

**HOSPITAL, MEDICAL, AND SURGICAL SERVICE PLANS
IN VIRGINIA**

**REPORT OF THE
VIRGINIA ADVISORY LEGISLATIVE COUNCIL
to
THE GOVERNOR
and
THE GENERAL ASSEMBLY OF VIRGINIA**



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VIRGINIA ADVISORY LEGISLATIVE COUNCIL

Richmond, Virginia, December 7, 1961.

To:

HONORABLE J. LINDSAY ALMOND, JR., *Governor of Virginia*
and
THE GENERAL ASSEMBLY OF VIRGINIA

The General Assembly at its 1960 Session drastically changed the pattern of regulation theretofore in effect applicable to those contracts and plans for future hospital, medical and surgical services, generally known as Blue Cross and Blue Shield Plans. Although in their inception these plans had operated without any regulation by the State, they had been for many years subject to control by the State Corporation Commission through its Securities Division. The 1960 legislation brought them, in limited respects, within the coverage of the laws applicable to insurance and placed the supervisory power in the State Corporation Commission through its Bureau of Insurance. The control formerly exercised by the Commission over charges to subscribers of such plans was eliminated. The General Assembly, feeling that it should have as much information as possible as to the general operations of the plans and as to the effect of these changes, adopted a resolution directing the Virginia Advisory Legislative Council to make a study of the plans, the text of which is as follows:

SENATE JOINT RESOLUTION NO. 54

Directing the Virginia Advisory Legislative Council to make a study and to report upon the laws concerning contracts and plans for hospitalization, medical and surgical services.

Whereas, the public welfare of Virginia requires the solvency and soundness of contracts and plans for hospitalization, medical and surgical services, under which approximately 700,000 of its citizens are presently protected; now, therefore, be it

Resolved by the Senate of Virginia, the House of Delegates concurring, That the Virginia Advisory Legislative Council be and the same is hereby directed to make a comprehensive study of the contracts and plans for hospitalization, medical and surgical services, as authorized by Title 32, Chapter 11 of the Code of Virginia of 1950 as amended, and without excluding any phase of the subject not herein specifically mentioned, to include within the scope of the Council's scrutiny:

1. The operating practices, actual and potential, under such contracts

The matter of rates and the bearing thereon of administrative,

3. The advisability of deductible provisions, both voluntary and compulsory.

4. The nature and size of desirable reserves.

5. Taxation of annual gross premiums, dues or charges received by such plans for services rendered or to be rendered.

6. The extent, if any, to which such plans should be classified and treated as insurance.

7. All other ancillary and pertinent phases of the subject under investigation.

The Council shall complete its study and make a report, containing its recommendations, to the Governor and the General Assembly not later than November one, nineteen hundred sixty-one.

The Council selected Dr. J. D. Hagood, Clover, member of the Senate and member of the Council, as Chairman of a committee to make the initial study and report to it. Selected to serve with Dr. Hagood on the Committee were: Howard P. Anderson, Attorney and member of the House of Delegates, Halifax; Floyd L. Boddicker, Plant Manager, Hercules Powder Company, Hopewell; H. B. Boyd, President, Virginia AFL-CIO, Richmond; Roy R. Charles, Smith-Douglass Company, Incorporated, Norfolk; Mrs. Martha Elizabeth Foxwell, Falls Church; Dr. E. E. Haddock, member of the Senate, Richmond; William H. King, Attorney and Counsel for the Virginia Hospital Service Association and Virginia Medical Service Association, Richmond; Dr. John P. Lynch, Richmond; Harold Prather, Administrator, Richmond Memorial Hospital, Richmond; William R. Shands, Vice-President and General Counsel, The Life Insurance Company of Virginia, Richmond; and James M. Thomson, Attorney and member of the House of Delegates, Alexandria.

The Committee organized and elected Dr. Haddock as Vice Chairman. John B. Boatwright, Jr., and G. M. Lapsley were appointed Secretary and Recording Secretary, respectively.

The Committee collected information concerning the operations of Blue Cross and Blue Shield plans and other plans offering hospital, medical, and surgical services on a prepayment basis, both in Virginia and throughout the nation. For comparative purposes (since many problems are common), it secured much information as to experience of insurance companies which write policies indemnifying for expenses incurred for hospitalization and medical and surgical care. It secured copies of the major studies which have been made of problems related to prepayment plans for hospital, medical and surgical service in the nation. It held a public hearing to which the public, as well as representatives of the prepayment plans and of insurance companies, were invited. It conferred extensively with administrative officials of the major plans operating in Virginia and with the staff of the State Corporation Commission charged with enforcement of the regulatory statute. It formed an Executive Committee and subcommittees which gave detailed study to data bearing on the several aspects of the study.

Based upon the voluminous data before it, and the views expressed to it, the Committee submitted its report to the Council. The Council has carefully considered the report of the Committee and now submits its conclusions and recommendations, and a synthesis of the factual data upon which the same are based.

CONCLUSIONS

1. The Blue Cross and Blue Shield plans and private insurance which provide on a voluntary basis for the prepayment of hospital, medical and surgical costs are vital to the health and welfare of the American people and must be preserved; they are a bulwark against the assumption by the federal government of responsibilities in this field which properly should be discharged by the citizens of this country themselves; to the extent that these plans and the insurance companies writing health insurance are unable to continue to provide for the public at a reasonable price prepayment plans covering hospital and medical costs, it may be expected that the federal government will act.

2. The cost of such coverage depends in large measure upon the cost of hospital and medical care and the utilization of such care by the public.

3. The charges made to subscribers and policy holders for hospital, medical, and surgical costs have been increasing sharply during recent years; this increase has resulted in part from two factors which are beyond the control of the plans and the insurers—the reflection in hospital and medical costs of the general price rise which has taken place in the nation and the provision of improved but much more expensive medical care.

4. The public needs and demands the best hospital and medical service that can be provided at reasonable cost and the public must be prepared to pay such cost; to the extent that charges to the subscribers and policy holders reflect this improvement in hospital and medical care, they are justified and further increases might be expected.

5. There are some elements in the rise in charges to subscribers and policy holders which are within the control of the public, the hospitals, and the medical profession; there have been some abuses—such as overutilization—which have adversely affected the rates charged by both the plans and by insurance companies; if the charges made to meet future hospital, medical and surgical costs are to be kept within limits which the public can pay, a concerted effort on the part of all concerned is essential.

RECOMMENDATIONS

1. The problem of unnecessary hospitalization should be faced realistically by the Blue Cross and Blue Shield Associations, by health insurers, and by the medical profession; the State and local medical societies should be acquainted with the facts concerning abuses and should take action to correct them.

2. It is highly desirable that subscribers be subjected to some part of the cost of hospitalization to discourage too many admissions and undue length of hospital stays. This should be accomplished through educational processes and not made statutory.

3. The Blue Cross-Blue Shield Associations should conduct a more vigorous public education program including a general explanation of hospital costs and the provisions of prepayment contracts which exclude hospitalization services when rendered only for diagnostic purposes.

4. The Advisory Hospital Council should withhold approval of government funds for new general hospital beds when there is no need for the additional facilities.

5. The present tax-exempt status of charges to subscribers under contracts for hospital, medical, and surgical services should be continued.

1. REGULATORY LEGISLATION

Pre-1940 Period

Prior to 1940 the issuance and sales of contracts for future hospital or medical and surgical services were not regulated, as such, by statute in Virginia. The 1940 act states in its preamble that such activities were conducted under the supervision of the Corporation Commission "upon the principle that such contracts and undertakings, when involving direct obligation on the part of the operator, or operators, of the hospital, or hospitals, proposing and contracting to perform the services, constitute service contracts and are securities".

1940-1960 Period

In 1940 the General Assembly adopted a statute (Chapter 230, Acts of Assembly, 1940) placing the offering of future hospitalization or medical and surgical service contracts under the supervision of the State Corporation Commission. The Act authorized hospitals, and groups of physicians and surgeons, acting directly or through nonprofit agencies, to offer such contracts. It required licenses of organizations engaging in the business and of solicitors or salesmen for such plans. It stated that the participating hospitals and physicians and surgeons, respectively, would be liable on the contracts issued on their behalf by such plans. It forbade any hospital or any physician or surgeon to be a participant in more than one such plan unless approved by the State Corporation Commission and gave the Commission power to establish the territorial jurisdiction of the several plans so as "to minimize competition which might prove obstructive to a healthy growth". It provided specifically that the statute would not be applicable to insurance companies, required contracts issued to state that they were not contracts of insurance, and forbade advertising giving the appearance of insurance. It prohibited payments directly to subscribers on account of services rendered except in cases of emergency service when the hospital or physician performing the service required or actually received payment from the subscriber. The statute further prescribed the extent to which the general corporation laws and the Securities Law would be applicable to such contracts. It provided that the license fees required of the plans by the statute would be in lieu of all State and local licenses, fees and taxes except taxes on physical property.

While the 1940 Act did not in terms provide for approval of forms of contracts and regulation of rates, control of these was exercised by the State Corporation Commission under an interpretation of the Securities Law.

The original regulatory statute remained unchanged until 1956. At the 1956 session of the General Assembly the law was totally rewritten; however, most of the changes were for the purpose of clarification and simplification, the substantive provisions remaining generally the same. A provision was added making it clear that the State Corporation Commission would have no jurisdiction in controversies regarding the carrying out of subscription contracts, but it was provided that in the event of breach of contract by a participant, a judgment could be satisfied out of assets held by the plan. It also was made clear that, while a participating hospital or physician could withdraw from the plan, it or he

would still be liable on subscriber contracts up to the end of the subscriber's contract year; and that new participants would assume liability on outstanding contracts. The Commission was required, under this Act, to assure itself that the expenses of operation of the plans were reasonable. Approval of contracts and rates was specifically provided for. Experience rating of individual groups was permitted and, whereas the original act had stated that no specified reserves were to be required, the 1956 amendment directed the fixing of rates so as to allow the plans to maintain reserves between one-sixth and three-sixths of the preceding year's subscriber income. Other relatively minor changes of a technical nature were also made.

1960 Changes

In 1960 a bill, which was urged by Blue Cross representatives, and supported by the State Corporation Commission, was adopted by the General Assembly to make two drastic changes in the regulatory statute although retaining generally the form and most of the provisions of the 1956 amendments. The provisions which had formerly required the Commission to approve the contracts issued by the prepayment plans and the rates at which the same were sold were repealed; and the Associations were made subject to the insurance laws to the extent of giving the Commission the power to examine them periodically with a view of insuring that their financial condition was such as to afford protection to subscribers and to approve contract forms. The specific requirement for reserves was eliminated, but the Commission was empowered to assure itself of the solvency of the Associations. The statutes prohibiting unfair trade practices were also made applicable. Thus, after the enactment of this legislation, the plans were able to fix their rates at such figures as, in their individual judgment, would be sufficient to meet anticipated charges and to change rates without the necessity of going to the Corporation Commission with the burden of justifying each change, being, in this respect, on an equal footing with insurance companies insuring against hospital and medical and surgical expenses.

2. DEVELOPMENT OF BLUE CROSS AND BLUE SHIELD ORGANIZATIONS IN VIRGINIA

The Blue Cross concept, originating in Texas in 1929, spread rapidly throughout the United States and the State of Virginia was no exception. The dates on which the several Virginia Blue Cross and Blue Shield plans were organized were as follows:

Blue Cross

Tidewater Hospital Service Association (Norfolk) — 1935
Virginia Hospital Service Association (Richmond) — 1935
Piedmont Hospital Service Association (Lynchburg) — 1938
Hospital Service Association of Roanoke — 1939

Blue Shield

Virginia Medical Service Association (Richmond) — 1945
Surgical Care, Incorporated (Roanoke) — 1945

There were also formed additional groups which latter became affiliated with the Richmond Plan. Originally there was no statute to prevent overlapping or duplicating services and in some instances, notably that of

the Grace Hospital Plan in Richmond, there was such overlapping. With the adoption of the 1940 statute, however, the State Corporation Commission was given power to allocate jurisdictional areas between the Associations and today only one hospital in Virginia is a participating hospital in more than one Plan, and the geographical lines of the Associations are clearly fixed. There follows a map showing the principal associations operating in Virginia and the territory within which they function.

(The map does not show, nor does this report discuss, the several other plans, not affiliated with Blue Cross or Blue Shield, operating in Virginia, since their operations are limited and their clientele restricted.)

3. THE VIRGINIA ASSOCIATIONS

(a) The Richmond Plans

Development of the associations can best be shown by a detailed examination of the Richmond Plans. Parallel information will be set forth for the other major groups but in less detail.

(1) *Organization*

At the time of the organization in 1935 of the Richmond Blue Cross Plan, it covered only certain hospitals in Richmond. In 1939, an independent Plan operated by Grace Hospital, in Richmond, was merged with the Richmond Plan. In 1948 two additional Plans—the Winchester Memorial Hospital Plan and the Northampton-Accomack Hospital Plan also merged with the Richmond Plan, the name of which had been changed to Virginia Hospital Service Association, and in 1951 this Association took over the territory and contracts of the Virginia Peninsula Hospital Service Association, operating in the Newport News area. By 1958 the northern Virginia area (Alexandria, Arlington, Fairfax and Falls Church) which was formerly served by the Richmond Plans had been ceded to and accepted by District of Columbia Association.

(2) *Growth*

There follows a table showing for each year since its organization the number of hospitals embraced in the Richmond Plan, and the total bed capacity of the several hospitals. There also follows a table showing the membership of the Richmond Area Blue Cross and Blue Shield Associations and it will be noted that in each of the years when there was a merger, there was a significant increase in number of subscribers. The number of subscribers reached its peak in 1957 for Blue Cross and since that time there has been a gradual decline. Blue Shield, on the other hand, has shown a relatively steady growth and in 1960 enrolled more subscribers than at any previous time. (In considering the subscriber membership figures for the two Associations it should be remembered that the Richmond Area Blue Shield provides Blue Shield services in the geographical areas served by the Tidewater Hospital Service Association and the Piedmont Hospital Service Association as well as in its own Blue Cross area.)

