

HOSPITAL
ADMINISTRATION
ORAL HISTORY
COLLECTION

Lewis E. Weeks Series

Bernard R. Tresnowski

BERNARD R. TRESNOWSKI

In First Person: An Oral History

Lewis E. Weeks
Editor

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Bernard R. Tresnowski

CHRONOLOGY

- 1932 born Chicago, October 14
- 1955 University of Michigan, B.S.
- 1958 University of Pittsburgh, M.P.H.
- 1958-1961 Albert Einstein Medical Center, Philadelphia
 Assistant Administrator
- 1961-1962 University of Michigan, Bureau of Hospital Administration,
 Research Associate
- 1962-1967 St. Joseph Mercy Hospital, Pontiac, MI,
 Associate Administrator
- 1967-1969 Blue Cross Association, Medicare coordinator
- 1969-1977 Blue Cross Association, Senior Vice President, Federal
 programs and health care services
- 1977-1978 Blue Cross Association, Executive Vice President and
 Chief Operating Officer
- 1978-1981 Blue Cross and Blue Shield Association, Executive
 Vice President
- 1981- Blue Cross and Blue Shield Association, President

MEMBERSHIPS & AFFILIATIONS

American College of Healthcare Executives, Member
American Hospital Association, Member
American Medical Association Health Policy Agenda for the American People,
Steering Committee, Member
American Public Health Association, Member
American Public Welfare Association, Member
BCS Financial Corporation, Board Member
Brookings Institution National Advisory Panel on Long Term Care for the
Elderly, Member
Commission on Professional and Hospital Activities, Board Member
Community Programs for Affordable Health Care, National Advisory Committee,
Member
Department of Health and Human Services, Secretary Bowen's Private/Public
Sector Advisory Committee on Catastrophic Illness, Member
Employee Benefit Research Institute, Member of Board and Research Committee
Health Management Education Association, Member
Hospital Research and Educational Trust and the American Hospital Association
Office on Aging and Long Term Care, Member Advisory Board
International Federation of Health Service Funds, Member Council of Management
International Foundation for Employee Benefits Plan, Member
National Advisory Committee for Health Services Research Center
National Council on Patient Information and Education
Royal Society for Promotion of Health, Member
Society for Health Service Administrators, Member
The Conference Board, Member
The Dunlop Group of Six, Principals

WEEKS:

This is an oral history which is basically partly autobiography and partly a discussion of the work you are doing and the things you've done, and what the future might hold.

I note you were born in Chicago and that you have your B.S. from the University of Michigan and your Master of Public Health in Hospital Administration from Pittsburgh.

TRESNOWSKI:

Yes.

WEEKS:

In looking at that, I was wondering, was McNerney still at Pittsburgh then, when you were there?

TRESNOWSKI:

That question leads to an interesting aspect of my career. My bachelor's degree at Michigan was in medical care administration. It was an experimental program designed by Sy Axelrod, who, of course, you know well. He took in a group of undergraduates. Actually, I was going into my junior year in college, and they fashioned the curriculum, which was an admixture of natural sciences and business courses, because the School of Public Health, where this program was located, didn't have the course work. So I found myself taking microbiology and anatomy and organic chemistry and all those sorts of things in the mornings, and I was over in the business school in the afternoons taking accounting, and in the economics department taking economics courses. So I had a broad smattering of educational material. I graduated with a bachelor's degree in medical care administration. Of course I got to know Sy Axelrod very well and I got to know Carl Metzner and Nate Sinai and

Ben Darsky and others in the School of Public Health. But Sy Axelrod was my counselor. I was very young and looking to make some career decisions.

The choice obviously was: do I go to work, or do I go on for further education? Sy felt that I would be well advised to go on to get a master's degree. We talked about that. He felt that in the context of medical care administration there was a variety of programs around the country in hospital administration, medical care administration, and so on. Well, we looked over the range of possibilities, and he said that in fall of 1955, they expected to start a program in Ann Arbor, a master's program, and that he was on the committee to organize it and to find a person to head it up. I said, "Wouldn't I be well-advised to stay here in Ann Arbor to get my master's degree?"

He said, "No. First of all you will probably have taken all the courses that will be offered in the graduate program, and you really ought to go and have a different view of the world." And he recommended Pittsburgh -- as contrasted with Chicago or Minnesota or Yale or whatever. And the reason he recommended Pittsburgh was two-fold.

He said that John McGibony, who was heading the program at the time, had an outstanding reputation. But equally important, there was a young guy there by the name of Walter McNerney whom Sy had come to know and said, "I think you would enjoy studying under this young man and John McGibony.

So I went to Pittsburgh, was interviewed, and accepted into the graduate program. After graduation in June, at the time I was registered to start in the fall, the program at Michigan came together, and they recruited and hired McNerney to head the program at Michigan.

That becomes significant in terms of my relationship with Walt, and where

I sit today. I went to Pittsburgh, and Walt had made a commitment to Pittsburgh to do both things -- to set up the program in Ann Arbor and still teach a lot of the coursework at Pittsburgh. So I had him as a teacher. Now he wasn't in residence, but I got to know him as a student in the graduate program.

I'll skip through some things, just to make the point about McNerney. I finished at Pittsburgh and did a residency in Philadelphia at the Albert Einstein Medical Center, and stayed on at Albert Einstein when I finished my residency to take a position as the assistant director of the medical center.

In 1960, I was in Atlantic City for the Mid-Atlantic Hospital Assembly and happened to meet Walt McNerney, who had been in Ann Arbor for five or six years. We chatted, and he said, "How would you like to come back to Ann Arbor? We've got some research studies that we need to pursue -- particularly one for the American College of Surgeons, which wants the university to do a study of social and economic factors influencing surgical practice in the United States. How would you like to come back to Ann Arbor to do that?"

I said, "I'd love to come back to Ann Arbor." So I counseled with my wife, and we moved from Philadelphia to Ann Arbor.

I had agreed to come over there in October of 1961. But, between the time I saw Walt in the spring and October, he took the job as the president of the Blue Cross Association. So I'm on my way to Ann Arbor -- now this is twice that I'm going from one place to work under Walt McNerney, and both times he left before I got there.

I went to Ann Arbor and stayed on the faculty as a research associate. I did the study for the surgeons and did a number of other things while I was there, and that's where you and I met, of course. Then, I went on to Pontiac,

Michigan, in hospital administration.

About five years later, it was actually the February of 1967, shortly after the Medicare program had begun, I was in Chicago for a meeting of the American College of Hospital Administrators and met Walt McNerney in the lobby of the Sheraton-Chicago. Walt said, "What are you doing?"

I told him I was running this hospital, and so on. I was thirty-four years old by this time. And he said, "You are too young to die. Exciting things are happening in the business; the federal government has taken on an enormous role, and the private sector relationship with the government is very significant -- the intermediaryship under the Medicare contract --and we need somebody at the Blue Cross Association to head that up. Wouldn't you like to come to work for me at the Blue Cross Association?"

I immediately said to him, "The last two times you and I had conversations like this, you left before I got there." And there was speculation at the time that Walt was going to leave BCA and go to work in the government as Secretary of HEW.

He said, "Oh, that's just rumor. Don't pay any attention to it."

To make a long story short, I did accept the job as the Medicare coordinator, the head of the Medicare division, and came to work for Walt at the Blue Cross Association.

