross and Blue Shield of Minnesota (BCBSM, as it was known after the merger) initiated its own health maintenance organization (HMO) now known as HMO Minnesota. One of Minnesota's early HMO's, it had been in the planning stages for years in response to the Group Health Plan.

"I was on a committee that looked into Blue Cross subsidizing an HMO," Dick Faricy recalls. "It was a series of heated debates but the committee and the board determined that the needs of our community could be served by an HMO. I think this also was a marketing decision. If we didn't have an HMO our subscribers might go to organizations that had them, so we established HMO Minnesota. We also had a subsidiary called Minnesota Indemnity, Inc., a for-profit organization."

HMO Minnesota was indicative of the new era Blue Cross and Blue Shield of Minnesota was about to enter — an era of changing systems, increased competition from commercial and non-profit carriers, and tremendous rises in hospital and medical costs.

THE BOARD OF TRUSTEES named James Regnier president following Johnson's resignation. Regnier had been a Blue Cross employee for twenty-nine years. Within a month after Regnier assumed his new role in April, 1976, Blue Shield moved from its Nicollet Avenue location to the corporate office in Eagan. That year, also, BCBSM created a seventy-eight member public corporate body to directly elect the public trustees. But the board's evolution to public representation did not stop there. In 1978, the board's make-up changed again when public trustees were given a majority on the board, exceeding the combined number of hospital and physician members.

"The hospital people and the physicians had felt proprietary about Blue Cross and Blue Shield because they started the programs," Dick Faricy says. "I took the position that it was the subscribers' program, not the hospitals' or the doctors'. This led to the concept,

developed while I was chairman of the board, that most of the board members should represent the subscribers."

Under Regnier, the corporation's contingency reserves increased through 1979, despite a $1.9 million underwriting loss. The loss was due to inflation which in 1979 reached 13.3 percent, the highest since World War II. The cost of medical care rose 10.1 percent nationally. These two specters — inflation and rising hospital costs — did not go away, and the situation was compounded, in 1980, by a 6 percent loss in subscribers. That year, also, income rose 7.5 percent but payments went up 19.2 percent! The result was a $26 million loss that lowered the BCBSM reserve to $53.6 million.[71]

In 1981 and 1982, BCBSM lost $7 million and $4 million, respectively. The substantial loss of 1980 was slowly being turned around, even though the national economy still created surprises. In 1981, for example, BCBSM suffered a $3.8 million loss from a decrease in the market price of stocks held. Subscriber rates increased, but so did the organization's effort to contain costs through capping statewide customary charges and renegotiating agreements with hospitals.[72]

On January 1, 1983, Andrew Czajkowski replaced the retiring Regnier as president and chief executive officer. He has continued the turn-around. In 1983 Blue Cross and Blue Shield of Minnesota showed a $4 million gain. Soon after taking office, Czajkowski oversaw the introduction of the "Aware" program to establish predictability in hospital and physician reimbursements. Through negotiations, initially with twenty Twin Cities hospitals, payments were established for different categories of hospital care, and lengths of stay were predetermined for specific types of ailments. Within nine months of its inception, "Aware" saved groups $7 million while keeping annual cost increases down to 9 percent — compared to the 20 percent figure of the previous years.[73]

UNDER CZAJKOWSKI new attempts to revitalize Minnesota Indemnity, Inc. (MII) are underway. When Blue Shield came back into the fold, MII contract holders were encouraged to shift back to Blue Shield and MII developed into a carrier of dental, disability, and weekly indemnity insurance. In 1983, it introduced group term life insurance. Also in 1983, Blue Cross and Blue Shield of Minnesota became the writing carrier for the Minnesota Comprehensive Health Association, which covers uninsurable persons in Minnesota. Membership in HMO Minnesota rose from 52,000 to 65,000. Blue Cross and Blue Shield of Minnesota had just under 800,000 members and Medicare disbursements reached $684 million.[74]

In 1937, van Steenwyk clearly saw what the Minnesota Hospital Service Association should be: . . . "the Association is a service agency."[75] Today, Czajkowski sees BCBSM evolving from van Steenwyk's conception of agent into the role of a medical manager. Compelled by diversity in the medical delivery systems' marketplace, BCBSM has established a preferred provider organization through its "Aware Gold" program. Under this program a large percentage of the state's doctors and all Aware hospitals give subscribers a wide choice of health care providers, unlike HMO's which tend to offer staff doctors and a small choice of hospitals. Thus, this aspect of "Aware Gold" competes against HMOs. Why?