The Virginia Medical Service Association—the Richmond Area Blue Shield Plan—was organized in 1945 with a total of 437 participating physicians. The number of participating physicians for this plan has shown a steady increase throughout the sixteen years of its existence and had risen in 1960 to a total of 1,671 participating physicians.

Growth of Hospital Membership—Richmond Blue Cross Plan

<i>Year</i>	<i>No. of Hospitals</i>	<i>Total Beds</i>
1935	5	765
1936	5	779
1937	5	778
1938	6	886
1939	7	971
1940	7	971
1941	13	1820
1942	13	1820
1943	13	1841
1944	15	1850
1945	33	2826
1946	33	2893
1947	37	3793
1948	37	3793
1949	35	3569
1950	35	3797
1951	40	4399
1952	38	4672
1953	32	4172
1954	34	4201
1955	33	4308
1956	38	4928
1957	39	5163
1958	39	5632
1959	39	5872
1960	42	6437
1961	43	6718

Growth of Physician Membership of the Richmond Blue Shield Plan

1945	437
1946	567
1947	624
1948	694
1949	765
1950	829
1951	841
1952	788
1953	981
1954	1224
1955	1325
1956	1456
1957	1568
1958	1629
1959	1656
1960	1671

Growth in Number of Subscriber Contracts of
Richmond Blue Cross and Blue Shield Plans

<i>Year Ending (Dec. 31)</i>	<i>VHSA</i>	<i>VMSA</i>
1936	1,965	
1937	5,447	
1938	10,792	

<i>Year Ending (Dec. 31)</i>	<i>VHSA</i>	<i>VMSA</i>
1939	17,517	
1940	22,184	
1941	27,119	
1942	29,117	
1943	30,408	
1944	39,006	
1945	52,120	7,393
1946	69,564	31,648
1947	87,321	50,691
1948	103,202	68,786
1949	113,120	85,564
1950	124,149	102,552
1951	141,411	114,820
1952	145,537	123,148
1953	144,559	129,088
1954	137,044	126,774
1955	141,512	136,755
1956	159,429	151,922
1957	169,369	166,846
1958	167,246	167,916
1959	154,693	159,074
1960	145,842	170,863

(3) *Control*

The original Blue Cross by-laws of the Richmond Blue Cross Plan specified that the Board of Directors should consist of not more than 14 members but did not specify its composition. Three years later, in 1938, the composition of this board was specified as one member from each hospital (there being six member hospitals then), and one lay member for each hospital member, plus the Chairman of the Board of Trustees of the Richmond Academy of Medicine. At this time also provision was made for a nonvoting Technical Advisory Committee to consist of the Superintendent or another representative of each participating hospital. Members of this Committee could attend board meetings.

The number of directors was set at 19 in 1942; in 1949 it was provided that 7 of the 19 should be representatives of the following hospitals: St. Lukes, Henry Franklin, Johnston-Willis, St. Elizabeths, Stuart Circle, Retreat for the Sick, and Medical College of Virginia. In 1955 the membership of the Board was increased to 29; in addition to representation of the same named group of hospitals it was provided that 7 directors should represent participating hospitals located outside of the City of Richmond and that one should be the nominee of the Richmond Academy of Medicine.

The present Board of Directors of the Richmond Area Blue Cross consists of 33 members, elected by members of the Association with representation from the same named hospitals, from 9 member hospitals other than the named hospitals, the nominee of the Richmond Academy of Medicine, and 16 members at large; and it is provided that the Board shall be "broadly representative of the interests of the Association and of the public throughout the geographic area of operations of the Association".

The Board of Directors of the Virginia Medical Service Association initially consisted of 35 persons, one or two of the lay members being representatives of labor. In 1953 the composition of the Board

was changed to provide that at least two-thirds of the Directors would be doctors of medicine actively engaged in practice and that there should be representatives of each of the hospital service associations operating in the area. This is substantially the composition of the present Board except for the additional provision that not more than one-third of the Directors may be lay members of the subscribing public served by the Association and 12 of the physician members shall be designated by the Medical Society of Virginia.

The Members of both Boards serve without compensation.

(4) *Coverage Written*

Coverage under the Blue Cross Contract

As originally offered in 1935, the Blue Cross contract provided, generally, for services available to be performed by hospital staff members, with occupancy of a semi-private room, and provision of medicines, dressings, etc., for a maximum of 21 days in any contract year. Excluded from coverage were electrocardiograms, basal metabolism tests, physiotherapy, and hospitalization for nervous and mental conditions, tuberculosis, or pre-existing conditions. The care was offered only in participating hospitals.

In 1937 emergency care in non-participating hospitals was provided for and the number of days coverage was increased to 35 for the second and succeeding years of membership. In 1939 coverage for nervous and mental conditions and tuberculosis in general hospitals was provided for; this was limited to 10 days in a contract year in 1947. In 1941 coverage for obstetrical cases was limited to 10 days.

Further changes and the years in which they occurred were as follows:

1945—EKG, basal metabolism tests, physiotherapy covered.

Half-coverage for 120 days after 35 days full coverage.

1947—Pre-existing conditions covered after one year.

60 days full coverage, 180 days half-coverage.

Semi-private rate allowed towards private room.

1951—Private room allowance limited to \$6.00.

1952—Private room allowance raised to \$8.00.

1954—Semi-private rate allowed towards private room.

Obstetrical coverage limited to 8 days.

Half-coverage eliminated.

1958—10 day limit eliminated on nervous and mental conditions and tuberculosis.

Obstetrical coverage limited to 7 days.

\$50.00 deductible endorsements provided for.

The present contract provisions were adopted in 1960. These place a limitation of \$12 a day on allowances for room, board and nursing and fix a total of \$80 maximum allowance for obstetrical cases. Endorsements are offered whereby these limitations may be eliminated upon payment of a higher rate. These endorsements, however, are offered only if elected by the majority of members of the group concerned and are not individual options. Similarly, the many other endorsements offered to experience rated groups are available only to the group as a whole.

Coverage under the Blue Shield Contract.

Few changes have been made in the Blue Shield contract of the Virginia Medical Service Association. As offered initially, it provided full service where the individual income was \$2,000 or less, husband-wife income \$2,500 or less and family income \$3,000 or less. Persons with income over these limits received, toward the physician's or surgeon's bill, payment according to a fee schedule which contained a maximum limitation of \$150. In medical cases hospitalized, however, no provision was made for payment for medical care in the first three days of the patient's stay. Maximum payment for X-rays was set at \$10.

In 1951 the income limits were raised to \$2,400, \$3,200, and \$4,000, respectively. First day coverage was provided for medical cases and X-ray benefits were increased to a maximum of \$50 in one year. In 1958 the fee schedule was increased to provide a \$200 maximum, the former limitation of 35 days on medical care was increased to 60, and Blue Shield included coverage for anesthesia (formerly provided only by endorsements), pathology, and treatment with X-ray, radium and related materials.

The above brief summary does not attempt to exhaust the subject of coverages offered. There are many endorsements both expanding and limiting coverage; in fact, we are advised that as to experience rated basic contracts there are as many as 300 permissible combinations of endorsements. Furthermore, "comprehensive" in addition to "standard" contracts are offered which materially increase the benefits provided under both Blue Cross and Blue Shield at a somewhat higher rate.

Non-Group Coverage by Blue Cross

The above summary of provisions of Blue Cross contracts are applicable to what has always been the basic coverage written by the Association—group coverage. It has also been a policy of Blue Cross, however, to issue non-group or "pay-direct" contracts, consistently with its policy that persons will not be denied Blue Cross coverage because of age or health conditions arising subsequent to original enrollment in Blue Cross. Thus, upon cessation of employment by a person in a Blue Cross group, he has the right to convert his coverage to a non-group policy. These are written at somewhat higher rates but may provide basically the same coverage.

In addition, beginning in the late 1940's Blue Cross began offering its contracts to the general public regardless of group affiliation. It was realized that this would permit adverse selection and in an attempt to avoid this the Association permitted enrollments only during two brief enrollment periods each year. However, their experience with these contracts was unfavorable, and in 1952 Blue Cross ceased to offer them on such a basis. Group conversions, however, were continued.

In 1956 Blue Cross contracts were again offered to the general public, without group affiliation. At this time, a basic change in policy was made and the applicant for such a contract was required to fill out an application containing a medical history, and to allow the Blue Cross to secure information concerning his health from such sources as might be available. Upon receipt of this information, the Blue Cross either accepts the application, rejects it, or accepts it with a waiver applicable to certain known conditions of health disclosed by information before it. Blue Cross experience with this type of contract has been more

favorable than its group business as a whole. A statement of its non-group experience follows.

Expense to Income Ratios, Pay-Direct Contracts

<i>Type of Contract</i>	<i>Blue Cross</i>	<i>Blue Shield</i>
Underwritten	76.3%	75.8%
Community Enrolled	117.9%	94.1%
Group Conversions	115.5%	96.9%

It will be noted that, although the community enrollment was discontinued in 1952, those contracts which had been issued were continued, and show the highest ratio of loss to Blue Cross of any of these classifications.

Beginning in April, 1961, the Richmond plans are offering what is called the "Senior Citizen Contract" to persons 65 or over not otherwise eligible for membership. This is a combined hospitalization and medical surgical contract, offering semi-private accommodations, but with a co-insurance feature requiring a patient payment of the first \$50 of hospital charges or \$4 per day of hospitalization, whichever is greater. The rate for the contract is \$8.44 a month *per person*, which is materially higher than the rates applicable generally to other individuals.

Experience Rating.

The Richmond Plan is the only plan headquarters in Virginia which offers its contracts to groups on an experience rated basis, (other than on a very limited basis). This practice arose as a result of adverse experience with certain groups and has been in effect since 1958. At the time it was initiated, Blue Cross rates and contracts were controlled by the State Corporation Commission and experience rating was limited to groups of employees on behalf of whom management made a contribution toward the cost of coverage. Since that time, other groups have been and are being included. Nearly 190 groups are experience rated at the present time, and these involve more than 61,000 subscriber contracts. The average size of these groups amounts to more than 800 subscribers and the contracts vary, perhaps a third of them being the "basic contract", which is the least expensive coverage offered by Blue Cross but which can be supplemented by endorsements tailored to meet the desires of the particular group. These endorsements relate to both expansion and contraction of coverage and more than 300 combinations are possible; accordingly, the coverage and rates available to experience rated groups are not readily susceptible of analysis. Moreover, the rate is determined by the experience of the group and changes at periodic intervals according to such experience.

Experience rating of groups is based on actual hospital billings to patients in the group. Thus an unusually expensive hospitalization or an erroneous billing will affect the rate of *that group* at its next adjustment; such a case for a subscriber under the community rate will have an effect in subsequent Blue Cross payments to the hospital concerned but will be reflected, in the long run, by a smaller change in rate to a larger group.

While the number of *groups* which are experience rated is less than those under the community rate, the number of *members* so rated amounts to approximately three-fourths of the members of the Richmond plan.

Included in this number are more than 40,000 federal employees, who are in a group the rate for which is set by experience rating on a national basis.

(b) Other Associations

(1) *The Norfolk Plan*

The Tidewater Hospital Service Association, with headquarters in Norfolk, was organized in 1935, approximately one month before the Richmond plan. It is governed by a Board of Directors with representation of the hospitals, the medical profession, and the public.

From the beginning, this Association has set a limit on room allowances for semi-private and private accommodations, although ward care was for a time provided in full. Initially, only \$3.00 was paid toward the room, but in 1938, a \$5.00 optional benefit was offered, and beginning in 1951, even higher allowances (up to \$14.00 a day) were provided for at higher rates. Originally only 21 days hospitalization in a contract year were covered, but additional coverage for years after the first was made available from 1936 on until in 1955 up to 70 days were allowed in the 4th and subsequent years. In 1960 this feature was changed to allow 60 days per confinement for all coverages. Diagnostic hospitalization for nervous and mental conditions and tuberculosis for 7 days was originally permitted, and the contract now provides up to 14 days in a 12-months period in each such case. The original full coverage for maternity cases was limited to a 10 day maximum in 1940. Outpatient services in accident cases were originally excluded, but in 1945 a \$5.00 allowance was made for such cases, which was raised to \$10.00 in 1955. In 1957 initial care in full was allowed and the current contract allows all outpatient care for accidental injuries.

The Tidewater Association does not cover Blue Shield services, these being available to subscribers in the area through the Virginia Medical Service Association of Richmond.

The Tidewater plan has not expanded to the same extent as the Richmond plan. The number of participating hospitals has been small, remaining at 7 hospitals since 1949. The bed complement of the hospitals increased, however, from 879 in 1942 to 1,482 in 1960, and the number of subscriber contracts has risen from 3,432 in 1936 to 42,438 contracts covering 110,950 members in 1961. (Of these, 17,978 contracts covering 54,851 individuals, are held by federal employees, who are covered under a national contract).

(2) *The Roanoke Plan*

The Hospital Service Association of Roanoke was organized in 1939. The Blue Shield plan associated with this Association, Surgical Care, Incorporated, began in 1945. The board of directors of the Blue Cross plan originally had 15 members, was increased to 25 in 1953 and is so organized as to give representation to the hospitals, with ten representatives, the medical profession, with four representatives, and the community generally, with ten members. The board of directors of the Blue Shield plan has always been composed predominantly of physician members, with two-thirds to three-fourths of the membership representing the medical profession. The board currently consists of twelve members including one representative of the Roanoke Academy of Medi-

cine and one participating physician who practices outside the immediate vicinity of Roanoke, and three lay members.