When I came to work at the Blue Cross Association to head up Medicare, that really began my career. I realize I was thirty-four years old then, but I tended to look at the period prior to that as preparation time. I felt that I had accomplished a great deal in hospital administration, learned a lot about the delivery of health care services, the sense of dynamics of delivery of care, the personality of physicians, and the interplay of all the

associated healing professions as they operate within a hospital environment. All excellent background, but in terms of making decisions, policy decisions, and influencing the direction of health policy in this country, the career really began when I came to the Blue Cross Association. Because now, for the first time, I was engaged in shaping the quality of the relationship between the federal government, and the awesome power of the federal government under the Medicare program, and the private sector, both in terms of the contract, with the Blue Cross Association to administer it, and as intermediary interfaced with the provider community.

If you recall back in 1966 and 1967, those formative years of the Medicare program, there was a lot of shaping that took place. Clearly it has gone on. When one looks back at those years and compares that time to this, there is a significant change in the quality of and in the nature of the relationship. But that was a critical turning point for me. I spent about the first eight years at the Association in that environment of the negotiation of contracts, the development of health policy as applicable to Medicare, and I became fully cognizant of the workings of the United States Congress and the administration. I developed my skills in those relationships in testimony before the Congress and with the executive branch, -- and it was a good proving ground as well as a good training ground for me.

As time went on, my responsibilities broadened. Walt -- being the kind of person he was, when someone demonstrated an ability to do things and take on added responsibilities, he was ready for it. So my Medicare responsibilities were expanded to include the federal employee program, and were further expanded to include all our health care services activities -- hospital payment, hospital utilization, health planning, all other health

related activities. So I found myself touching a broad base of matters having to do with the government, having to do with health care delivery in this country. And I had an absolute ball. It was one of the best times of my life -- the period from when I arrived here until I was about forty-two years old. A lot happened in the industry in that time.

I'll stay in the autobiographical part, and then we can turn to the substantive.

Then I had the added opportunity of working with Gene Sibery whom Walt brought to the Association as Executive Vice President. I broadened my responsibilities and began to think about Blue Cross as an organization. Prior to that time, I dealt only with it as an organization related to administration of the Medicare contract or the FEP contract or the health care services responsibility. But now I began to look at it in a different light.

When Gene Sibery left the Association, Walt promoted me to the executive vice president's job, and now I had to pay attention to all aspects of the organization. I spent one year doing that as executive vice president of the Blue Cross Association. Then, when we combined the two associations, Blue Cross and Blue Shield, I stayed as executive vice president of both organizations.

Interestingly enough, when the associations were combined, Walt took me away from the government side of it and put me totally into the business aspects of Blue Cross -- the data processing and the financial. So I had now gone full-circle and touched all the bases without any grand design on my part, certainly. I never aspired to the job I now sit in. Nobody ever said, if you do these things, you'll prepare yourself to become the CEO. And I never did. But life has its interesting twists and turns, and it certainly

applied in this case.

So in 1981, when Walt decided to retire, I was in a position with a wealth of background and knowledge and information, both about the industry and about the Blue Cross and Blue Shield enterprise, and the board saw fit to name me president. And this is where I have been for the last four years.

Now, that's all autobiographical information.

WEEKS:

I don't know if you want to say anything about the merger, how it came about, the difficulties you had. I don't know whether this is important or not.

TRESNOWSKI:

Let me comment on that and then maybe go back to what I think were other, critical developmental issues in the life cycle of Blue Cross and Blue Shield.

The merger itself was fascinating. What it demonstrated more than anything else was that it was an idea whose time had arrived. It was not a new idea that Blue Cross and Blue Shield should merge. In the minds of the American people they never drew a distinction between the two. Blue Cross was always referred to when they talked about Blue Shield. The American people never drew this distinction. Indeed, as time went on the distinction between professional benefits under Blue Shield and institutional benefits under Blue Cross didn't make any sense, because benefit design had changed so dramatically — the move to out-of-hospital coverages, outpatient ambulatory surgery, and on and on. So there were a lot of reasons why the distinction between Blue Cross and Blue Shield should not be retained.

But over time, as one can imagine, as institutions grow people have vested interests, large stakes, personal business and otherwise. And changing

that was not an easy thing. Over a period of years the subject would come up, task forces would be appointed, reports would be filed, all saying that they ought to be brought together. But as soon as those reports were filed and the chairman of the task force announced his intentions, he was held in disrepute and the matter would go away for another year or more. Then the subject would re-emerge, and another task force, and the cycle would repeat itself.

However, there were a couple of significant events that occurred to make it different in 1976. Those events were that the two largest Blue Cross and Blue Shield Plans merged -- in Michigan and in New York City. In both cases they had been separate corporations, even though they had shared some common services and facilities. They were separate corporations with separate boards and chief executive officers. But in 1976, the Michigan Plan merged into the Blue Cross and Blue Shield Plan of Michigan and New York City did also.

Now you had the two largest corporations in the Blue Cross Association and the Blue Shield Association as merged corporations with single chief executive officers. They looked at the national association and said, Why are we paying dues to two separate organizations? Why are we duplicating our Washington offices? The conversation went on and on. So you now had powerful forces in the system saying let's not continue with this any longer.

In 1977, June of 1977, two months after I had been named executive vice president, I went to my first meeting of the Executive Committee of the Blue Cross Association. I had worked very hard on building the agenda, putting materials together. Walt and I spent a lot of time going through what was to be accomplished. We worked with the chairman of the executive committee on the agenda. We got to the meeting -- it was in Los Angeles -- and we were in the meeting for five minutes and Ed Werner, President and CEO of the New York

City Plan, said, "I would like not to get to that agenda. I would like to introduce a different topic. The topic I want to introduce is how we can, in the next four months, combine the staffs of the two national associations into a single organization."

So for the rest of that meeting -- we never got around to the rest of the agenda -- we spent time talking about how a merger could be orchestrated.

What happened is that following that meeting in early June, in Los Angeles, the executive committee of the Blue Cross Association and the executive committee of the Blue Shield Association held a joint meeting where they laid out a program with a target of October of that year -- this was now June -- for a special meeting of the member Plans, Blue Cross Plans and Blue Shield Plans, would be held and where a specific proposal would be made to merge the staffs of the two associations. We called it the "long hot summer of 1977." There were task forces and groups and meetings were held to deal with a whole variety of issues.

But it all came together, coalesced, and the recommendation was made to a special meeting in October of that year. It was a fascinating meeting because there were some strong feelings, mostly on the Blue Shield side, mostly held by doctors who felt that the merger with Blue Cross would destroy the Blue Shield Plans. That they would be consumed, and that the influence of medicine in the Blue Shield environment would be subjugated to Blue Cross interests. So there were pockets of opposition. But when the issue came to a vote, some very large and powerful Blue Shield Plans, Blue Shield-only Plans like Pennsylvania -- highly respected -- chose to vote in support of the merger, and it passed.

In January of 1978 all of it came together and a new CEO was named, and

that was Walt McNerney. The merger was a merger of the staffs. One of the compromises was to keep the two corporations separate, with two boards, but with a single CEO and a single staff. It stayed that way until 1982. When I took over as president in December of 1981, one of the first things that I put on my agenda was to clean up the situation and effectively merge the two associations.

Getting back to the point I made about an idea whose time has arrived — I said I took over in December of 1981 and appointed a task force to work on the mechanics and logistics of effecting a merger of the two corporations, combining the boards and that sort of thing. We all worked hard and did a very thorough job, prepared the documents, cleared all the committees and the boards, and a special meeting of the Plans was called in June of 1982.