"It gives us one more approach to the marketplace," Czajkowski maintains. "We feel we should be a leader in the health care field . . . Even though we're non-profit, we still have the same desire to grow and spread as a for-profit company. It's a matter of pride."[76]

Dorothy Hunt describes the changes in health care, and how the statistics she worked with reflected those changes.

"After the Salk vaccine came in," she says, "we saw a little surge upward again in tonsillectomies. Maternities went down with the advent of the Pill. Years ago college students had very low rates as good health risks. In the 1960s, when drugs became a problem, students were no longer a low-rated population segment, unfortunately."

Dick Faricy looks back on what he sees as the biggest changes of the last few years in Blue Cross and Blue Shield.

"First was the merger of the two organizations. Next was the development of the HMO as a service and marketing element for the two groups. Thirdly, there was the change in the board of trustees to a majority of public members and their election through a corporate body."

Andy Czajkowski adds that Blue Cross and Blue Shield was also a pioneer in recognizing the role of women in business. As early as the 1950s Frances Rossiter was manager of the claims department and Dorothy Hunt was vice president during the early 1960s when it was rare for women to assume a leadership role in a business organization.

"We also were one of the first companies to make maternity coverage available to its female employees," he says. "Most organizations provided coverage only for dependents of male employees. Also, all fringe benefits were equally available to male and female employees. Most organizations wouldn't

The key punch department at 2610 University, ca. 1958.

respond to equal treatment in areas of fringe benefits until the 1970s."

The board of trustees also recognized women in the business world as early as the 1950s and 1960s. Two women who served during that time were Sister Marybelle, who was hospital administrator at St. Mary's Hospital, Duluth, Minnesota, and Dorothy Petsch, administrator of the Worthington Regional Hospital. Today there are five women on the twenty-three-member board.

Today, the problems and alternatives confronting BCBSM are more complex than those van Steenwyk confronted fifty years ago. One element hasn't changed, however. In 1934, Rufus Rorem asked van Steenwyk a question about prepaid, non-profit health care, "Are you a bull or a bear . . .?" Van Steenwyk's answer mirrors BCBSM's attitude today. "The answer is an emphatic bull."[77]

FOOTNOTES

1. Anderson, Odin W., *Blue Cross Since 1929: Accountability and the Public Trust* (Cambridge, Mass: Ballinger Publishing Company, 1975), 45.

2. Fletcher, Abbott Lee, *History of Minnesota Blue Cross* (No publisher, no date, 1970?), 108.

3. The Committee on the Cost of Medical Care, *The Five-Year Program of the Committee on the Cost of Medical Care* (Washington, D.C., 1928), 6.

4. Carpenter, Niles, *Hospital Service for Patients of Moderate Means* (Washington, D.C.: Committee on the Cost of Medical Care, 1930).

5. Davis, Michael M. "The Patient of Moderate Means — Shall We Help Him?" *The Modern Hospital,* 32 (May 1929), 75-77.

6. As reprinted in Carpenter, *Hospital Service for Patients of Moderate Means,* 13.

7. Carpenter, *Hospital Service for Patients of Moderate Means,* 101.

8. Falk, I.S., Martha D. King and C. Rufus Rorem, *The Cost of Medical Care* (Chicago: University of Chicago Press, 1933), 22 (No. 27 of the publications of the Committee on the Costs of Medical Care). This brief account is taken from the above which contains a review of the existing forms of health insurance at the time.

9. Falk, *et al, The Cost of Medical Care,* 451.

10. Williams, Pierce, *The Purchase of Medical Care Through Fixed Periodic Payment* (New York: National Bureau of Economic Research, 1932), 236.

11. Anderson, *Blue Cross Since 1929 . . . ,* 36.

12. This figure appears uncited in Williams, *History of Minnesota Blue Cross* and in Ward, Peter and Calvin, Arthur, "St. Paul's Group Hospitalization Plan," *Minnesota Medicine,* 15 (December 1932) 854.

13. Fletcher, *History of Minnesota Blue Cross,* 8.

14. *Ibid.,* 9.

15. Abbott Fletcher noted in his *History of Minnesota Blue Cross,* 15, that former president of the Blue Cross Association, Walter J. McNerny, referred to van Steenwyk as a "giant" in the Blue Cross movement.

16. Stuart, James E. "The Blue Cross History: An Informal Biography of the Voluntary Non-Profit Prepayment Plan for Hospital Care," (Unpublished manuscript, 1966), 34.