Coverage of the Roanoke Blue Cross plan has also increased comparably with that of the other plans. Initially set at 21 days per contract year, it now allows 70 days per admission. It has also been broadened to include X-ray coverage up to \$15 and the coverage of medicinal items has also been broadened. It is interesting to note that the Roanoke Blue Shield plan is and has been from its inception a complete service plan regardless of the income of the subscribers. Unlike the Richmond plan, however, this Blue Shield group is limited to surgical benefits and does not cover medical services.

Like the Richmond plan, the Roanoke Blue Cross has grown tremendously over the years. It initially began with 6 hospitals in the city having approximately 450 beds, and presently includes 40 hospitals in 26 counties with an aggregate of 3,259 beds. The number of subscribers at the present time is more than 76,000 and the number of individuals covered is over 211,000 persons. The membership growth of the Blue Shield plan is comparable and it now has more than 69,000 subscribers with contracts covering over 191,000 persons. About 95% of the physicians in the areas covered have always been participating and their number has grown to 475.

(3) *The Lynchburg Plan*

The Piedmont Hospital Service Association is the smallest of the four Virginia groups, operating only in Lynchburg and vicinity. It is controlled by a Board of Directors of twelve, six representing hospitals, two appointed by the local Academy of Medicine and four representing segments of the general public. It, too, has had changes in its coverage, initially offering a service contract providing for semi-private accommodations but from 1947 to October 1, 1960 providing for a flat allowance toward the cost of accommodations occupied. On the latter date the contract was revised to cover semi-private accommodations and this has continued. Almost since its inception the plan has covered the four hospitals in Lynchburg, with a total bed capacity of 511, and its membership has shown a steady growth, increasing during the last 10 years from 13,435 to 20,018.

In addition to the four major Blue Cross and Blue Shield groups which we have discussed above, there are a number of other plans which are subject to the regulatory legislation. We have not gone into detail concerning these because they either serve a small and a typical group or their Virginia operations are merely a small part of the operations in other States. (As to the Blue Cross and Blue Shield groups in the Washington metropolitan area, however, we make reference to some facts which are interesting from a comparative standpoint.)

The following prepayment service plans fall into the above categories: (1) Group Hospitalization, Inc., and Medical Service of the District of Columbia, which cover Arlington and Fairfax Counties and the Cities of Alexandria, Falls Church and Fairfax. The number of subscribers of these Associations who are Virginia residents amounts to about 3% of the total number of their subscribers. (2) Tennessee Hospital Service Association (which provides Blue Shield services as an optional part of its contract). The Virginia business of this Association is confined to the Bristol area and is a very small part of the overall business of the group. (3) Associated Hospitals, Inc., and Surgical Service, Inc., of Blue-

field. With respect to these groups also the Virginia business is small, compared to the other business of the groups and compared to the Associations headquartered in Virginia. (4) Mattie Williams Hospital and Grundy Hospital, Inc., (5) Clinch Valley Clinic Hospital and (6) Austinville Group Hospitalization, Medical and Service Plan. These are all small plans, not Blue Cross affiliated, and serve restricted clientele.

4. RISE IN HOSPITAL AND MEDICAL COSTS

(a) Compared to Cost of Living Index

The price increase of the preceding 25 years in all commodities and services for which the American consumer must pay is a painful fact of which everyone is aware. Based on a figure of 100 for the period 1947-49, the Consumer Price Index published by the U. S. Bureau of Labor Statistics shows a figure for all items in 1935, of 58.7. For the year 1959 this figure had risen to 124.6 and by September, 1960 it was standing at 126.8. This increase has been general for almost all commodities and has, as to most, been continuous throughout the 25 year period, the major exception being textiles generally which have shown some decline within the past decade. The cost of medical care has increased along with all other costs, and especially those for services. Standing, in 1935, at a higher figure than the general index—71.4—it had more than doubled, to 150.8 for the year 1959 and in September of 1960 stood at 156.9.

(b) Medical Care Costs

A number of items make up the medical care index. Included are physicians' and dentists' fees, optometric examinations and eye glasses, prescriptions and drugs, and hospital rates and the cost of hospitalization and surgical insurance. However, the increase in the hospital rate figure has been drastically more than for the Consumer Price Index generally as well as for the other items involved in general medical care. This is illustrated by the following tabulation of cost increases for selected items over the period 1936-1956, taken from figures compiled by the Bureau of Labor Statistics of the U. S. Department of Labor:

	Percent increases 1936-1956
Hospital room rates	264.8
Men's haircuts	220.9
Shoe repairs	135.0
Movie admissions	113.9
Public transportation	112.9
Laundry service	107.8
Automobile repairs	84.2
Dentists' fees	82.1
General practitioners' fees	72.8
Surgeons' fees	59.5

In 1935 hospital rates were low—less than half of the 1947-1949 average—and they were the lowest component of this section of the Index. But while medical care costs generally increased only a little more than 50% since 1949, from 110.4 in 1949 to 156.2 for the year 1960, hospital rates went from an index figure of 104.1 in 1949 to 225.8 in September, 1960.

(c) Increase in Costs in Virginia Hospitals

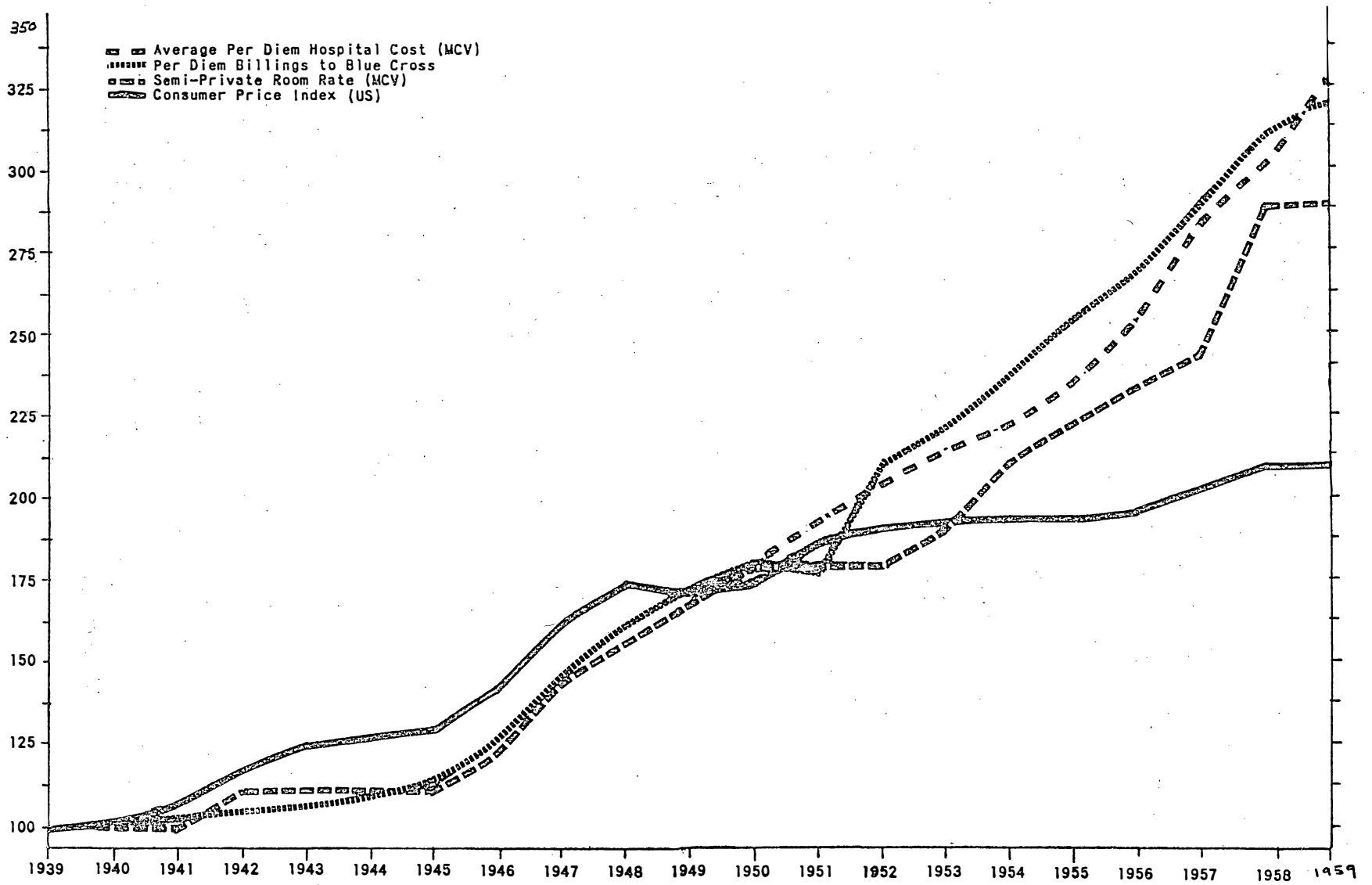
No accurate data are available to show with certainty what hospital costs in Virginia were a quarter of a century ago. However, based on the assumption that Blue Cross payments present a reasonably accurate measure of costs, we have had prepared and show as Figure 1 a graph indicating the increases in the average per diem costs at the Medical College of Virginia, per diem billings to Blue Cross, and the semi-private room rates at the Medical College Hospital as compared with the Consumer Price Index. From this graph it will be noted that up until approximately 1951 the trends were relatively the same. At that time, however, there began a sharp divergence; thus, while the Consumer Price Index continued to increase at relatively the same rate, the indicia of hospital costs showed a dramatic rise.

Since the essence of the prepayment plans as well as of commercial hospitalization insurance is the payment of hospital costs it is obvious that one of the major causes in the increase in rates and in expenditures

EXPLANATION OF GRAPH ON PAGE 21

In the graph depicting the average per diem hospital cost (MCV), semi-private hospital room rate (MCV) and per diem billings to Blue Cross and their comparison to the "U. S. Consumer Price Index", the base period selected was 1939 and for index purposes the year 1939=100. The average per diem hospital cost and the semi-private hospital room rate are pertinent only to the Medical College of Virginia as data from other hospitals, as of this date, have been unobtainable. The data used, however, were incomplete as to the years desired and cover the period 1950-1959. The per diem billings to Blue Cross were available back to 1939. As the movement of the two MCV items were similar to the Blue Cross per diem billings for the period beginning 1950-1959, it was assumed that the trend for the period 1939-1950 would not vary significantly from the course followed during the fifties. As a consequence, the percentage increase from 1939-1950 of Blue Cross per diem billings was determined and the rate of increase applied to the two MCV items for the year 1950 and from this data a 1939 cost estimate was developed for these two items and then projected for the missing years. The three medical cost items were then related to the "U. S. Consumer Price Index" as a state CPI is not available. The CPI base period was also revised to 1939. The graph picturing these medical costs as related to the CPI indicate that these medical cost items advanced relatively slowly to 1950 with the CPI running a little bit above the index of these medical items. There was a crisscross of indexes for the next two years, but by 1952 the medical cost items in this study began to show a rapid rate of increase as contrasted to a significant but gradual rise in the CPI.

The index for the MCV per diem hospital cost is not pictured on the chart prior to 1950 as the 1939-1950 data for this item was based on the percentage change occurring in the per diem billings of the Blue Cross and as a result naturally would follow the same curve until 1950. This would also be true of semi-private room rates for MCV except the hospital room rate cost increase was adjusted to a fifty-cent increment, and this necessitated a slight adjustment in the index for this component.



by the prepayment plans and by the insurance companies is the amount that must be paid for hospital services. For this reason, all available data on the causes of the increased costs in Virginia were assembled and carefully studied. Detailed cost information for a period of years was obtained from representative hospitals and consultations were held with hospital administrators to examine into this facet of the problem. We attach to this report as an appendix a letter setting forth in detail an explanation of the major factors responsible for this increase at the Medical College of Virginia (which is not representative of hospitals generally) and a portion of a letter from a representative proprietary hospital. Briefly summarized, the reasons for the difference between the rate of increase in hospital costs and the general rise in the cost level appear to fall within two categories—personnel costs and improved patient care.

With respect to personnel costs it should be noted that hospital salaries at one time were notoriously low and hours of work were long. The hospitals, however, have been in competition with other employers and have found it necessary to conform more nearly to prevailing patterns of wages and hours. The operation of a hospital, by its very nature, not being susceptible to automation and hospitals being staffed seven days a week and twenty-four hours a day, it is natural that personnel costs should represent at least half of overall hospital costs and the material increase which has been necessary in connection with these has been sharply reflected in the per diem costs of hospital operation.

As to improvement in patient care, it is noted that the practice of medicine has, since the end of World War II, undergone almost revolutionary development in a number of fields. Practices and techniques which were unknown a quarter of a century ago now are commonplace so as to give patients the best treatment that modern medicine affords. The use of new and expensive drugs and the expansion of laboratory techniques have all contributed toward the rise in per diem costs which, at the Medical College of Virginia, increased between 1950 and 1960 from \$13.87 to \$25.16, or 81%.

It is realized that the Medical College of Virginia, being a teaching hospital and equipped to perform many services which the average general hospital does not offer, is not typical; its cost increase, percentage wise, has been higher. However, of the ten selected hospitals for which itemized cost data were available over a period of a number of years, eight showed percentage increases ranging from 26% to 57% within the last seven or eight years.