I'll never forget it, because it was my first major meeting of all the Plans around a very substantive issue. They all came together at the O'Hare-Hilton in Chicago. Materials had been mailed out in advance. I got up and introduced the topic very briefly -- five, eight minutes -- the background leading up to the recommendation. I introduced the chairman, John Morgan, who also said a few brief words. Then someone rose from the audience and moved the merger. It was seconded. The chairman asked if there was discussion, but there was none. The vote was taken. It all happened within a period of twenty minutes. When they finished — I had never seen it happen before and I have never seen it happen since -- when they finished the vote, everybody rose to their feet and applauded themselves.

I tell that story because, going back to the point about an idea whose time has arrived, when I look back at all the controversy in the previous eight years around the topic of the merger of Blue Cross and Blue Shield, and

the emotions and all that went with it, and the personalities, yet here we were in June of 1982, and it took twenty minutes for it to be effected. Now, clearly, it didn't take twenty minutes. It took eight years and twenty minutes for the idea to settle, for personalities to change, for the environment to cause us to think about the world in different ways. But that was the merger.

It was an excellent decision. Both the merger of the staff and, subsequently, the merger of the associations. We are a much better organization than we ever could have been otherwise.

I dwell on it a bit because of my own experience with it, but I view the introduction of Blue Cross Plans and Blue Shield Plans as intermediaries and carriers in the Medicare program as a very significant milestone in the organization life cycle.

We had been health care underwriters prior to that time. We were intermediaries, conceptually, between the providers on the one hand and the buyer on the other. So the intermediary concept was not new to us. But the role of intermediary between the provider community on the one hand and the federal government on the other, under circumstances and terms that were quite different from any other buyer's, was a very significant one. Aside from the sheer magnitude of it, the dollar magnitude and the claim volume, Blue Cross and Blue Shield almost doubled their capacity in terms of buildings, computer capacity, personnel, in order to do the intermediary-carrier job. That doubling was an aggregated number. In some parts of the country it was much larger than that -- in places like Florida and California, where there are large segments of the Medicare population. The Florida plan may have had a hundred employees, prior to Medicare, and in a very short period they added

another five hundred.

WEEKS:

This Medicare intermediaryship revenue, or fees, or whatever you call it, was very important to some of the smaller plans, wasn't it?

TRESNOWSKI:

It was. It was an acquisition of business. It was ASO business -- defined as administrative services only. We got paid our costs, but costs being broadly defined to include a fairly substantial share of the overhead. So you enlarged your ability to support your overhead. You also attracted people. People in an organization don't keep their minds on just one thing. They become part of the organizational culture. So you were able to attract people that you otherwise couldn't have afforded. You were able to pay your management staff more money because you had a broader base and could attract better management staff. It was a tremendous opportunity for Blue Cross and Blue Shield to broaden and expand.

The negative during that period was that the demands of the Medicare program were so awesome that we ignored the private market, in significant ways. We ignored it from the standpoint of our service capacity. While we were building computer systems for Medicare, we were ignoring them in the private side, and our service capacity was deteriorating -- our beneficiary services, claim services. That was hurting us.

In addition to that, health care costs were rising at phenomenal rates. You'll recall, during that period it was not unusual to have health care costs rising at fifteen percent every year. When we got into the seventies, it was up to twenty percent per year. That translated into higher premiums, and the marketplace was beginning to become highly price-sensitive and dig its heels

in. There was a strong desire to move into cost containment techniques. That required time, energy, people, strategizing, and you were torn because, again, you had this awesome responsibility with government, and yet you had this cost-containment initiative that needed to be pursued sensitively in order to be responsive to the private market.

So Blue Cross and Blue Shield went through some very difficult periods. We had enjoyed, for a very long time, large market growth. If one were to look at the market growth on a curve, it would be steeply up until about 1978. What happened then was that health care as an item in corporate budgets had become very significant. The buyers began to look at health care benefits in a different way. They became attracted to comprehensive major medical. That gave them a way to achieve the affordability. Then they looked at HMOs as an option to continue comprehensiveness of benefits, but at an affordable price.

So the buyer began to look around. And Blue Cross & Blue Shield found out that the marketplace didn't operate according to the rules and regulations that had been institutionalized within Blue Cross and Blue Shield. It was different. And the steep growth curve that we had experienced for a very long time dipped.

Not only did we lose market, but in 1980 we sustained very large financial setbacks. As a system our operating results were \$450 million negative. And as bad as 1980 was, 1981 was worse. We lost \$465 million. And there aren't many corporations that can sustain losses of those dimensions back to back and be around very long. So there was deep concern in the organization about market loss and financial jeopardy. Those are aggregate numbers. When you disaggregate the numbers on a Plan by Plan basis, some Plans were in significant jeopardy. A couple were technically insolvent, with

market share loses of twenty percent.

It was in that environment, in December of 1981, that I took over as the CEO of the Blue Cross and Blue Shield Association. Even though you had been with the organization for a long time, the full impact never hits you until you assume the top responsibility and then you begin to absorb what you already know.

Business Week interviewed me in January of 1982, shortly after I had taken over. The purpose of the interview was to make the case that Blue Cross and Blue Shield was probably going to go out of business because their markets were dropping and they were in financial jeopardy. It was an unfortunate article. It was quite premature and they printed a picture of me as part of the article. The picture -- I'll keep it forever in a frame because it shows me with a deep frown. I didn't realize that they were doing a number on me when they interviewed me and took the picture. It's interesting that the picture they took had nothing to do with the subject. When they took the picture, the photographer was asking me about my golf game and I had this pained look on my face and the frown having to do with my golf game. But it appeared in Business Week related to the demise of Blue Cross and Blue Shield.

Since then, of course, things have improved very substantially. Our market position is much stronger. We are on an upswing again. Financially, we were able to add \$2.5 billion to reserves at the end of 1984. We are in better financial position today than we have ever been in before, and the market is reflecting that. Now I would love to be able to say that that is all related to the excellence of management and the quality of our cost containment initiatives, and I certainly think there is a lot to be said for that. However, the most significant contributor to the improvement of our

situation has been the very substantial decline in hospital utilization -- which is another topic that we can talk about.

But as we sit here today, just from a sheer numbers standpoint, Blue Cross and Blue Shield share of the market is improving, and we expect to recapture a lot of the market that we lost in the early years of the 1980s. And financially, as I mentioned, we are much stronger than we ever were before.

But beyond that, as one of my first annual reports noted we are "an enterprise in transition" I repeated that theme and modified it in terms of change and noted that Blue Cross and Blue Shield is a different organization today, clearly, than it was when it began. But it is even quite different from what it was in 1979 or 1980.

It is different primarily because the buyer has asked that we be different. The buyer wants comprehensiveness of benefits at an affordable price, and buyers have learned that they can get that through either an HMO option or a PPO (preferred provider) arrangement, or they can stay with traditional benefits but wrap around it some components of managed care -- many drawn from the HMO and the PPO -- like preadmission certification to the hospital, ambulatory surgery, second opinion in surgery, the opportunity to move people out of the hospital to home health, to hospice service, concurrent review while in the institution, discharge planning. All those things, all those incentives and sanctions, among other things that are going on in the health industry, have contributed to the substantial drop in utilization.

But the demand for that kind of product, the linking of financing and delivery, HMO and PPO, managed care, has substantially changed our product portfolio, and where we spend our time and energy. I say substantially

changed, but I would quickly add that it really takes us back to where we began. A very strong linkage between financing and delivery around selectivity of arrangements with doctors and hospitals.