17. "Mr. Blue Cross and Son," *Corporate Columns* (published for Blue Cross and Blue Shield employees, April, 1983), 10-11.

18. Van Steenwyk apparently worked with Calvin and Ward before the Association formed (see *Corporate Columns,* 4/83). Biographical information on van Steenwyk appears in Anderson, *Blue Cross Since 1929 . . . , The Blue Cross Association Exchange,* extra edition, April 4, 1962, and *Corporate Columns,* April, 1983.

19. "Group Hospitalization for Employed Men and Women in St. Paul," (June 1, 1933), pamphlet in the MN Blue Cross and Blue Shield papers.

20. Fletcher, *History of Minnesota Blue Cross,* 22-26; and Stuart, "The Blue Cross History. . . ," 34.

21. Van Steenwyk, E.A. "The Story Behind Group Hospitalization in St. Paul," *The Modern Hospital,* 43:4 (October, 1934). Information on Thomas Good comes from a memorandum in the Blue Cross papers, July 7, 1967, two days after Mr. Good's death. The first year figure of 1,812 comes from an unpublished account written by van Steenwyk, "Notes on the History of the St. Paul Hospital Service Association and

the Minnesota Hospital Service Association," August 4, 1939, in the Minnesota Blue Cross and Blue Shield papers.

22. Van Steenwyk, "The Story Behind Group Hospitalization in St. Paul," discusses this problem as does Fletcher, *History of Minnesota Blue Cross*.

23. Van Steenwyk, "The Story Behind Group Hospitalization in St. Paul."

24. *Ibid.*

25. As quoted in Stuart, "The Blue Cross History. . . ," 35.

26. The Blue Cross symbol is mentioned by van Steenwyk in his 1934 article, "The Story Behind Group Hospitalization in St. Paul," and discussed in Anderson, *Blue Cross Since 1929 . . .*, 36; Fletcher, *History of Minnesota Blue Cross*, 17-19; and Stuart, "The Blue Cross History . . . ," 35-36.

27. Van Steenwyk, "The Story Behind Group Hospitalization in St. Paul."

28. *Ibid.*

29. *Ibid.*

30. Fletcher, *History of Minnesota Blue Cross*, 29.

31. "Annual Report, Minnesota Hospital Service Association," (for year 1935, January 15, 1936).

32. "Annual Report, Minnesota Hospital Service Association," (for year 1936, January 21, 1937).

33. Van Steenwyk, E.A., "Notes on the History of the St. Paul Hospital Service Association and the Minnesota Hospital Service Association," (Unpublished manuscript in the Blue Cross papers, August 4, 1939) 19-20.

34. *Ibid.*, 23.

35. Van Steenwyk to A.G. Stasel (president of the board, Minnesota Blue Cross), November 21, 1938. Blue Cross/Blue Shield papers.

36. "A tribute to E.A. van Steenwyk, (Blue Cross Association) *Exchange*, (extra edition, April 4, 1962) 2.

37. Fletcher, *History of Minnesota Blue Cross*, 32.

38. Form letter in the Blue Cross papers thanking those who cooperated with obtaining the petitions, September 6, 1939.

39. "Minnesota Hospital Service Association Annual Report," (for year 1940,January 15, 1941).

40. "Minnesota Hospital Service Association Annual Report," (for year 1941, December 31, 1941).

41. "Blue Cross Plan Announces Increase in Dependent Benefits on Tenth Anniversary," *Blue Cross News*, 4 (July, 1943).

42. "Minnesota Hospital Service Association Annual Report," (for year 1943, December 31, 1943). Other information in this paragraph comes from the 1942 Annual Report).

43. "Minnesota Hospital Service Association Annual Report," (for year 1946, December 31, 1946).

44. Fletcher, *History of Minnesota Blue Cross*, 42.

45. Anderson, *Blue Cross Since 1939 . . .*, 54.

46. "Minnesota Blue Shield Historical Data", (unsigned, undated manuscript in the Blue Cross Blue Shield papers).

47. Fletcher, *History of Minnesota Blue Cross*, 42-43.

48. Information from this paragraph comes from two unsigned addresses given before the House of Delegates of the Minnesota Medical Association at the Hotel St. Paul dated May 13, 1957, and May 21, 1958, in the Blue Cross/Blue Shield papers.

49. "Two Ways to Safeguard Your Family's Health," (promotional brochure for Blue Cross and Blue Shield, January, 1948) Blue Cross/Blue Shield papers.

50. "Annual Report, 1952, Minnesota Medical Service, Inc."