It should be noted, however, that the per patient day costs of the several hospitals, expressed in dollars, varies widely. This depends to a large extent on the services offered but it is also to some extent a question of hospital policy and management. One local hospital, for instance, showed a 56% cost increase from 1952 to 1959, but the per diem cost figure at the end of the period was only \$17.66 as against a weighted average cost for the Richmond area plan of \$22.27. Another hospital showed only a 1% increase over a period of seven years (although this figure is somewhat illusory since it is based on the first year of operation of a new hospital which is always relatively expensive); another showed only a 10% increase over an eight year period and actually decreased its per diem cost during three of those eight years. However, overall, the history of hospital costs in Virginia corresponds to that of the nation generally; it might be added that as to actual dollar costs of hospitalization, those in Virginia hospitals are below those in most of the rest of this country.

We set forth on page 24, in summary form, per diem cost figures for ten hospitals in the Richmond area. (Detailed cost analyses for some of these hospitals for the year 1959 are shown elsewhere in this report.) These include large hospitals and smaller ones, state owned hospitals, community non-profit hospitals and proprietary hospitals, hospitals located in large cities and hospitals in medium sized and small cities. Taken together, they represent a cross section of hospitals throughout the State, and the pattern is generally the same—a steady increase in costs over the period.

One of the major factors affecting hospital costs, as well as utilization of hospital services, is the number of beds which are occupied. It was estimated by one hospital administrator that it costs 60% as much to maintain an empty bed as it does an occupied one. Personnel to take care of patients, should they come in, must be available, and salary costs go on. Another hospital administrator estimated his "break-even point"—the point at which his operating losses would be balanced by income—at 80%. Rates of occupancy for the hospitals in the group above ranged from as low as 68% to as high as 99.97% in the years 1957-1959. It is perhaps significant that the hospital designated "J" in the above table, which had a 99% rate of occupancy in 1958, dropped to less than 80% in 1959, when its capacity was enlarged; and for that year it showed an increase in operating costs of 11.87% although it had shown decreases in three of five years immediately preceding.

It is obvious that the long-time trend toward higher costs for hospital services cannot be reversed by any hospital or group of hospitals; however, evidence before us indicates that an able hospital administrator, carrying out policies established by a cost-conscious board of directors, can do a great deal to minimize the inevitable increases. One of the hospitals shown in the table above, whose record for economy of operation appears outstanding, had 2.3 employees per bed in 1953 at an average salary of \$1,750 a year. In 1959 this same hospital had 1.8 employees per bed, at an average salary of \$2,100 a year. The administrator of this hospital wrote that "In spite of competition with industries and other nearby hospitals * * * the * * * Hospital was able to curtail its personnel costs to a relative minimum. The key to this curtailment has been the fact that where areas of services were least productive (bed occupancy, treatments, etc.) immediate action was taken to reduce operating expenses."

Discussing the subject generally, the same writer continued: "It is difficult to establish at times why certain factors and services continue to, nevertheless, increase without some semblance of control. It has definitely been established, and in fact, demanded by the patient, that certain standby services must carry on regardless of rate of utilization. These are recognized as inherent factors and cannot be drastically changed. However, there may be certain so-called 'gray areas' where scrutiny and action by those responsible can make necessary changes."

In view of the direct relation of hospital costs and charges to the rates to be charged and the coverage which can be provided patients both by the prepayment service plans and insurance companies writing such insurance, the Council feels that those who administer hospitals as well as the physicians who require services for their patients have a duty to the public to make constant examinations of the "gray areas" to keep hospital services within financial reach of the private organizations who now are seeking to provide them.

PER DIEM COST AND PERCENTAGE INCREASE (DECREASE) FOR
SELECTED VIRGINIA HOSPITALS, 1952-1959†

Hospital	1959	1958	1957	1956	1955	1954	1953	1952
A	\$23.07	\$21.69	\$19.90	\$18.00	\$16.91	\$16.16	\$15.06	\$14.27
% Change	6.39%	8.99%	10.56%	6.45%	4.64%	7.30%	5.54%	
B	\$25.60	\$23.87	\$20.90	\$20.01	\$19.59	\$19.21	\$18.65	\$16.55
% Change	7.25%	14.21%	4.45%	2.14%	1.98%	3.00%	12.69%	
C	\$20.28	\$19.27	\$19.87	\$18.44	\$18.06	\$18.50	\$20.40	
% Change	5.24%	3.02%*	7.75%	2.10%	2.49%*	9.31%*		
D	\$21.79	\$21.18	\$20.13	\$18.49	\$17.86	\$17.44	\$17.63	\$14.63
% Change	2.88%	5.22%	8.87%	3.53%	2.41%	1.08%*	20.51%	
E	\$21.64	\$21.12	\$20.21	\$19.22	\$17.46	\$17.14	\$16.93	\$16.02
% Change	2.46%	4.50%	5.15%	10.08%	1.87%	1.24%	5.68%	
F	\$17.66	\$16.83	\$15.42	\$14.36	\$13.95	\$13.38	\$12.45	\$11.31
% Change	4.93%	9.14%	7.38%	2.94%	4.26%	7.47%	10.08%	
G	\$18.26	\$16.34	\$15.86	\$14.46	\$13.96	\$13.24	\$12.88	\$11.96
% Change	11.75%	3.03%	10.00%	3.58%	5.44%	2.80%	7.69%	
H	\$22.19	\$20.88	\$20.47	\$19.05	\$18.91	\$17.40	\$17.66	
% Change	6.27%	2.00%	7.45%	.74%	8.68%	1.47%*		
I	\$21.66	\$19.39	\$17.82	\$16.28	\$15.92	\$14.71	\$14.34	\$13.82
% Change	11.71%	8.81%	9.46%	2.26%	8.23%	2.58%	3.76%	
J	\$20.25	\$18.15	\$17.21	\$17.53	\$17.74	\$17.07	\$17.73	\$18.33
% Change	11.57%	5.46%	1.83%*	1.18%*	3.93%	3.72%*	3.27%*	

† For two of the hospitals, no cost figures are available for 1952.

* Decreases

5. RISE IN RATES OF UTILIZATION

Utilization of hospital facilities by any group of individuals comprises two factors—the number of admissions to hospitals and the average length of stay. In 1950, nationwide, Blue Cross subscribers used a little over 34 million days of hospital care. By 1959 this figure had increased to more than 58 million days. In addition, there were more than 2.5 million cases involving outpatient care only. Inpatient admissions for each 1,000 Blue Cross members stood at 133 in 1956 and by 1960 had increased to 141. Outpatient visits per 1,000 members, which amounted to 25 in 1953, had increased to more than 50 by 1959. The average length of hospital stay, which was 7.33 days per admission in 1956, had increased to 7.62 days per admission in 1960 so that the end product—the number of inpatient days per 1,000 members for which the prepayment plans must pay—had risen to 1,074 in 1960, which was an increase of more than 10% in the space of five years. As to both of the facets of utilization our study indicates that, with respect to some of the Blue Cross Associations in Virginia, utilization is at a higher rate than for the nation as a whole. In the year 1960 the national average of inpatient admissions per 1,000 members was 141. For the same period, the number of such admissions for the four groups headquartered in Virginia ranged from 150 to 164 per 1,000 members. Similarly, the average number of days of hospital stay for the Virginia Hospital Service Association in 1960 was 9.03 which compares with the national average of 7.62. The other three groups were lower than the national average.

A combination of the two factors produced, for the Richmond area plan, 1,354 inpatient days per 1,000 members, for the Roanoke plan, 1,191, for the Tidewater plan 1,168, and for the Lynchburg plan 1,122, as compared to the national average of 1,074. The figures for 1960 were not an isolated occurrence, but confirmed a trend which has been continuing for some years past.

A table showing comparable figures for a 5-year period follows:

	<i>Average Length of Stay (Days)</i>				
	<i>National</i>	<i>Richmond</i>	<i>Roanoke</i>	<i>Norfolk</i>	<i>Lynchburg</i>
1956	7.33	7.56	6.73	7.21	6.42
1957	7.36	7.61	6.99	7.21	6.40
1958	7.40	7.87	7.32	7.14	6.13
1959	7.50	8.32	7.33	7.59	6.59
1960	7.62	9.03	7.54	7.49	6.84

	<i>Rate of Admissions (Per 1,000 members)</i>				
	<i>National</i>	<i>Richmond</i>	<i>Roanoke</i>	<i>Norfolk</i>	<i>Lynchburg</i>
1956	133	149	150	131	135
1957	135	150	160	126	144
1958	138	158	166	144	150
1959	140	165	164	150	164
1960	141	150	158	156	164

Similar data are not available for the individual hospitals comprising the Blue Cross membership, but the following tabulation of income received and cases paid during June, 1959 through May, 1960, for certain

groups of subscribers of the Richmond plan shows wide variations in loss ratios for different geographic subdivisions of the State:

<i>Area</i>	<i>Loss Ratio</i>
A	98.9%
B	120.6%
C	93.9%
D	95.3%
E	108.6%
F	92.1%
G	87.5%
H	83.0%
I	92.4%
J	111.1%
K	83.7%

Review of Claims by Blue Cross and Blue Shield

In view of the steady trend toward increased utilization, the methods used by the plans to check the validity of claims should be pointed out. The procedures of the Richmond plans are typical. When a hospital bills for services rendered a subscriber the claim is sent to specially trained and experienced employees who are charged with screening out those which appear dubious. Claims passed by them—the majority—are automatically processed for payment. Those which appear doubtful are again reviewed and the final decision is made by the plan's Executive Director unless, in the case of Blue Shield claims, he finds it desirable to refer the claim to the Executive Committee of the Blue Shield's Board of Directors.

The information furnished by the hospital initially is generally sufficient for a determination, since it shows length of stay, diagnosis, name of attending physician, and possibly an indication of complications which may have developed. More information may be secured from the attending physician or from the hospital. (This is specifically authorized in the subscriber's contract with the Association.)

Claims may be rejected for a variety of reasons. Some, such as for elective surgery before the end of the waiting period, are not covered under the contract. One of the most troublesome classes of cases is that involving hospitalization for diagnostic procedures. The Blue Cross Contract does not cover hospitalization for observation or diagnosis. However, we are advised that the criterion for allowing or rejecting a claim is whether the diagnostic studies could have been made upon the patient in an ambulatory condition.

In surgical cases, questions of professional judgment are frequently involved. These may include whether minor surgery could have been performed on an out-patient basis, or whether there was a longer hospital stay than the patient's condition warranted, and in some cases the actual necessity for the operation itself may be dubious. The practice of medicine involves a highly personal relationship between the physician and his patient and no two doctors would handle all patients in the same way. Therefore, the Blue Shield must in most cases rely to a large extent on information furnished by the attending physician.

Other Methods to Control Unnecessary Hospital Admissions or Extended Stays.

All accredited hospitals are required to have a "tissue committee",

whose function is to review charts of surgical cases and compare pathologic findings with tentative admitting diagnoses and the surgeons' diagnoses at the time of operations. The findings of these committees can be of assistance to Blue Cross and Blue Shield in some questionable cases.

In addition to the tissue committees which all accredited hospitals must have, a number of hospitals have developed utilization committees to supervise utilization of the hospital facilities and search out abuses. However, these have not been generally satisfactory because there is normally too close a personal relationship between physicians utilizing the hospital.

There has been some experimentation with regional or inter-hospital utilization committees. The "Program of Improved Medical Service" of the Pennsylvania Medical Society provides for a Blue Cross Advisory Committee for Blue Cross cases and a Health Insurance Review Committee for cases covered by commercial insurance. These committees have been helpful both in reaching decisions on disputed cases and in reviewing other cases suspected of overstay or other abuse; the review is done by a rotating panel of physicians under conditions which make both the patient and the admitting physician anonymous to members of the committee. These committees have been more successful than those operating at the hospital level. Furthermore, the fact of their existence has been of benefit to physicians in refusing patients' requests for unnecessary hospitalization. With many physicians serving on the review panels, the program has also proved valuable as an educational measure for the profession in the area where it operates.

6. EFFECT ON PLANS OF RISE IN HOSPITAL AND MEDICAL COSTS AND IN RATES OF UTILIZATION

The combined effect on Blue Cross and Blue Shield plans of the increase in utilization and rise in hospital and medical care costs has been drastic. In 1959, hospital, surgical and medical expenses paid for by Blue Cross-Blue Shield and other hospital-medical plans throughout the nation totaled \$2.3 billion, a 96% rise over similar payments in 1954 and more than five times the amount paid in 1949 by these organizations. The result was that of the 83 plans accredited by the American Hospital Association, 49 showed a deficit for 1958 or 1959, or both. Of the five Associations serving the largest number of subscribers in Virginia, only the Hospital Service Association of Roanoke was able for both the years 1958 and 1959 to show a ratio of total expenses to earned subscription income of less than 100%; and in 1959 the ratio for the Roanoke plan had increased to 98.0%.

Nor is the problem peculiar to the prepayment plans. The same factors—utilization and hospital costs—have had their effect on payments by insurance carriers. Over \$1.3 billion in hospital expense benefits were paid insured persons by insurance companies in 1959, which was more than twice the amount paid in 1954, and surgical and medical benefits paid by these companies in the same year had reached \$683 million, an 82% rise over the previous five-year period.

Since the problem has been nationwide, it is natural that the search for its solution also would have been nationwide. Perhaps the most widely publicized activity along this line was the result of an adjudication made by the Insurance Commissioner of the Commonwealth of Pennsylvania on April 15, 1958 in connection with a rate increase application of the

Associated Hospital Service of Philadelphia, a Blue Cross group. In an exhaustive opinion, the Commissioner commented both on the abuse of Blue Cross benefits by unnecessary utilization and on the possibility of economies in the operation of hospitals without lessening quality or service. As a part of his adjudication, the Commissioner directed that action should be taken looking toward improvements in both of these fields.