I like to think, and I told my constituency, that what has happened in 1985, and as we look ahead to the next five years at least, the product that has been demanded is our bag. It's our strength. If anybody can do what the marketplace is demanding, Blue Cross and Blue Shield can do it.

There was a time in the mid-1970s that we thought the marketplace was asking for comprehensive major medical, deductibles, co-pays -- and clearly there was a lot of demand for that. At that time we had cause to be concerned, because that was not our product. That was the commercial insurance industry's product. So we struggled during the mid-70s, and I think, in part, that contributed to our market deterioration. But now, it's a different product, and it's our product. It's our negotiation with hospitals and doctors, it's our payment methods to extract differentials. It's our expertise in utilization controls.

WEEKS:

When you are talking Medicare intermediaryship, I wonder, are you still maintaining your percentage?

TRESNOWSKI:

Yes. As a matter of fact our percentage of share, if you want to call it that -- we don't measure it the same way we do in the private market, we measure it more in terms of providers that are served in geographic areas -- has gone up consistently. We are the major government intermediary in Medicare today. Translated, about ninety percent of the market is Blue Cross and Blue Shield. A lot of the other intermediaries, the commercial

intermediaries, have gotten out of the business -- for a whole lot of reasons. And quite frankly, it's not such good business anymore. Although it continues to help pay overhead, with the tight financial constraints that the government operates under, we are not able even to get our full overhead any longer, so the financial advantages that we enjoyed for a long time aren't there any more. So you have to weigh, from a business standpoint, whether you stay in that market. You stay because of the added leverage it gives you with the providers in the community. If you are paying fifty percent of a providers income by virtue of your intermediary role and another twenty-five percent by virtue of your private role, then you are influencing that provider to the extent of seventy-five percent of its income. And you can capture the provider's imagination and attention better than you could otherwise. So you stay.

What we have had to do is to clean up our administrative act, combine our administration of the Medicare intermediary role in order to continue to make it a financially viable relationship. For example, in the state of New York, where we have seven Blue Cross Plans, each of them serving as an intermediary, about three years ago we combined that into a single operation being run by the New York City Plan out of Syracuse, New York. So that we could combine our administrative capacity and live with the financial restraints.

We also did that a year ago in Ohio, where we had five intermediaries. We now have one. We did it in Pennsylvania, where we had several, and in Virginia, where we had several. So we made a number of moves administratively, and more will come. We are now looking at crossing state lines, combining some of the capacity on a regional basis in order to improve our administrative arrangement.

WEEKS:

This combination of Plans that you are doing in the fiscal intermediaryship field, would this be likely to be carried over into mergers of Plans themselves on a regional basis?

TRESNOWSKI:

Yes, it would. But, quite apart from pressures the government brings to bear, in 1982 we formulated a set of propositions that the Plans adopted, one of them having to do with mergers and consolidations. They travel under the designation of Propositions 1.1 and 1.2, 1.1 being the proposition which says that all Blue Cross and Blue Shield Plans should be merged, and that should happen by the end of 1985. And 1.2 says that there should be only one Plan per state, unless there are business reasons that dictate otherwise, and that should happen by the end of 1986.

A lot has happened since those propositions were adopted. There have been twenty mergers and consolidations that have taken place. We are down to 86 Blue Cross and Blue Shield Plans, from almost 100 when the propositions were formulated. Places like Oregon, where there was a Blue Cross and a Blue Shield Plan, separate and, indeed, competing with each other. They merged two years ago into a single Blue Cross and Blue Shield Plan. In Georgia, where there were two Plans, one in Atlanta and one in Columbus, Georgia, they merged in January this year. Maryland, where there were separate Blue Cross and Blue Shield Plans, merged in January 1985. The District of Columbia merged in January. In the state of West Virginia there were five Blue Cross and Blue Shield Plans; there is now one in West Virginia. In Virginia, there were two Blue Cross and Blue Shield Plans, and they did compete with each other, and they are now in the process of merging pending approval by the Justice

Department. And on and on, I could go across the country and point out more. Now, clearly, those actions would not have taken place if the Plans hadn't adopted that proposition in November of 1982, and then followed it up with a lot of initiative and administrative action out of the Association to cause those things to occur.

You can readily recognize that when you are dealing with merger and consolidation, you are dealing with highly complex matters, high tension, personal lives, careers -- all are at stake. Mergers don't happen easily. For every involvement I described or listed -- and there are others I could list -- there is a story to be told in terms of statesmanship, or lack thereof. When one talks about history, writing the history of Blue Cross and Blue Shield, I hope one never forgets this period from 1982 until now, when these mergers and consolidations took place, because they happened in an environment where the wrong set of signals or the wrong set of pressures could have ruptured the system. It didn't happen that way because people kept their cool.

The action taken in November of 1982 was placed on the books; and then there was a slow, deliberate process of working through the problem, community by community. There was a lot of energy devoted to that initiative without any acrimony, without any petulance on the part of anybody from the national level, but a consistent pressure to get the job done and to improve the organization from that standpoint.

Now, those mergers and consolidations have been taking place. Meanwhile, the marketplace has been demanding the same thing. We talked about the government, the intermediaryship, causing these things to happen. In the state of Georgia, for example, we had told the Georgia Plans that they had to

select one or the other to be the administrative intermediary for Medicare. They said, well, wait a while. We are going to merge the corporations. Leave us alone for a year, because we think the merger is more important than Medicare. And that was done, not only by the Association, but we convinced the government to leave Georgia alone while they worked their way through the problems of merger and consolidation.

There were market pressures brought to bear at the same time, and other market pressures that would influence merger and consolidation. A most important pressure has to do with the legal environment. There is a lot of concern for antitrust, if you keep corporations alive and you need a critical mass in order to keep them viable business organizations. You have several alternatives. You either merge or joint venture with somebody in order to enlarge your base, or you go into somebody else's territory and compete in order to take the business away. Therefore, one of the compelling reasons for mergers and consolidations, the proposition that we adopted, was in an orderly way to accomplish enlarging this base so that you have the critical mass.

The legal issue is that when you consolidate or merge independent corporations, there are those who will say, "They should be competitors, and therefore we are not going to allow them to merge." In other words, if they merge they will become too large.

As we have proceeded to accomplish that objective over the past several years the Justice Department gets involved by virtue of the pre-merger notifications that are required to be filed. They have approved every one where the Plans involved were not prior competitors. If they have been prior competitors, the Justice Department has taken a different view. It is not clear yet how they are coming out on it. That's one aspect of the legal

problem.

The other aspect of the problem is that, in those areas of the country where no merger is taking place -- and you've got two viable corporations, in most cases fairly large -- if they don't merge before they become competitors, there will be forces at work, legislative or otherwise, forcing them to compete. Blue Cross and Blue Shield Plans, come together under the Association by virtue of our membership requirements and our license requirements.

WEEKS:

Do you have competition other than a Blue Cross Plan that sells medical services as well as hospital service, or a Blue Shield Plan that sells hospital as well? Do you have other competition? Michigan Blue Cross, as an example, has Michigan as its turf, doesn't it? It doesn't go outside of Michigan except on national accounts or something of that sort.

TRESNOWSKI:

That's right. The license agreement, that is, the agreement that is entered into between the Association and the Plan to use the name and the mark, prescribes a geographic territory.

WEEKS:

I see. This goes back to the symbol.

TRESNOWSKI:

It goes back to the licensing of the name and the mark. Some of the Plans have spun off some subsidiaries to do certain kinds of business, like ASO business -- administrative services only business. They will cross territorial lines in order to accomplish that. But the geography is designated in the license agreement. That's a point of controversy at the

moment. The attorney general of Maryland has us in court claiming that the license agreement itself is a per se violation of the antitrust laws, that we have used the licensing of a trademark for purposes of carving markets.