51. Fletcher, *History of Minnesota Blue Cross*, 108.

52. "Mr. Calvin Says," *Blue Cross-Blue Shield Bugle*, (July-August, 1954), 7.

53. Fletcher, *History of Minnesota Blue Cross*, 44.

54. *Ibid.*, 46.

55. *Ibid.*, 51. Fletcher goes into more detail about the Blue Cross and Blue Shield disagreements in the 1950's.

56. *Ibid.*, 52-53.

57. *Ibid.*, 56-57. The specifics of this case and the concessions are difficult to determine since the only available references are found in Fletcher's book and the non-descriptive minutes of the Blue Cross Board. Other records relating to the case seem to have been discarded, as have many records of Blue Cross and Blue Shield, likely because of the moves both organizations have made and the space shortages prior to these moves.

58. Enrollment and financial statistics come from Fletcher, *History of Minnesota Blue Cross*. Other statistics come from the "Blue Cross Annual Report, 1958."

59. Blue Shield statistics come from "Minnesota Medical Service, Inc., Annual Report, 1952," and "Blue Shield of Minnesota, Annual Report for 1968."

60. These statistics appear in Fletcher, *History of Minnesota Blue Cross*.

61. *Ibid.*, 86.

62. "Minnesota Blue Cross 1967 Annual Report."

63. Figures from this paragraph come from "Blue Shield Annual Reports" for the respective years.

64. Financial figures of Blue Shield's troubles come from the minutes of a special meeting of the board of directors held April 22, 1970.

65. Fletcher, *History of Minnesota Blue Cross*, 93.

66. *Ibid.*, 94.

67. Minutes of the special meeting of the Blue Shield Board of Trustees, April 22, 1970.

68. *The Minneapolis Star*, May 21, 1970.

69. *Ibid.*, May 19, 1970.

70. "Blue Cross and Blue Shield Agree to Merge," *Heartbeat* (a monthly report from Minnesota Blue Cross, Blue Shield of Minnesota and MII), 10, (May, 1972). 1.

71. BCBSM 1979 and 1980 Annual Reports.

72. "BCBSM 1981 Annual Report."

73. Walden, Gene, "Blue Cross/Blue Shield: A New President Has the 'Blues' Singing a Happy Tune." *St. Paul City Business* (April 19, 1976).

74. "BCBSM 1983 Annual Report."

75. "Annual Report, Minnesota Hospital Service Association," (for year 1937, January 21, 1938).

76. Walden, "Blue Cross/Blue Shield: A New President . . ."

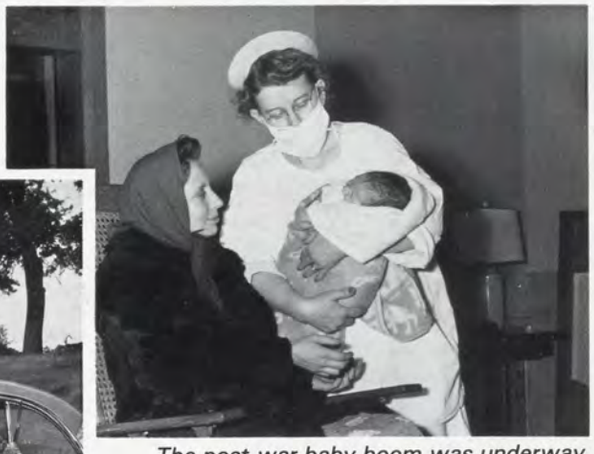
77. Van Steenwyk, "The Story of Group Hospitalization in St. Paul."

Note: Quotations and other material contributed by Richard Crist, Dorothy Hunt, James Flavin, Ben Stephens, Bert O'Leary, Richard T. Faricy, and Marcella Connolly are excerpted and adapted from interviews the author conducted with each person during September of 1984.

Ramsey County History
published by
the Ramsey County Historical Society
323 Landmark Center
75 West Fifth Street
St. Paul, Minn. 55102

Andrew Czajkowski, chief executive officer, Blue Cross/Blue Shield of Minnesota.

Blue Cross's second home, at 2388 University Avenue.



The post-war baby boom was underway when Mrs. Herman Kluegel and her son left Bethesda Hospital in 1946.

Freelance photographer Nick Burkowski shot this descriptive photograph in 1959.

The Gibbs Farm Museum, owned by the Ramsey County Historical Society, at Cleveland and Larpenteur in Falcon Heights.

NON-PROFIT ORGANIZATION
U.S. Postage
PAID
St. Paul, MN
Permit #3989