Following this decision of the Pennsylvania Insurance Commissioner, the study of utilization has been the subject of a developing program in the State of Pennsylvania under the sponsorship of the State Medical Society, following initial pioneering by the Society's Tenth Councilor District which embraces county medical societies in the Pittsburgh area.

The following statement, taken from a report prepared by W. Benson Harer, M.D., Trustee and Councilor, Second Councilor District, Pennsylvania Medical Society, and dated August 15, 1960, discusses the results of the Pennsylvania program.

"A number of intangible but clearly demonstrated benefits have already been obtained under the program. A close and friendly relationship has been established among the medical profession, hospital council, hospital administrators, Blue Cross and commercial insurance carriers. All are in agreement that abuse of hospitalization has been practically eliminated in the Tenth Councilor District. Physicians, aware of the fact that their professional work is being constantly reviewed by their colleagues, are more careful and thorough in the handling of all patients. The quality of medical care has therefore been raised above its previous high level. The steadily increasing cost of medical care has been retarded by more prompt diagnostic procedures and consultations, shorter stay in hospitals and by uniformly reasonable charges by all physicians. Patients, now more fully informed about medical society grievance mechanisms long in existence, are taking their complaints about physicians to the profession itself instead of to friends and neighbors. They are finding, at times to their surprise, that prompt and effective action is taken on all valid complaints and a full explanation is given in cases of misunderstanding."

A number of studies by both public and private groups have been made in other states within the past several years. These states include New York, New Jersey, Wisconsin and Maryland, among others.

The New York study is probably the most comprehensive in the field. Initiated by that State's Insurance and Health Departments, it was conducted by the Columbia University School of Public Health and Administrative Medicine, and went into great detail as to the operations of the eight Blue Cross plans in New York. While some of the report's recommendations dealt with problems peculiar to New York, many were of general applicability. One was the formation of state and regional Hospital Review and Planning Commissions to deal, among other matters, with control of future hospital construction and expansion of bed capacity to see that these would fit into a proper regional hospital system. The study group also recommended consideration of Blue Cross payment of costs of post-hospital care in nursing homes under adequate professional standards, and experimentation with provision of certain diagnostic facilities by Blue Cross on an outpatient basis. It further urged requiring utilization committees in all hospitals, and closer scrutiny of actual need for prolonged hospitalization. Many of the Columbia Report's recommendations were cited by the New York Superintendent of Insurance in connection

with his 1960 decision on a rate increase application of the Associated Hospital Service Association of New York, and his opinion made it plain that he favored a cost-based reimbursement formula, but only if costs of hospital services unrelated to patient care were eliminated. Specifically, he disapproved inclusion of a share of emergency and other outpatient care in the Blue Cross reimbursement formula. Of further note was the fact that the Superintendent's decision recognized the inevitability of future increases in hospital costs, and indicated that inclusion in the subscriber rate of provision to meet these increases would be reasonable.

The Maryland study was conducted by a Special Committee on Blue Cross Insurance of the Maryland Legislative Council and concurrently with its study an investigation was made under the auspices of the Medical Chirurgical Faculty of Maryland which included a survey by the Opinion Research Bureau, Inc., among Maryland doctors as to alleged abuses of Blue Cross. The results of this survey are reported in the November, 1960, Report of the Maryland Legislative Council Committee as follows:

- (1) 80% of physicians received requests from patients for hospitalization to avoid the costs of diagnostic studies.
- (2) 77% of physicians felt that hospital facilities are used in an uneconomical or unnecessary manner.
- (3) 78% of physicians felt that some of their colleagues admitted patients to the hospital solely for diagnostic studies in order to save their patients' money.
- (4) 52% of physicians admitted that they themselves engage in this practice.
- (5) 66% of physicians felt that hospital facilities are used to a greater degree than medically indicated.
- (6) 61% of physicians said there was unnecessary prolonged hospitalization.
- (7) 58% of physicians felt that there were admissions solely for the convenience of the physician.

This survey and the recommendations of the Medical Chirurgical Faculty were considered by the Insurance Commissioner of Maryland in connection with an application for a rate increase by Blue Cross in 1960 and the Commissioner solicited cooperation between the Chirurgical Faculty, The Hospital Council of Maryland, and the Blue Cross, in seeking to alleviate the situation. No specific information is available at this time concerning the results of subsequent activities in Maryland.

One further development might be commented on. In view of indications that Blue Cross utilization tends to increase the availability of hospital beds, the Blue Cross Associations in some cases have adopted as a criterion of approval of a hospital for participation in Blue Cross, that it must have been constructed in response to a definite community need for hospital beds. This criterion has recently been adopted by the Virginia Hospital Service Association and was adopted by the Michigan Blue Cross Association, among others. The head of that Association reported to the Committee that, although it could not be said with certainty what the effect of this had been, it was his belief that the existence of this standard had had some effect in preventing increases in hospital bed capacity where additional beds were not needed.

7. REIMBURSEMENT OF HOSPITALS

(a) Richmond Plan

One of the least understood phases of the operations of the Blue Cross plans is the method by which they reimburse hospitals for services to Blue Cross patients. We discuss in detail the method of reimbursement followed by the Richmond area plan, and will subsequently point out the differences applicable to the other plans.

A Blue Cross patient, on discharge from the hospital, generally receives from the hospital an itemized bill showing the charges which he has incurred and, prior to a recent change in administrative procedure by the Richmond area plan, when the claim had been approved and paid by Blue Cross, received a statement indicating that Blue Cross had paid the bill. As a matter of fact, it has never been the practice of the Richmond area plan to pay the hospitals' itemized charges for services.

This is, of course, in contrast to what occurs in the case of a patient who pays cash, or whose expenses are covered in whole or in part by commercial insurance. In this case the charges for room and general nursing, operating room, drugs, laboratory examinations and the like, are itemized on the bill and charged for at the billed amount.

(1) Pre-1952 Method

Prior to 1952 this plan paid to its member hospitals a uniform, fixed amount for each patient day of hospital stay by a Blue Cross subscriber. This was an amount, determined by negotiation between the Blue Cross and its member hospitals, which was thought to compensate the several hospitals adequately for services rendered, having due regard to the fact that payment would be swift and certain. There was, however, a limit established; no hospital could, under the formula then in use, receive more than 97% of its total billings, although, as to an individual case, the payment might be more or less than the hospital would have received had the patient been a private pay patient.

As hospital costs increased, there began to be a wider spread between the costs of operating the several hospitals in the plan and it was observed that the reimbursement formula discriminated against those hospitals which by reason of the provision of greater services or otherwise were incurring a higher per diem costs. In 1952, therefore, the Richmond area plan changed to its present method of reimbursement.

(2) Present Method

Under the present formula the determinant of Blue Cross reimbursement is the actual cost per patient day incurred by the particular hospital for the most recent period for which the same has been determined. In determining the reimbursement figure, cost of care of all patients, Blue Cross, private pay, and charity, is taken into account. All hospital costs are included, such as salaries, purchases of materials and supplies including medicines and drugs, utility costs, dietary, building maintenance, etc. Direct expenditures are charged to each major hospital department. Service departmental costs, such as housekeeping, laundry and linens, are apportioned, to inpatients, outpatient departments, etc., based on services rendered. Inpatient costs not covered by Blue Cross as included services, such as blood for transfusions, telephone services, and X-rays in certain cases, are deducted. Statistics are compiled showing the total number of

inpatient days for the calendar year involved. (These include only adult and children patient days; newborn and premature patient days are excluded). The total cost for inpatient hospital service is then divided by the total number of inpatient days of care rendered to all patients by the hospital; the result is the per diem cost. An amount up to \$1.00 per day is allowed for depreciation and the resulting figure is the reimbursable cost for Blue Cross patients.

Set forth below are actual cost figures for a group of ten hospitals in the area served by the Richmond area plan. These include the largest hospitals in the State but also some of the smaller ones. They include the two State-owned hospitals—Medical College of Virginia and University of Virginia—and also non-profit community hospitals and proprietary hospitals. It will be noted that there is a considerable dollar variation between the several items of cost and between the total per diem cost figures; but it is worthy of note that of the thirty-five hospitals in the Richmond area for which figures are available for 1959, only eight showed a per diem cost less than \$20.

AVERAGE PER DIEM COST

	1	2	3	4	5	6	7	8	9	10
<i>General Services</i>										
Administration	\$.10	.11	.13	.13	.09	.13	.09	.12	.07	.06
Dietary	2.56	2.91	2.54	1.85	3.07	2.81	1.76	2.08	1.39	2.59
Housekeeping .....	.48	.65	.62	.68	1.09	.75	.88	.54	.44	.54
Laundry and Linen .....	.60	.76	.50	.58	.37	.78	.57	.48	.64	.60
Operation of Plant .....	.66	.69	.45	.48	.63	.52	.67	.63	.39	.91
Repairs & Maintenance .....			.22	.47	.75	.22	.25	.29	.30	.38
Total General Services	4.40	5.12	4.46	4.19	6.00	5.21	4.22	4.14	3.23	5.08
<i>Professional Services</i>										
Nursing Service	7.56	7.75	6.87	6.63	8.50	6.79	2.85	7.59	7.29	6.14
Nursing Education .....	.76	1.77	.91	1.25		1.16	2.31	1.31	1.01	1.78
Interns and Residents .....	.70	1.37	.26	.12	.39	.12	1.32	.57		.42
Central Sterile Supply .....	.63	.95	.83	.21	1.02	.08	.08	.65		
Medical Records .....	.27	.22	.28	.22	.42	.20	.29	.35	.17	.32
Social Service .....	.08	.19								
Total Professional Services	10.00	12.25	9.15	8.43	10.33	8.35	6.85	10.47	8.47	8.66
Total Professional and General Services	14.40	17.37	13.61	12.62	16.33	13.56	11.07	14.61	11.70	13.74
<i>Special Services</i>										
Operating Room	2.15	2.47	1.21	1.38	2.07	1.37	1.67	2.21	1.14	.93
Delivery Room .....	.63	.63	.68	1.13	.99	.44	.40	1.07	.40	.72
Anesthesia .....	.44	.75	.11	.85	.13	.87	.57	.85	.12	.46
Radiology .....	.47		.80	1.42	1.38	1.33	.96	.87	.86	1.31
Laboratories	1.64	1.59	1.62	2.26	1.43	2.14	1.24	1.65	1.38	1.70
E.K.G. and B.M.R. ....	.12		.23		.15			.13	.14	.20
Physical Therapy .....	.44	.17	.18	.15	.30	.08		.05	.10	.08
Medical & Surgical Supplies..	.72	.80	.25	.38		.53	.66		.72	.81
Pharmacy	1.24	1.13	1.27	1.51	1.80	1.13	1.09	1.55	1.70	2.19
Oxygen .....	.05	.18	.25		.05					
Occupational Therapy .....	.06	.17								
Other .....	.71	.34	.07	.09		.19		.06		.05
Total Special Services	8.67	8.23	6.67	9.17	8.30	8.08	6.59	8.44	6.56	8.45
Total All Services	23.07	25.60	20.28	21.79	24.63	21.64	17.66	23.05	18.26	22.19

Blue Cross pays the hospital 105% of the reimbursable per diem cost multiplied by the number of subscriber patient days but there is credited against this payment 90% of all moneys collected by the hospital from subscribers for services any part of which is covered by Blue Cross, such as payments under a deductible option or payments above the Blue Cross allowance for a private or semiprivate room. (An optional formula permits the hospital to collect only 100% of cost but to retain such payments by subscribers in excess of Blue Cross allowances). In no event, however, can a hospital collect more than its aggregate billings to Blue Cross subscribers for the accounting period nor an amount which is greater than 115% of the weighted average of the costs in the participating hospitals multiplied by the number of Blue Cross subscriber patient days. (The weighted average is determined by dividing total includable costs for all patients in all hospitals by the total number of patient days of care furnished.)

Costs attributable to outpatient departments are not included in fixing the inpatient reimbursable cost; but the Plan reimburses for covered outpatient services at cost plus 5%, up to 115% of the weighted average cost of all outpatient departments in participating hospitals.

It should be emphasized that in some cases Blue Cross may pay more than would have been charged the subscriber had he been a private pay patient and in some cases it will pay less.

This can be best shown by the following illustration taken from actual records of a Richmond hospital. The two patients each stayed eight days in the hospital. Each had a standard Blue Cross contract, which allowed \$12.00 a day toward the \$16.00 cost of a semiprivate room and covered the other indicated charges in full. The actual billings, the amounts paid by the patients, and the amounts paid the hospital by Blue Cross based on a reimbursement figure of \$24.00 per patient day were as follows:

	<i>Patient A</i>	<i>Patient B</i>
Service charge (room and nursing) 8 days	\$128.00	\$128.00
Drugs	51.55	.60
Laboratory	70.00	13.00
Dressings .....	.50	.50
X-Ray	15.00	.....
Electrocardiogram	20.00	.....
	\$285.05	\$142.10
Total Billings	32.00	32.00
Patient Paid	\$253.05	\$110.10
Net due on billings	\$160.00	\$160.00
Blue Cross paid (8 days @ \$20.00)	\$ 93.05	
Excess of billings over payments		\$ 49.90
Excess of payments over billings		

From the above it would appear that the hospital "lost" on Patient A and made a "profit" on Patient B, but it should be observed that Blue Cross pays, directly, the same for an extraordinarily expensive

hospitalization of one of its subscribers as it does for a routine case. The extra expense is borne initially by the hospital but it appears as an item of overall cost for the next succeeding accounting period and is reflected in the long run in Blue Cross reimbursement of the hospital. The hospital would have collected more from Patient A than from Patient B, had they been private-pay patients, but to the extent that billings accurately reflect costs, each would have paid what it cost the hospital to furnish him care.