Our belief has been, and it is true, that we've been in this business for fifty years, and we've been doing this for fifty years, so why all of a sudden does somebody come along and say it's a per se violation of antitrust? It's a very strong defense. On the other hand, it is being challenged, for a whole lot of reasons.

WEEKS:

But the fact is that you are not a national corporation in a sense, but a trade association in a sense, aren't you?

TRESNOWSKI:

We are a trade association. Yes, clearly we are that. But when one examines what we do, about twenty percent of what we do is trade association. About eighty percent of what we do is as an operating company. We are the contractor. The Association is the contractor for the Federal Employee Program. We have 100 employees in Washington and an operation center for operating the Federal Employee Program. The Association is the prime contractor under Medicare. We then subcontract with the Plans. We do all of the relationship with the government in terms of contract negotiations, and so on. We operate a telecommunications network out of Chicago. We operate an inter-Plan bank and transfer program. We operate a national employee benefit program, our national pension program, life insurance. We have a subsidiary corporation, BCS Financial Corporation, a holding company which has a couple of insurance companies, a casualty company and a life company. They were set up some years ago for purposes of filling some gaps within the states.

So when one says that the Association is a trade association, about twenty percent of what we do is that -- trade association being defined as representation, our Washington operation, education, a clearinghouse of information for our membership keeping them abreast of what's happening. That's what a trade association does. But that's twenty percent. The rest of it is largely operational.

In addition to that, the licensing of the name and the mark puts us in a kind of quasi-franchising organization too. So, behind that licensing and the membership in the Association stand requirements which are monitored. We have a monitoring system. We watch financial performance, market performance, cost containment performance, claims processing performance, and keep a very close eye on how the Plans are performing in general.

WEEKS:

Would you like to speak a little bit to how you monitor this? And what you do when you find something wrong?

TRESNOWSKI:

Well, the monitoring is, in the first instance, through data gathering. We accumulate an extensive amount of financial data on a regular basis from each Plan. We accumulate a lot of market data. We accumulate so-called operational data through a system -- NMIS. NMIS stands for national management information system, which is a monthly reporting, in some detail, of measures of operational performance. They are filed monthly, collated, analyzed, and so on. Then there is a cost containment data base that is built in terms of the cost containment initiative.

So you take that profile of information on every Plan, and you monitor very closely. We watch the financial performance very carefully, obviously:

reserve position, liquidity, ratios. There are various things that we examine in some detail, financially. We watch the market and we break it down into various segments. And that's monitored carefully. The national management information system measures are very carefully monitored in terms of our service performance.

When that profile is built, several things happen as a result. Annually, plans come up for membership renewal. Based upon the data that we've got, decisions are made. Either full membership or conditional membership may be maintained, or membership can be terminated. We now have a Plan whose membership was terminated that will appeal that decision at our September board meeting. The membership is being terminated on the basis of its financial condition, its noncompliance with reporting requirements, and its cost containment activities. So there's a variety of actions that can be taken. But that's a one-time-every-year look.

Beyond that, though, we have a standing committee of the board -- the membership and plan performance committee -- that takes data on these profiles and groups Plans. We have a so-called jeopardy list. The top ten, or whatever you want to call it. A whole series of actions flows from that. If it gets very severe, there is a protocol, which the Plans have approved, which calls for the Association to assemble a team of people who move into the plan and do a lot of work with the Plan in correcting the performance. There is also provision at a political level that if there is lack of cooperation or lack of assistance, we move past the CEO of the Plan and go directly to the board. And a series of actions then flows from that.

That protocol for intervention was adopted by the Plans in 1983, following that period I described earlier where some of the Plans were in

significant jeopardy. Some of them were technically insolvent. We found ourselves potentially embarrassed as a system, with deep concern in member Blue Cross and Blue Shield Plans, and how they perform. Any time any Plan is in jeopardy, it could be potentially troublesome, even on a very superficial level, in terms of reputation.

A case in point: The Nevada Blue Cross and Blue Shield Plan, a very small Plan, has had a lot of trouble over a long period of time. About a year or two ago it was essentially insolvent. The Association supported it financially and arranged essentially for the transfer of most of the Nevada operation to the California Plan. But there were things that went on around Nevada, because if Nevada had ever defaulted on any of its Blue Cross and Blue Shield subscribers, even though there were very few, a story like that in the newspaper could be picked up by wire services, and people don't draw the distinction between Nevada Blue Cross and Blue Shield of Iowa or Michigan or New York. So the name is besmirched, and it could be very troublesome. So we worry a great deal about that.

WEEKS:

You do have the power to take over the business in an instance where membership was not approved for the following year?

TRESNOWSKI:

Yes. First you start from the understanding that every Plan is a separate corporation, and the book of business they have is that corporation's book of business. Now if you take the name and mark away from them and drop their membership in the Association, they no longer are a Blue Cross and Blue Shield Plan, either by action of the Association or by their own action -- they may just say they want to quit. Then several parts of their book of

business change. For example, any national account gets taken back and is reassigned to some other Plan. The same thing is true of any government contract. Beyond that, you have to make a judgment about local business. you have to make a judgment. How much of that was acquired because of the expertise of that corporation, and how much as a result of the goodwill of the name Blue Cross and Blue Shield?

We have not had to face that recently, except in one instance, and the judgment was made not to contest that point. The incident was the Wisconsin Physician Service, which was a Blue Shield Plan located in Madison, Wisconsin. It competes with the Milwaukee Blue Cross and Blue Shield Plan. When pressure was building up to merge and consolidate in Wisconsin, Wisconsin Physician Service said, "We don't want to be a Blue Shield Plan any longer. We'll be Wisconsin Physician Service and go our separate way."

WEEKS:

Would you like to talk about national accounts? This has been a very important part of your business, hasn't it?

TRESNOWSKI:

The national account market was the reason for establishing the Blue Cross Association which when I arrived in 1967 was a combination of two organizations, the Blue Cross Association and the Blue Cross Commission. The Blue Cross Commission was an organization within the framework of the American Hospital Association. At that time the American Hospital Association held in trust the name Blue Cross and the mark, the symbol. They administered that program through the Blue Cross Commission.

The Blue Cross Association was created by the Blue Cross Plans and set up in New York City as a separate organization, primarily for the purposes of

marketing national accounts, going into the national account business. When the two organizations were merged, in 1961, -- the Blue Cross Commission and the Blue Cross Association -- and brought here to Chicago, the two functions, the management of the name and the mark and the marketing of national accounts, were combined. But if one were to look at the reason for existence of the Blue Cross Association, the primary reason was for national account marketing. And one could say that we were highly successful as a system of Plans in acquiring national accounts. It represents thirty percent of our business. As our advertising now says, we enroll seven out of ten of the Fortune 500. So we have been very successful in doing business with the national account market over that period of time.

In recent years, however, that performance has dropped. The most noteworthy example was DuPont, a very large piece of business and a very prestigious account for us, which we lost two years ago. There were a lot of reasons that we lost it, but they all relate to problems we face in the national account market and our ability to deliver across territorial lines.