(b) Roanoke and Lynchburg Plans

The Hospital Service Association of Roanoke and the Piedmont Hospital Service Association also use the per diem cost method of reimbursement and their reimbursement formulae differ only in minor details from that of the Richmond area plan. Both reimburse at 105% of reimbursable per diem costs with a ceiling equal to the hospital's aggregate billings for Blue Cross subscribers. In the case of the Roanoke Association, however, there is also a ceiling consisting of 120% of the weighted average cost for the participating hospitals, as compared with 115% in the case of the Richmond area plan.

(c) Norfolk Plan

Reimbursement of its participating hospitals by the Tidewater Hospital Service Association is based on what the hospitals actually charge rather than on hospital costs. The reimbursement formula calls for payment by the Association of not less than 80% and not more than 97% of the respective hospital's net billings to Blue Cross subscribers. (The term "net billings" means the total amount billed less any payments made by a subscriber such as payments in excess of the allowance made for his hospital room under his contract or for non-included services such as, in the case of this Association, electrocardiograms.) The exact amount to be paid to the hospital is determined in accordance with the Association's income for the preceding six months' period but there is a provision in the contract which states that when the Association's income is in excess of 90% of the aggregate billings to subscribers, the excess over 90%, up to 5% of gross contract fees, is added to the reserves of the Association before reimbursement to the hospitals is increased.

(d) Northern Virginia Plan

The method of reimbursement of the fifth Blue Cross Association serving large numbers of Virginia residents—Group Hospitalization, Incorporated, which is headquartered in and operates out of the District of Columbia—combines to some extent features of both of the methods previously discussed. Current payments to hospitals are made on the basis of 97% of the hospital's regular charges for hospital services furnished participants under the terms of their contracts. However, at the end of the calendar year, the hospital's account with the Association is retroactively adjusted to the lower of the following:

- (1) 97% of the regular charges to participants for services rendered, whether paid for by the Association under the subscribers contracts or payable by subscribers under deductible features of their contracts; or
- (2) 106% of the hospital's average patient day cost for covered services rendered participants. This cost is determined according to the same accounting system used for the Richmond, Roanoke and Lynchburg plans.

8. INCOMES, EXPENSES AND RESERVES OF PLANS

We attach tabulations of income, claims expense, administrative expense, and reserves for the several Virginia plans. With reference to the matter of reserves, it should be pointed out that the statute initially did not require the Plans to maintain any specific reserves. In the 1956 revision it was provided that the State Corporation Commission should fix rates sufficient to permit accumulation of between one-sixth and three-sixths of the preceding year's income from subscribers. The American Hospital Association, the national Blue Cross accrediting agency, sets as its standard an amount sufficient at least to meet hospital and operating expenses for a period of three months.

The 1960 amendment eliminated the statutory reserve requirement along with the Commission's power to control rates.

RICHMOND PLAN

Blue Cross

	Income (a)	Claims Expense (b)	Admin. Expense (c)	Reserves at end of period (d)
1960	\$10,925,882.18	\$10,154,207.88	\$ 645,406.70	\$ (531,984.64)
1959	11,660,512.86	11,879,288.93	672,621.75	(658,252.24)
1958	10,346,637.90	11,298,686.52	619,264.78	233,145.58
1957	8,660,727.38	8,546,323.34	547,630.51	1,804,458.98
1956	7,962,818.89	6,959,608.85	476,135.37	2,237,685.45
1955	7,468,178.23	6,149,969.46	443,031.20	1,710,610.78
1954	6,669,449.35	5,652,293.44	393,921.46	835,433.21
1953	5,600,847.76	5,073,293.81	330,187.51	212,198.76
1952	4,687,410.24	4,627,138.83	303,724.19	14,832.32
1951	3,654,898.84	3,377,153.36	275,453.98	258,285.10
1946-50	9,758,963.21	8,923,446.63	1,024,514.33	255,993.60
1941-45	2,722,391.39	1,919,378.85	418,482.04	444,991.35
1935-40	696,276.97	503,921.95	132,394.26	60,460.75

Blue Shield

	Income (a)	Claims Expense (b)	Admin. Expense (c)	Reserves at end of period (d)
1960	\$ 7,933,280.41	\$ 6,000,982.10	\$ 650,919.38	\$ 1,557,998.77
1959	7,317,348.86	6,753,364.08	678,134.43	276,619.84
1958	5,795,908.09	4,994,996.52	620,642.94	390,769.49
1957	4,281,693.96	4,064,515.17	539,136.86	210,500.86
1956	3,743,641.52	3,340,874.21	470,017.21	532,458.93
1955	3,339,674.07	2,898,591.59	417,479.85	599,708.83
1954	3,148,556.85	2,706,598.48	388,683.63	576,106.20
1953	2,968,315.91	2,590,017.89	330,187.51	522,831.46
1952	2,895,668.63	2,306,591.65	326,316.87	474,720.95
1951	2,422,951.19	2,088,005.35	283,338.81	211,960.84
1946-50	5,495,985.35	4,456,214.62	892,221.49	160,353.81
1944-45	28,686.31	2,744.50	13,137.24	12,804.57

Parentthesis indicate minus figures.

ROANOKE PLAN

Blue Cross

Year	Dues	Benefits	Admin.	Reserves
1960	\$ 4,991,098	\$ 4,954,540	\$ 119,284	\$ 346,734
1959	4,875,634	4,682,724	110,753	379,918
1958	4,673,498	4,318,443	74,451	466,578
1957	3,537,972	3,523,087	54,881	221,206
1956	2,965,572	2,980,736	51,244	318,585
1955	2,806,126	2,546,500	48,381	369,039
1954	2,416,294	2,297,995	54,795	161,305
1953	2,234,334	2,100,880	52,269	317,845
1952	1,673,870	1,579,058	44,209	359,644
1951	1,403,464	1,269,313	23,493	335,332
1946	354,813	304,028	24,533	195,101
1941	65,965	37,084	10,326	19,485

Blue Shield

Year	Dues	Benefits	Admin.	Reserves
1960	\$1,934,148	\$1,621,071	\$143,805	\$767,828
1959	1,897,468	1,587,658	141,635	567,853
1958	1,814,934	1,590,107	150,107	384,506
1957	1,732,123	1,443,424	149,822	327,114
1956	1,623,685	1,318,547	137,777	180,996
1955	1,532,420	1,238,257	126,771	11,759
1954	1,321,639	1,227,823	113,031	(219,581)
1953	1,205,212	1,093,282	100,202	57,666
1952	1,057,000	930,220	88,278	45,547
1951	874,790	780,845	90,125	6,625
1946	140,878	77,509	22,858	40,511

Parenthesis indicate minus figures.

NORFOLK PLAN

Year	Earnings	Hospital Cost	Admin. Cost	Reserve
1960	\$1,855,890.63	\$1,887,073.46	\$164,740.13	\$ (96,084.09)
1959	1,884,331.07	1,801,886.22	167,573.97	91,638.71
1958	1,814,201.51	1,616,646.05	159,378.79	164,916.00
1957	1,608,507.24	1,359,119.26	141,150.35	119,710.96
1956	1,368,297.27	1,205,252.05	136,079.66	14,046.75
1955	1,093,883.24	976,547.20	116,256.08	(33,450.94)
1954	1,047,721.88	858,023.86	106,777.57	(38,133.35)
1953	909,953.42	868,413.34	101,604.61	(22,736.73)
1952	765,111.22	729,159.77	93,383.59	50,653.20
1951	599,594.52	553,369.76	71,967.08	104,999.23
1950	549,244.44	448,305.44	56,819.86	127,912.35
1945	262,777.68	232,789.35	31,599.62	58,655.13
1940	134,115.49	118,196.85	15,206.74	15,846.03
1936	14,970.01	6,354.20	5,437.08	3,178.73

Note: From 1956 on these figures are based on calendar year; all previous years are reported on a fiscal year from September to September.
Parenthesis indicate minus figures.

LYNCHBURG PLAN

Year	Earned Income	Hospitali- zation	Operating Expenses	Reserve
1960	\$310,629.87	\$291,403.18	\$40,632.77	\$ 98,872.83
1959	282,501.25	282,847.45	37,657.54	98,411.61
1958	269,162.98	247,420.47	35,646.84	115,720.45
1957	245,692.36	201,406.34	31,809.51	113,647.79
1956 ..	201,433.80	156,533.50	28,269.03	89,307.00
1955	184,948.11	139,889.67	22,979.31	62,369.16
1954	166,878.20	136,634.29	21,602.41	30,537.87
1953	122,271.42	112,999.35	21,623.19	13,589.15
1952	116,302.78	129,690.55	20,436.89	18,128.84
1951	129,331.65	126,361.32	20,673.99	36,820.09
1946	43,467.06	34,323.55	8,674.68	20,689.94
1941	24,060.73	14,319.00	5,133.32	6,500.77

It will be seen from the above figures that none of the Virginia plans has ever had excess reserves, judged by the criterion formerly set by the statute. It will be further observed that the Norfolk and Richmond Blue Cross plans have had the most erratic experience. The Richmond plan's reserves dropped to a low of under \$15,000 in 1952, increased to a high of more than \$2,000,000 in 1956, and showed negative figures for the years 1959 and 1960. The Norfolk plan has had negative reserves for four years out of the past ten. The other plans have had generally better experience but even with those, some impairment of desirable reserves has been indicated. The Blue Shield plans, on the other hand, have shown a much more satisfactory financial experience over the years with steadily increasing income and, generally speaking, an adequate reserve for contingencies.

In considering the amount of reserves as shown in the several tables, it should be noted that these do not indicate exactly the "profit" or "loss" for a given year or over a period of years. The reserve figure as carried on the books of each association includes an amount estimated as necessary to liquidate claims for cases then in progress of hospitalization and the whole balance shown cannot be considered as uncommitted and available for future expenditure.

However, two facts should be borne in mind when considering the status of the reserves of the plans. The first is that the accreditation standard set by the American Hospital Association exerts a strong compulsion on the plans to build up their reserve funds. A plan which, over a long period of time, fails to show adequate financial responsibility will lose the right to use the Blue Cross or Blue Shield name and insigne, and the other benefits which national affiliation provides.

More important, perhaps, from the point of view of the subscriber, is the fact that Blue Cross and Blue Shield are agents for the participating hospitals and physicians, and each participant is liable to subscribers for the remainder of the contract year of the participant regardless of reimbursement. Thus, in addition to the monetary reserves, each plan is, in a sense, backed by the assets of the hospitals and the contractual obligations of the physicians for periods of up to twelve months.

Administrative Expenses of the Plans

One of the specific directives of Senate Joint Resolution No. 54 concerns the administrative costs of the prepayment plans and the bearing

thereof on rates. Careful consideration has been given this. Statements were secured from the plans showing their administrative expenses and these were considered in the light of the magnitude of the operation of each individual plan and its mechanics of operation. More than this appeared beyond the purview of the study; further, it was felt that such a study was neither feasible nor necessary, in the light of the fact that comparable information was available for similar groups throughout the United States. Furthermore, we are advised that the subject of plan administration is one that is constantly under consideration by the governing boards of the plans themselves and which is under periodic review by the national accrediting group. In fact, during the period that the subject was under consideration, the Board of Directors of the Virginia Hospital Service Association had a study made by a firm of outside consultants for its own guidance, and two of the plans were visited by representatives of the National Blue Cross Commission.

For the year 1959 the ratios between operating expenses and revenues for the several plans were reported as follows: Piedmont Hospital Service Association, 6.7%; Tidewater Hospital Service Association, 8.9%; Virginia Hospital Service Association, 5.8%; Hospital Service Association of Roanoke, 2.2% and Group Hospitalization Incorporated, 5.7%. Of 83 Associations throughout the United States and Canada for which data were available, it was noted that most had operating costs approximately the same as those of the Virginia plans. Some few were lower than all except the Roanoke plan and most were higher. The percentage figures ranged as high as 15.9% in one case and 12 out of the 83 plans reported on exceeded 10% for one or more of the last two years.

Information was secured from each of the plans headquartered in Virginia concerning the salaries paid the five highest paid employees of each of the plans. This information is similar to that which is required to be filed with the State Corporation Commission by insurance companies in some instances. A review of these salaries indicated that they are reasonable considered with due regard to the size of the several plans.

As to costs of administration of the Blue Shield plans, two things should be noted. First, that the Virginia Medical Service Association, with headquarters in Richmond, provides Blue Shield coverage in the geographical areas served by both the Tidewater and Piedmont Blue Cross plans. Secondly, attention should be called to the fact that whereas Blue Cross deals with a limited number of hospitals and makes payments in lump sum amounts at specific intervals, Blue Shield deals with a far greater number of doctors and must handle each claim on an individual basis and make payment therefor to the individual physician or surgeon. Therefore it is not surprising to find, in the case of the Blue Shield Associations, somewhat higher administrative costs than for Blue Cross, being 9.5% for the Richmond area Blue Shield in 1959, 7.4% for the Roanoke plan, and 8.6% for Medical Service of the District of Columbia.

9. CONTRACT RATES OF PLANS

All of the plans operating in Virginia have shown a steady increase in rates, paralleling to some extent the increases in benefits which have been provided, and showing sharp increases in the 1950's contemporaneous with the increase in hospital costs.

We set forth below a table showing rates for selected years for the family coverage contract of the several Virginia plans.

Monthly Rates for Family Standard Contracts of Virginia
Blue Cross Associations
for Selected Years

Association	Year				
	Original Issue	1945	1950	1955	1960
Richmond (1936)	\$2.00	\$2.00	\$2.75	\$4.90	\$9.40
Norfolk (1)	\$2.34	\$2.09	\$2.42	\$3.00	
(1937)					
(2)		\$2.67	\$3.34	\$4.00	\$6.20
Roanoke (1939)	\$2.00	\$2.00	\$2.50	\$4.40	\$6.60
Lynchburg (1938)	\$2.00	\$2.00	\$2.25	\$3.95	\$5.40

(1) This rate for \$3.00 allowance toward cost of room, discontinued Oct., 1955.

(2) This rate for \$5.00 allowance toward cost of room. Higher allowances are offered at rates indicated: \$10.00—\$8.90; \$12.00—\$9.50; \$14.00—\$10.10.

Monthly Rates for Family Standard Contracts of Virginia
Blue Shield Associations
for Selected Years

Association	Year			
	1945	1950	1955	1960
Richmond	\$2.00	\$2.00	\$2.70	\$4.84
Roanoke	\$1.75	\$1.75	\$2.60	\$2.90

It must be emphasized that the above rates are the community rates for standard family contracts under group coverage. Higher rates are in effect for all "pay direct" contracts. Experience rated groups may have higher or lower rates depending on their experience and on the coverage elected; and any group may elect different endorsements to the standard contracts. In addition, "Comprehensive" contracts are offered by both Blue Cross and Blue Shield which provide additional benefits at higher rates.

As between the Plans, it should also be noted that benefits of the contracts differ. For example the Roanoke Blue Shield does not cover medical services. The Norfolk Plan has never offered full semi-private accommodations and has had a variety of allowances toward the cost of room and nursing, at different rates. For most of its history the Lynchburg Plan offered only a flat payment toward cost of room and nursing but in 1960 reverted to provision of full semi-private accommodations, whereas the Richmond Plan changed in 1960 to a \$12 allowance in lieu of the semi-private accommodations theretofore provided.

No comparable data are available as to premiums charged by insurance companies for hospital and medical expense insurance. Such policies have never been subject to control by the State Corporation Commission, as to either provisions or rates, and vary so widely because of differences in coverage, limits of liability, and underwriting practices that any attempt at comparison would be misleading.

The 1960 legislation grew out of a rate increase case involving the Virginia Hospital Service Association. In 1959 a rate increase was sought, and the State Corporation Commission directed that a \$50.00 deductible provision be inserted in all contracts issued by that Association. An appeal was taken to the Supreme Court of Appeals from the Commission's decision, and a supersedeas prevented the putting of the Commission's order in effect. While the appeal was pending, the Blue Cross and Blue Shield groups, with the acquiescence and support of the members of the State Corporation Commission secured the passage of the bill which eliminated the power of the Commission to pass on rates and contract provisions of the plans.

10. HEALTH INSURANCE COMPANIES AND HEALTH INSURANCE CONTRACTS

No discussion of Blue Cross and Blue Shield can be complete without consideration of the substantial role of insurance companies in providing accident and health insurance for the people of Virginia.

Accident and health insurance is being written in this State by 175 life insurance and 81 casualty insurance companies. Twenty of these life insurance companies are domestic Virginia companies. All 256 companies are properly qualified to do business in Virginia.

Each of these companies is subject to comprehensive and effective regulation by the State Corporation Commission of Virginia through the Bureau of Insurance under the immediate supervision and control of the Commissioner of Insurance. Foreign insurance companies are subject to the additional supervision and control of their respective domestic States. Each insurance company is subject to the regulation of each State in which it is authorized to do business.

Insurance companies, under the Virginia statutes imposing a 2 $\frac{3}{4}$ % premium tax on Virginia accident and health business, paid to Virginia approximately \$2,440,000.00 on their 1960 business. These companies also paid income taxes to the United States in accordance with existing revenue statutes.

Accident and health insurance written in Virginia by insurance companies include (a) hospital expense insurance (individual and group), (b) surgical expense insurance (individual and group), and (c) major medical insurance (individual and group). Such insurance affords insurance in some respects comparable to the service contracts of Blue Cross and Blue Shield plans.

In addition, these insurance companies write accident insurance policies and policies providing benefits for loss of time resulting from accident and sickness or either.

No accurate breakdown is available as to the premium tax paid by these companies on the hospital and surgical expense benefit and major medical insurance written by them in Virginia. But it is thought that the

premium tax on such business accounts for about one-half of the total accident and health insurance premium tax paid in Virginia.

While the Blue Cross-Blue Shield organizations initiated, in Virginia, plans for the prepayment of hospital and medical expense, the insurance companies have in a comparatively few years entered the field and now provide a major portion of such protection.

Blue Cross-Blue Shield organizations provide, through their contracts with hospitals and doctors, hospital and surgical services for their subscribers or contract holders, while insurance companies contract to pay to their insureds money which may be used by such insureds to pay for such services. In practice, since the insurance proceeds are usually assigned by policyholders to the hospitals and doctors, the result is that in those instances services are rendered for the policy proceeds payable by the insurance companies.

While insurance contracts vary as to amounts and types of benefits to suit the buying public, competition and State regulation serve as leveling influences.

Neither accident and health insurance rates nor Blue Cross-Blue Shield subscriber rates are State regulated in Virginia.

Insurance companies and Blue Cross-Blue Shield organizations sell and write experienced rated group contracts providing hospital and surgical expense benefits in the case of the insurance companies, and hospital and write experience rated group contracts providing hospital and surgicalizations.

11. CONCLUSIONS AND RECOMMENDATIONS

1. The problem of unnecessary hospitalization should be faced realistically by the Blue Cross and Blue Shield Associations, by health insurers, and by the medical profession. We are confident that such abuses do exist and that advantage is taken of both Blue Cross and health insurance coverage, particularly in the field of diagnostic hospitalization and admissions to hospitals for the performance of treatment which could be done on an outpatient basis or in a doctor's office. The formation of utilization committees in the several hospitals is one approach to this problem and we are advised that in certain localities it has had some effect. However, we do not think that a committee in a single hospital can satisfactorily solve the problem. The personal element alone will defeat this approach. We believe that it is one which should be dealt with at the Medical Society level and we urge that all possible steps be taken to acquaint the local Medical Societies with the facts and to promote action by them to correct abuses. We feel that the Blue Cross Associations themselves have an obligation to bring cases of suspected abuse to the attention of the Medical Societies throughout the State and to secure their cooperation in ending them. The example of the Pennsylvania Medical Society is at hand.

2. We feel that it is desirable that there should be a built-in economic brake by which a subscriber would be subjected to some part of the cost of hospitalization and that this would discourage not only too many admissions but also unduly lengthy hospital stays. This might take the form of a deductible clause or possibly the elimination of coverage for the first day or two (the proposed medical coverage under the Social Security Act takes this approach). In the case of Blue Shield coverage it might be

more desirable to have a coinsurance clause rather than a flat deductible amount. We believe that to bring home to the subscriber something of the cost of hospitalization is particularly important as to those cases where the whole cost of the program is paid for by the employer and if the contract provides first dollar coverage the beneficiary simply does not realize what his hospitalization costs.

Finally, in this connection, the subscriber should always know what has been paid on his behalf by Blue Cross and Blue Shield. He should receive an itemized statement, after he is discharged from the hospital, showing what has been charged, what the Blue Cross has paid, and what, if anything, he himself has been required to pay from his own pocket.

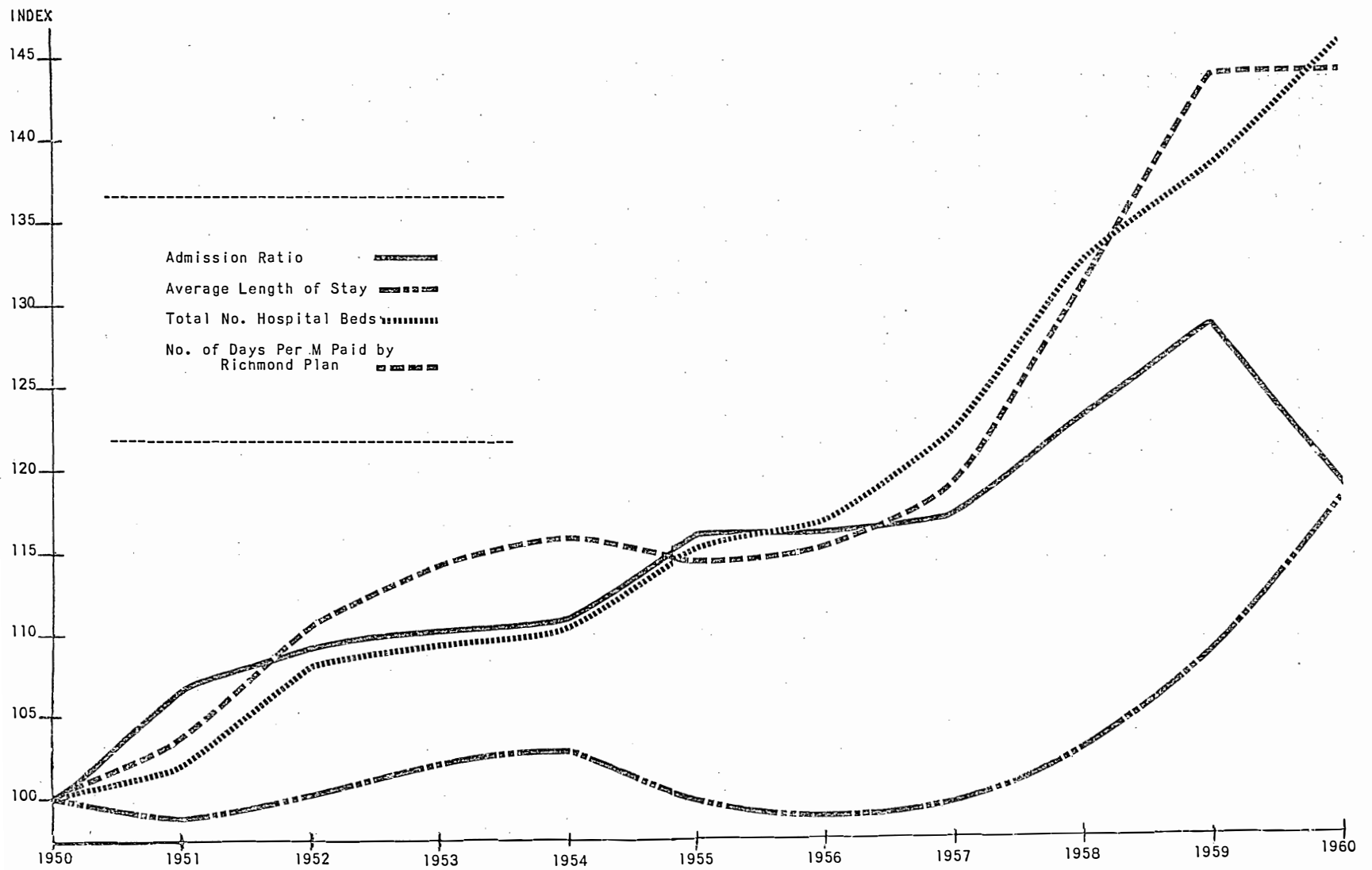
3. We believe that concerted efforts by all interested parties are necessary if the rising costs of prepayment plans are to be kept within bounds and to this end we feel that there should be a more vigorous public education program instituted by the Blue Cross explaining to the subscribers all of the above principles. This should include a general explanation of hospital costs, and the provision of the Blue Cross subscriber contract which excludes hospitalization services when rendered only for diagnostic purposes.

4. There appear to be too many general hospital beds in some parts of Virginia under present conditions. During the past five years the number of such beds in hospitals in the territory served by the Virginia Hospital Service Association has increased from 5,116 to 6,136 and there is in prospect a further substantial increase in the bed complement of these hospitals to an estimated 6,830 beds in 1962. This increase has created a vacuum which clamors to be filled, as hospitals must have paying patients to meet their fixed cost of operations. It has also allowed the admissions of patients who normally might not be hospitalized since there is no waiting for a bed. Nevertheless, percentage of occupancy has decreased in about half of the hospitals in the Richmond area; and in the city of Richmond some of the obstetrical units of older hospitals have been closed.

The close correlation between availability of hospital beds and the number of days of care for Blue Cross patients is strikingly illustrated by the attached graph showing experience of the Richmond Plan for the past decade.

The State Health Department, through its Advisory Hospital Council, is charged by statute with a continuing inventory of existing hospitals and the program of hospital construction. This program is the basis for allocation of federal funds under the Hill-Burton program and these funds have, to a large extent, been the source of financing of new hospital construction. We feel that a duty rests on the Advisory Hospital Council to limit the approval of government funds for new general hospital beds when there is no need for the additional facilities. This might, as a desirable by-product, result in more consideration being given to construction of additional facilities of less than hospital level for the chronically ill, and of other needed facilities.

In this connection it might be mentioned parenthetically that a decrease in bed occupancy for a given hospital may result in an increase in per bed cost for the occupied beds. This poses a problem for hospital management, it is true, but experience of one hospital has shown that costs can be curtailed by reducing operating expenses in areas of services which are least productive.



5. The Joint Resolution governing the conduct of this study directed that consideration be given to whether Blue Cross and Blue Shield plans should be subjected to "taxation of annual gross premiums, dues or charges received by such plans for services rendered or to be rendered". After thorough study, the Council has concluded that such taxes should not be imposed.

The Blue Cross and Blue Shield plans in Virginia, being non-profit organizations and providing for rendition of services, rather than cash indemnity payments, are not comparable to commercial insurance companies which are subject to taxation based on their annual gross premium income. That non-profit hospital service and medical service associations are not to be considered the equivalent of "insurance companies" has been often adjudicated in the courts.

The basic purpose of Blue Cross and Blue Shield is to render service, rather than to realize a profit. While the plans use some of the averaging principles of insurance, they are not insurance. Such plans are service benefit programs that pay for services rendered (regardless of cost) rather than merely providing limited cash indemnities. They maintain continuity of coverage regardless of employment, physical condition, age, or insurability. They guarantee to the subscriber that, once he is in the plans, he will have the opportunity to continue his membership as long as he is willing and able to pay the necessary fee (excepting only when as a Group member other coverage is arranged for him by the Group).