You may have heard a conversation I just had about our CEO Forum agenda, which is coming up in October and is going to focus on the four options for administering a national account. One option is a traditional approach in which we use a control Plan, which is the Blue Cross and Blue Shield Plan in the geographic territory of the headquarters office of the national account. A good example is auto. Then participating Plans -- a syndicate as it's called -- supplement the control Plan. The participating Plans in the auto industry are all over the country, wherever GM, for example, has plants -- Kansas City, Georgia, a whole lot of them. I think there are some thirty Blue Cross Plans participating in the GM syndicate. You administer the account on

the basis of a control Plan, decentralized to the syndicated participating Plans, with local benefit agreements, and so on.

As the buyers demanded more of us on national accounts, greater uniformity of administration, more sophisticated product, and so on, the syndicated approach, which is the traditional way of doing it, has had trouble responding to that market. So other alternatives were developed.

One alternative is the so-called account specific, where not only is the control Plan the negotiator, because of the headquarters, but it becomes the operator, and a computer application is developed to process centrally. Instead of using the participating Plans, you use them as a front-end, but the processing is done centrally.

Those essentially are the two options, and there are some variations. It is the single most important business demand on the Blue Cross and Blue Shield system. It's the subject that we spend most time on these days, trying to find a way to be more responsive and to improve our administration of national accounts — in the face of a buyer that's making new and different demands on us.

Again, let me use the auto industry as an example. The auto contract that was recently negotiated with General Motors, that went into effect on April 1, 1985, was altogether different from anything we had ever done with General Motors. It's the so-called Informed Choice Program, the HMO, the PPO and the managed care choice that was given to the General Motors employee. General Motors said to us, "We not only want to know whether you can administer that informed choice program, but we want it at a ten percent reduction in your normal premium over the next three years." So you have both an administrative challenge to be able to deliver that triple option and you

have the administrative challenge to be able to do it at a price significantly less than what you had before. The control Plan, in this case Michigan, working with the participating Plans in the auto syndicate, have had to change the way we've done things in massive ways. I couldn't begin to tell you what the changes are, because they are different every day.

WEEKS:

Some you haven't seen yet.

TRESNOWSKI:

Some we haven't seen yet. We are continuing to feel our way along. One that I will mention by way of illustration is in the managed care part of the choice -- the so-called pre-admission certification. That is, before elective patients can be admitted to a hospital, they must be certified by the carrier. In the auto contract, we chose to do that centrally out of Detroit, with a central team of doctors and nurses talking to doctors and nurses all over the country. Now one can argue that that should have been decentralized so the decisions are sensitive to each of the local communities. On the other hand, the buyer was saying, "I don't want inconsistent decision-making. I want those decisions to be consistent." The weight of the administrative demand was on uniformity and consistency. So it was centralized in Detroit.

You can imagine a doctor in Kansas City, wanting to admit a patient into a hospital, having to call Detroit to get approval. It has been a significant administrative challenge.

But the national account market is undergoing significant change, and there has been some difficulty. What it really challenges is the ability of Blue Cross and Blue Shield to operate as a system rather than as individual entities. Any time you cross Plan territorial lines and try to respond to a

market, you get into trouble. You've got to solve those problems as a system of Plans. You've got to begin to look like a national corporation. That's the tricky part of it.

WEEKS:

Do the Plans seem willing to go along with this idea?

TRESNOWSKI:

They are, and they will. But there are so many variations on the theme that it's hard to know whether they can go along or they can't go along. Let me give you a couple of variations.

Rochester, New York, is very proud of its utilization program, proud of its hospital payment program. When General Motors says we want to do things in a certain way and it's inconsistent with what Rochester has done over a long period of time, with good performance and good results, then Rochester says, "You either play the game in Rochester according to my rules, or I don't want to play." Every community looks at the prescriptions of that national account from its own perspective. So you bump into problems.

I say that to you in order to respond to the question are the Plans cooperative. Yes, they're cooperative, overwhelmingly cooperative, because they want the business. But they may become uncooperative when the demands are so different from the way they do business in general, often quite legitimately so. So the debate takes place, negotiations occur, and from one approach or another they try to iron them out. If they can't, and in some cases they can't. K-Mart, for example, is another account operated out of the Michigan Plan as control Plan. There are a couple of states in the country that will not participate in the K-Mart syndicate because of the demands by the control Plan, which are so inconsistent with the way they do business that

they say, "No, you administer them out of Detroit. I can't play in your ball park, I can't do your thing." That's unfortunate.

WEEKS:

In other words, if someone was a K-Mart employee and went to a Blue Cross or Blue Shield Plan that did not want to be in the syndicate...

TRESNOWSKI:

Then some alternative would have to be made available, and it is. Let me give you an example. Arkansas chose not to stay in the K-Mart syndicate. So the Michigan Plan had to set up, in the state of Arkansas, an administrative capacity to service K-Mart employees, apart from the Arkansas Plan. That's unfortunate, because one of the real assets of Blue Cross and Blue Shield is that we have this tremendous distribution system, if you will, for our product. Every state has a Blue Cross and Blue Shield plan. Whatever an account demands, we can say, "Well, we can take care of you in states where you have employees." But because of the vagaries of these situations, the Arkansas Plan choose not to and, therefore, you've got a problem.

But these are all the ebb and flow, the dynamics, of an organization that's trying to find its way to service a national account market in different ways. It will find its own level, I am sure.

WEEKS:

Would you like to talk about how HMOs and PPOs enter into this? Certainly they enter into national accounts. They enter into everything, don't they?

TRESNOWSKI:

Yes. In most of the histories that you've taken, I'm sure, others have talked about the history of HMO and I certainly wouldn't want to....

WEEKS:

I talked with Sidney Garfield, as an example.

TRESNOWSKI:

I pick up on HMOs only in the current context, in the point I made about the buyer's behavior. When the buyer in the mid-1970s looked favorably at comprehensive major medical benefits, or major medical itself, large deductibles, copayments, they got out from under the burden of cost containment. They threw the burden back on the individual employee. They were able to make it affordable just by simply raising the deductible or the co-pay.

The problem that the buyer found there was, one, they ran into trouble with organized labor and collective bargaining through that technique. But beyond that, they found themselves in the position of making decisions on the border of money and medicine. Those are always difficult to make. They are very sophisticated. When do you make a judgment in terms of your benefit, either in design, or whether you use indemnity, or what, that serves as a barrier to the receipt of care. The buyers became very concerned about that and began to look around for a solution. They found a solution in the HMO, because the balance between money and medicine was pushed down to where the transaction was. In other words, pay the HMO a capitated amount and let those decisions be made by the people delivering the care. That became very attractive to the buyer. It was sparked also by the HMO Act, which gave opportunities to the HMO to approach the buyer. But, both the approach to the buyer and the buyer's response to it tell you something about why HMOs have grown as they have in the last five years.

In our case, we now have seventy owned and operated HMOs. It's our

fastest growing line of business. It's grown twenty-two percent a year over the last three years. In the face of the market losses we have sustained, HMOs have grown.

WEEKS:

Have HMOs made up the difference?

TRESNOWSKI:

No. They haven't.

WEEKS:

They will.

TRESNOWSKI:

Well, I don't know whether they will or not, but they certainly have been a happy turn of events for us. The HMO option is there, and we feel that it's an opportunity for us to gain some market share. Not only from what we lose on the other side but to gain some market away from other people. We have a major initiative under way to increase the number of HMOs we own and to build a national product, our so-called HMO/USA, which we have in the marketplace now, and to strengthen it.

PPO -- you'll get a lot of points of view on what sparked the PPO. One view says that the PPO was prompted by HMO competition and I suppose one could say that's true. One of the early PPOs in the Blue Cross and Blue Shield organization was in Minnesota, its so-called AWARE program. In the Twin Cities of Minnesota, they took sixteen of the twenty-four hospitals and set up a selective contract with them as preferred providers. They took that product to the market at fifteen percent below normal premium rates. That set of ideas has just gone like wildfire across the country. Not only in Blue Cross and Blue Shield, but in general. We now have twenty-two plans that have very

strong preferred provider benefits in the marketplace. We have another twenty-five plans that expect to have PPOs in the marketplace this fall.

WEEKS:

Can you distinguish a product fit, HMO versus PPO, where one is indicated and the other isn't? Is there such a thing?

TRESNOWSKI:

No. As it's evolving now it really comes down to a choice of the employee. They either choose the HMO or the PPO. In some cases, of course, we would take the product in total to the buyer and say, "Would you like this?"

The buyer will often say, "Yeah, I'll take it in total." But more often he'll say, "Just give it to me as an option that I can lay before my employees." Multiple option benefit is the name of the game for the future. The pattern set by General Motors, which has been followed by Ford, and now Chrysler is in negotiation and we expect that to take the same shape, is to offer the employees options, HMO, PPO, or the traditional benefit with managed care.

WEEKS:

But the traditional benefit will apply in all states or be administered from the outside if a state doesn't comply.

TRESNOWSKI:

That's right.

WEEKS:

And you'll be free of the local options that you might have had before, the many different kinds.

TRESNOWSKI:

Well, we'll either achieve a greater sense of uniformity in the way all the participants play or we'll centralize in order to get around those differences.

WEEKS:

If you wouldn't mind going back to HMO/USA, in looking at information on Blue Cross and Blue Shield HMOs, I notice there are two or three different types of ownership, or two or three types of incorporation, that are either a part of a Blue Cross and Blue Shield Corporation or a subsidiary of another sort. Is your ultimate goal a national network of that kind? That you could sell General Motors, as an example, a certain HMO contract for all over the country?

TRESNOWSKI:

The answer is yes. HMO/USA, which we put together because the national account market was demanding it. The first account we sold was United Airlines. They were delighted to find that they could do business in one place to deliver a network of HMOs for their employees. What it was though, was simply a loosely knit network of existing Plan HMOs. There was no consistency of benefits or administrative procedures. All we did was wrap them up in a bundle and put a pretty bow on them and present them to the account and say, "They will agree to certain things in order to respond to you as a national account."

What we need is a much tighter knit network of HMOs.

WEEKS:

As I remember, you came to BCA after the Medicare period had started. From what you found there on your arrival, will you talk about the problems

and moves necessary to implement Medicare?

TRESNOWSKI:

I arrived at the Association in early 1967 and found that the Medicare program was being implemented largely through the energies and dedication of people in the Blue Cross and Blue Shield organization. There was a myriad of questions that remained unanswered that could not have been included in the statute or the regulations that were initially promulgated. The answers were coming from Blue Cross and Blue Shield as intermediary and carrier, largely based on their own expertise and their own knowledge of health benefits delivery. Of course they were constantly seeking -- that is, the intermediaries and carriers were constantly seeking -- answers from the government bureaucracy -- at that time it was the Bureau of Health Insurance. But the Bureau of Health Insurance was not well equipped to answer all the questions. They were staffed largely with people out of the Social Security Administration who knew very little about the health care industry.

It was a time for Blue Cross and Blue Shield to exercise its good judgment and its leadership, and indeed it did. But there was a strain that developed between the intermediaries and carriers and the government. Because there were a lot of unanswered questions, and most of them involving policy issues, reimbursement policy, benefit policy, operational policy, the balance of power shifted from the government to the intermediaries and carriers. That was an anathema to the government bureaucracy. They felt that they needed to control the program. So a tug-of-war took place. It went on for a period of about two years, I would say from about 1967 to 1969, the time it took the government to staff up and understand their responsibilities.

Meanwhile, the program was going through growing pains. I remember

particularly the issue concerning custodial care. There was a provision in the Act that said the government would not pay for custodial care. As a matter of fact, I even recall the section of the statute. It was Section 1862A, which was an exclusion under the law. The government found that the expenditures for extended care facility services were way beyond their actuarial estimates. They insisted that the intermediaries and carriers rigorously administer the exclusion of custodial care. And we agreed, and proceeded to rigorously administer the exclusion. Well, that sent all kinds of political shockwaves through the Congress and through the provider community, because they never expected the kinds of definitions that were applied to custodial care. There was a great uproar associated with that. But it was illustrative of the problems of implementation in those early days of Medicare.

WEEKS:

Were there problems of tooling up, hardware, that type of thing?

TRESNOWSKI:

The program was implemented largely through manual systems. Because there were so many unanswered questions and because of the precision required by data processing, it could not be largely automated. What was automated and gave the Blue Cross Association a special advantage in those days was the eligibility query process. A telecommunications system was designed and developed to be implemented in mid-1966, for the purpose of querying eligibility through the membership files, if you will, or the subscriber enrollment files in Baltimore, Maryland. That was the most significant application of technology in those early days.

Following on it was a so-called tape-to-tape program developed by the

Michigan Plan, whereby the hospitals and other providers filed their claims on a tape format rather than hard copy and submitted them to the intermediary. The intermediary edited the tape and passed it along in tape format to the government — again, eliminating paper. The Association, through its prime contract responsibilities, picked up the software for the tape-to-tape application and broadly implemented it across the country. It was a tremendous cost saving for the government and a tremendous opportunity to close claims. In those days that was extremely important because of the volume of admissions and the need for rapidly determining eligibility.

But other than the Blue Cross Association telecommunication system and the tape-to-tape application, the early years were largely characterized by manual operation. That, of course, changed over the years, but there was a lot of tooling up that was necessary in those days.

WEEKS:

Other than these, were your other facilities sufficient?

TRESNOWSKI:

It's hard to know, looking back, whether anybody was sufficient to the tremendous demands of implementing the Medicare program. I suppose, in retrospect, a lot of things could have been done in a preparatory sense that would have made the program work a lot more smoothly. But one has to remember that at the time the law was passed there was a fairly short lead time -- from the end of 1965 to July 1, 1966 -- to get the program up and operating. Under the circumstances, I think everybody did an absolutely magnificent job.

I recall a quotation attributed to Lyndon Johnson that the implementation of the Medicare program was equivalent to the preparations for beginning World War II. I think clearly everybody did a yeoman's job in getting ready for the

implementation of Medicare. All the beneficiaries knew was that as of July 1 they had a broad scope of health benefits, they had their Medicare card, which was an important entrance into the delivery system, and by and large they were well taken care of.

Behind the scenes, of course, there were a lot of problems. Operational problems, policy problems. But I suppose they were expected, and they were worked out.

WEEKS:

Did you have any specific staffing problems?

TRESNOWSKI:

There were enormous staffing problems in the intermediary community. If you were to look at it on a Plan by Plan basis, the Florida Plan, which had a very large Medicare population, within months had doubled its workforce, and enlarged its facilities. You can imagine any corporation faced with that kind of challenge is bound to have problems. You don't double the workforce overnight. And that pattern was followed across the country — none as dramatic as Florida, except perhaps California. But, nonetheless, there were tremendous increases in personnel.

The major problem from a tooling up standpoint was manpower, and supervisory manpower. What the intermediaries and carriers did was to draw off the best talent from the private sector and bring it to bear on the government side. There are many, many stories to be told, most of which will never be told, of people who worked seven days a week, twelve hours a day, to make the Medicare program work — people drawn from the private sector of the business. Those same people were never to go back to the private sector. Some years later we look back at the price we paid in terms of our private

sector capacities and capabilities, and the fact that we lost some market share because we dedicated our resources to the government. That story will probably never be told and never well understood. But the fact of the matter is that that's precisely what happened.