The income dollars provided Blue Cross-Blue Shield by the subscribers to the plans are health-care dollars—not insurance dollars. Sight should not be lost of the fact that Blue Cross acts as the agent of hospitals. They are the sole proprietors of Blue Cross. It conducts the hospital's program or prepayment for hospital services. The hospitals of Virginia, all but few of which are voluntary community hospitals, guarantee to subscribers that the benefits offered by their Blue Cross plans will be provided by the hospitals regardless of the plan's ability to pay for that care. Blue Shield operates in like fashion on behalf of the participating physicians.

As opposed to Blue Cross-Blue Shield, most insurance companies are able to offer a complete group insurance package, including life, disability, and sickness and accident benefits, as well as hospital insurance. This competitive advantage which insurance companies enjoy is substantial. Blue Cross and Blue Shield can only provide pre-paid protection against charges made for hospital and medical services. They can not compete by offering additional types of coverage.

This competitive advantage of commercial companies has had a marked effect on Blue Cross plans in recent years. This is clearly shown by the steady decline of coverage provided by the Richmond plan:

	<i>Contracts</i>	<i>Participants</i>
April 30, 1958	169,638	431,629
December 31, 1959	154,693	397,560
December 31, 1960	145,842	381,068
July 31, 1961	140,158	366,400

It is quite apparent that subjecting Blue Cross plans to a premium tax (which necessarily would have to be passed on to subscribers) would hasten a decline in their coverage—something which all agree should be avoided.

This same question was posed to the Virginia Advisory Legislative Council in 1950. In its report, the Council said:

“Blue Cross associations should not be taxed on gross income, or net income. If a member hospital is a corporation operated for profit it is taxable on net income as any other corporation. Its property and other assets are likewise taxed on the same basis as like assets of similar concerns. Participating physicians in the medical-surgical plans are also subject to taxation.

* * *

“As noted above, Blue Cross associations are regulated on the basis of attempting to balance income and outgo as nearly as possible, except for the accumulation of sufficient reserves to assure the solvency of such plans under adverse conditions. Any tax which might be levied on the associations would either diminish these reserves or decrease the services which the plan is able to offer, or increase the rates which must be charged subscribers.

“The Council accordingly feels, that in view of the public service performed by such associations, and also in view of the fact that an extension of Blue Cross coverage, with governmental participation, has been widely advocated as the most effective way to counteract the considerable pressure throughout the country for the adoption of socialized medicine, the imposition of a tax on Blue Cross associations is not justified.

“The Council does not believe in tax exemption. The circumstances surrounding these associations are so different from the ordinary type of case that the distinction is not merely a distinction but a difference; it is an arrangement for giving services for a fee and does not constitute anything more than a collecting and disbursing agency for the participating hospitals and physicians.

“These considerations apply equally to the Blue Shield associations which furnish medical and surgical services in connection with hospitalization.”

These conclusions reached by the Council in 1950 are equally appropriate today.

For the foregoing reasons, it is recommended that the Blue Cross and Blue Shield plans of Virginia not be subjected to the payment of premium or other taxes on their income.

During the study it was proposed that Blue Cross and Blue Shield plans in Virginia be restored to the same status they occupied prior to the 1960 Session of the General Assembly; i.e. that the plans should again be made subject to rate regulation by the State Corporation Commission.

The Council considers that to compel Blue Cross and Blue Shield plans to return to the situation in which they found themselves prior to 1960 is inadvisable and should not be done.

The only substantial change made by the enactments of 1960 was to withdraw from the State Corporation Commission the authority to fix rates chargeable by Blue Cross and Blue Shield plans. Or, stated another way, Blue Cross and Blue Shield plans were made subject to substantially the same regulatory safeguards as are competing commercial insurance companies.

In view of this strictness in regulation, and the fact that the State Corporation Commission has itself declared unnecessary its continued regulation of rates to be charged by plans, the Council considers it inadvisable that Blue Cross and Blue Shield plans be required to return to the status existing prior to 1960.

It is significant that the Richmond plan has since the legislation of 1960, through self-adjustment of its charges to subscribers, recovered so that it is now adding steadily to its reserves. Also, the Norfolk plan is currently correcting its financial difficulty by a self-adjustment of its charges.

There having been but slightly more than one year of experience under the new arrangement, and no proof of discrimination or unfair result under the present regulations having been shown, the Council considers that a change at this time would be premature.

ACKNOWLEDGMENTS

As mentioned above, there was supplied to the Committee and to the Council a great volume of statistical data and other information, by the Blue Cross and Blue Shield groups operating in Virginia, by their national affiliates, by representatives of the insurance industry both within and without Virginia, by the staff of the State Corporation Commission, by the Virginia Council on Uniform Hospital Accounting, by the participating hospitals of the Associations, by physicians, and by others. Complete cooperation was given whenever it was sought. We desire to thank all who aided in connection with the study, and particularly to express our gratitude to the members of the Committee, who contributed so lavishly of their time and energy to assist us.

Respectfully submitted,

CHARLES K. HUTCHENS, Vice-Chairman

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APPENDIX

MEDICAL COLLEGE OF VIRGINIA

Hospital Division

January 18, 1961

Mr. John B. Boatwright, Jr.
Director
Division of Statutory Research
and Drafting
Richmond, Virginia

Dear Mr. Boatwright:

This is in reference to your recent letter concerning hospital cost. You asked if I could give you any information concerning the reasons for the large difference between the increase in hospital cost and the increase in the cost of living. The cost of living index has increased from 102.8 in 1950 to 126.8 in September, 1960, an increase of 23.3 per cent.

I forwarded to you a table showing the per diem cost at the Medical College of Virginia Hospital Division for a ten year period, 1950-51 through 1959-60. Our per diem cost increased from \$13.87 to \$25.16 for this ten year period; an increase of 81 per cent. There are several major reasons for this increase:

1. *Salary Increases*

Upward adjustment in salaries for hospital personnel accounts for approximately 50 per cent of this increase. It is necessary to increase nursing salaries because of the skills and training required of the registered general duty nurse and the demands for her services from the public health service, industry and physicians. Registered general duty nurse's salary has increased from \$2,340 in 1950 to \$3,812 in 1960, an increase of \$972 or 41.5 per cent. This is still considerably less than what the other agencies or individuals listed above pay for a graduate nurse's services. When you consider that the registered nurse has completed a three or four year program in nursing (many have degrees) and has to pass a State examination in order to practice her profession, the salary paid a nurse is not commensurate with her training. Salaries paid to graduate nurses are less than those paid semi-skilled laborers in industry. In 1950 most hospital personnel were working in excess of 40 hours a week. For example: our nurses were working 44 hours; this includes registered general duty nurses, hospital practical nurses, hospital aides and hospital attendants. Most of our housekeeping personnel were working 44 hours each week. The same is true also for our dietary personnel. In order to compete with private industry and attract and retain competent employees, it has been necessary to adopt the standard 40 hour week. This represents approximately 10 per cent of the per diem increase in our hospital cost.

2. *New Hospital Services*

Hospitals are developing new skills and techniques constantly, new products, if you please. Since the hospital's ultimate product is measured in terms of the cost to produce a day of patient care regardless of service rendered, we must take into consideration these new

services. Hospital cost cannot be compared with the cost of living index realistically because it would be unfair to compare the present hospital day of care with the day of care produced in 1950. The quality of care in 1960 is much greater than the patient care rendered in 1950. In 1950 we did not have the artificial kidney, cardiac catheterization procedure, postoperative recovery room, open heart surgery, complicated neurosurgery operations, intensive care unit, radio isotopes, and many new laboratory procedures. These additional hospital services require skilled technicians and the purchase of complicated and expensive equipment. To mention a few; heart-lung pump for open heart surgery, large sterilizers used in our clinical laboratories and pharmacy; cardiac pacemakers; radio isotope laboratory equipment; pulmonary function laboratory equipment; x-ray equipment used in the cardiac catheterization laboratory; portable x-ray machines. Increase in hospital personnel because of new procedures and techniques and reduction in work week from 1950-1960 increased the ratio of personnel per patient from 1.6 to 2.0.

3. *Expensive Drugs*

During the past decade the importance of pharmaceuticals in modern medicine has become increasingly evident. In fact, medical diagnosis, treatment and prevention of disease has become so closely identified with pharmaceuticals that today nearly all procedures depend upon pharmaceuticals for their implementation. The greater utilization of drugs in the treatment of patients can be shown as follows: We spent for Heparin in 1950 \$1,024—in 1960 \$7,714; new anesthetic agents such as Fluothane in 1950 - 0—in 1960 \$6,349; muscle relaxants in 1950 - \$1,750—in 1960 \$6,814; steroids (ACTH Cortisone) in 1950 - \$4,272—in 1960 \$14,737. Although in the antibiotics area expenditures for penicillin has dropped from \$39,261 in 1950 to \$23,090 in 1960, the other antibiotics have increased tremendously such as Chloromycetin (1950 - 0—1960 \$107,755). The advent of certain resistant strains of bacteria has required not only the use of massive anti-infective agents such as Chloromycetin but also the use of additional disinfectants such as Staphene (\$890 in 1950—in 1960 \$7,200) in the hospital's continuing fight against infections. Our per diem pharmacy cost have increased from \$.83 in 1950 to \$1.28 in 1960.

4. *Reduction in Bedside Care by Student Nurses*

In a medical center such as ours the bedside services provided by student nurses have been reduced in favor of more classroom work. We have recently discontinued the diploma program in favor of the baccalaureate degree program. Because of this approach to teaching student nurses, the hospital can use the student very little for service and have hired additional nursing personnel. For example: on our pediatric and psychiatric floors, our salary costs have increased approximately \$100,000 each year because of reduced student bedside patient

5. *Increase in Laboratory Facilities*

Our laboratory facilities at the Medical College of Virginia have been increased tremendously over the past ten years. Many new procedures have been developed, especially in the field of chemistry, hematology, serology, bacteriology and virology. In fact, laboratory

aids in making diagnosis of viral diseases did not exist in 1950. Blood transfusions have increased approximately 70 per cent reflecting the increase of major operations. However, this does not reflect the increased volume of work because of additional tests instituted by our Blood Bank to further reduce the possibility of a patient receiving the wrong blood. In 1950 expenditures for blood amounted to \$9,500; however, in 1960, our purchases for blood amounted to \$97,215. Prior to June 1, 1959 the hospital did not have to pay any administrative services to the Red Cross for those patients who received blood under the Red Cross Blood Donor Plan. The hospital is now paying a \$3.00 fee to cover blood typing and administrative costs for each pint of blood used. No charges are made by the Red Cross for the blood. The City of Richmond does not participate in this program.

6. *Hospital "Stand-By Costs"*

Certain hospital costs may be termed "stand-by costs". This represents costs incurred in making the hospital available to the community day and night. It is necessary to staff the operating rooms, delivery rooms, emergency rooms, clinical laboratories, etc. 24 hours a day every day of the year. A very small percentage of patients use these areas at night and week-ends and, therefore, it is a very expensive operation. This is, of course, due to the fixed charges such as heat, lights, building maintenance, staff services which continue whether beds are filled or not or emergency treatment rendered. The hospital must be ready to serve at all times.

7. *Hospital Services Cannot be Mass Produced*

Hospitals are unable to profit from the labor saving machinery which has kept industry so efficient. Hospital services do not lend themselves to mass production. Approximately 70 per cent of the dollar spent for hospital services is for salaries, this is considerably greater than the payroll costs in industry. As salaries increased in industry, a reduction in the number of man hours required for the making of a particular product was accomplished. This has been done in industry through automation. For instance, steel companies are producing more steel with fewer people and at the moment only 50 per cent of plant capacity. "Hospitals are still a handicraft industry trying to struggle along in the age of the machine."

Because of the demands placed on the hospital by the patient for more comfortable facilities such as air conditioning and telephone service, the scientific advances in the health field requiring expensive and complex equipment and skilled personnel, new procedures and drugs, hospital costs will continue to increase. However, an injury or disease which only ten years ago would have been fatal is now treated successfully and the patient returned to the community able to carry on a useful life. The health and well being of our citizens have been improved and longer life attained. To my way of thinking an investment in one's health is the best investment that a man can make, and in spite of increasing hospital costs, hospital services are still the best buy anywhere.

Sincerely,

W. H. GUSTAFSON,
Administrative Assistant

WHG/hb

* * * HOSPITAL

February 23, 1961

Mr. John B. Boatwright, Jr., Secretary
Virginia Advisory Legislative Council
State Capitol
Richmond 19, Virginia

Dear Mr. Boatwright:

Acknowledgment is made of your recent letter requesting for your Committee the cost analysis for a private hospital as compared to a State institution.

The cause of the increased per diem cost of a general hospital in this area is essentially the same. The one big item of increased expense we are all having, and one which is gradually increasing each year, is that of salaries. The percent of salaries to the total expense of hospitals in this area of similar size will vary from 48% to as high as 70%.

Listed below is a scale of the increased per diem cost of this hospital from 1952 through 1959:

1959	1958	1957	1956	1955	1954	1953	1952	Percent of Increase
21.66	19.39	17.82	16.28	15.92	14.71	14.34	13.82	57%

Of course, we have had increases from other sources similar to those pointed out by Mr. Gustafson. There is one item that a proprietary hospital would have that a State or community non-profit hospital would not have; that of taxes. As an example: in 1952 our taxes and license amounted to \$11,847.73. In 1960 they were \$35,457.03. An increase of 197%! The proposed increase in 1961 of real estate taxes will amount to \$1,090.00., or 8% increase in 1961 over 1960.