On the other hand one could argue that the Medicare program gave us the opportunity to enlarge our capacity, to spread our overhead and to attract a lot of people into the business who might not otherwise have been attracted. I can personalize that because I was the first Medicare administrator for the Blue Cross Association, and perhaps I never would have come to the Blue Cross and Blue Shield organization if it hadn't been for the demand for manpower that occurred during that period.

As I look back, many people who are now in the Blue Cross and Blue Shield organization came because of the opportunity presented by the government programs. I am one example of that, but probably a more noteworthy one was Alex McMahan. Alex McMahan came to the North Carolina Blue Cross and Blue Shield Plans, two of them at that time, for the express purpose of running the Medicare program for both plans in North Carolina. I remember shortly after I came on board in 1967 spending many long hours with Alex McMahan sorting out the problems of Medicare administration. And here we sit in 1985 and look back at Alex's career, which moved him from Medicare to Blue Cross and Blue Shield to leadership of the AHA, and my own career and its development -- all very closely tied and linked to the advent of the Medicare program.

WEEKS:

What criteria were in place for subcontracting to Plans?

TRESNOWSKI:

The subcontracts between BCA and the plans were intentionally very

general. The objective was to lay down certain broad criteria of performance, budget accountability, payment of legitimate costs. Article 2 of the contract simply spelled out that the intermediary, that is the Blue Cross Association, was to pay claims, audit providers, and conduct utilization review. To the extent that the Blue Cross Association found those capabilities and skills in the member Blue Cross and Blue Shield Plans, they were to contract with them through the subcontracts. Those contracts have changed dramatically over the years, but essentially they began that way. They were not standards in the sense of being highly specific; on the other hand, they served the purpose of allowing flexibility in those early days, before regulations and general instructions were incorporated as part of the administrative structure.

WEEKS:

Could you elaborate on the intermediary competition?

TRESNOWSKI:

There wasn't a lot of competition in the sense that we think about it today. In those early years, the intermediaries went out to the hospitals and the extended care facilities and home health agencies, and displayed their wares. Blue Cross had such an advantage because of its nomination by the American Hospital Association and the general good relationships and rapport that existed in the provider community with Blue Cross, that we received the lion's share of the designations and nominations. Most of the competition occurred in the area of extended care facilities, which today are called skilled nursing facilities. There we had not a lot of experience, and the commercial insurance industry, guessing that they could make inroads, captured a sizable share of that market. Their expectation was that if they could demonstrate their worth there, they would in time attract more of the

providers. In fact, it has taken a quite different turn. Most of the commercial insurance companies have found the Medicare business to be not particularly attractive, and a lot of them have gotten out of it. Our market share continued to grow to the high point that it has reached today.

WEEKS:

What type of claims problems did you run into?

TRESNOWSKI:

The biggest problems with claims administration -- there were several -- were benefit interpretation questions. What constituted a benefit? There were no manuals that existed at the beginning of the program, and today there are many manuals that define benefits. Those were the major questions. The others were administrative problems, as I mentioned earlier, because you were dealing with manual systems, the passing of paper, remote locations. One never knew exactly what a beneficiary's eligibility status was.

I remember, in a sort of humorous way, the concept of orbiting. Orbiting, I was taught in those days, was that when you queried for an eligibility, you created an open file in the Baltimore computer. And that open file stayed open until there was a claim that was processed to close it. It "orbited" until the claim came through. It was conceivable that you could have two or three claims opened in the time it took to process the claims. So there were constant volumes of "open items" or claims that were orbiting, waiting to get into the file because of some preceding claim. That's an oversimplification of a very complex set of processes, only by way of illustration. There were major problems in the handling eligibility queries and claims. A lot of shortcuts were taken in order to get around that problem.

The Social Security Administration which was the administrator of the program at that time, and its whole philosophy, going back many decades to the development of the Social Security Program was to minimize the assault on the beneficiary. Make it easy on them. These were the elderly of the country and everything should be done, to make the program as far as possible understandable, simplified. And that carried over into the Medicare program.

I don't disagree with those objectives. They were the right ones, but in trying to satisfy the needs of the beneficiary, a lot of compromises were made in otherwise responsible administrative procedures, which further complicated the program.

WEEKS:

You said it was a manual program in the beginning. When and how did computer capital costs come into play as a factor?

TRESNOWSKI:

It began in about 1970, when the need for the application of technology became apparent in terms of carrier and intermediary performance. Several of the Plans had taken their own initiatives to develop computer applications to administer the Medicare claims process.

The Blue Cross Association evaluated those various computer applications and picked out one that they found to be particularly well designed. It was a computer system developed at the Philadelphia Blue Cross Plan. That computer design was taken to New Jersey because of the great strains in claim processing performance by the New Jersey Blue Cross Plan, and implemented in New Jersey in order to get over the backlog of claims and other problems.

At the same time, we were experiencing performance problems in various parts of the country, and we concluded that what we needed to do was to take

the Philadelphia system and create a model part A claims processing system. Which we did. We took staff from the Association, staff from the Plans, and we developed a set of software for a model part A claims processing system. We not only developed it, but we put a maintenance staff together, with the cooperation and support of the Bureau of Health Insurance and the Social Security system. And we proceeded to implement that model A system broadly across the country. It remained in place for about 10 years.

There were a number of interesting aspects to that model Part A system. First of all, it was not a particularly sophisticated computer application, but it took advantage of the state-of-the-art technology at that time. Two things happened -- The Blue Cross Association said that we needed to upgrade the quality of the computer system to a higher level of the state-of-the-art. The second thing was to be selective in its implementation -- that is, not put it in every Plan because of the greater technological demands, but to regionalize, if you will, the processing of claims.

You can well imagine, given the politics of the situation, the problems that we ran into. First of all, the federal government, the Bureau of Health Insurance specifically, after we had gotten fairly far into the project, concluded that our development of a sophisticated claims processing system gave us a tremendous competitive advantage over all others, and that if we were able to develop it and implement it on a regional basis we would be the most effective and proficient performer of the intermediary function and lock everybody else out.

So the government stopped us, in other words they stopped us financing the development of the more sophisticated system. Secondly, they refused to support us in the regionalization, even though I had gotten all the Blue

Cross Plans to agree to the designation of regional claim processing centers. The head of the Bureau of Health Insurance at that time was a man by the name of Tom Tierney, who became a close friend. But Tom was extremely sensitive to the advantage that Blue Cross had in the program. He had been the president of the Denver Blue Cross Plan, had taken over as head of the Bureau of Health Insurance, and worked tirelessly to make the Medicare program work. But, he was very sensitive about Blue Cross, and he made the decision to cut off the financing of the development of the system, and to stop the regionalization.

The decision served its purpose. We remained splintered in our administration during that period. The irony of this, of course, in the light of current events, is that the government now wants us to collapse the number of contractors, and streamline the administration. I suppose I could say that I was ten years ahead of the government, but timing is everything in life, I suppose. In that case, the timing wasn't right.

WEEKS:

What effect did this workload have on your regular business?

TRESNOWSKI:

It had a profound effect on the private business. The demands of the Medicare program distracted us for a period of five to eight years. As I said earlier, we took our best talent and put it in the Medicare program. We concentrated all our energies in that direction. And we suffered. We still feel the results of that.

For example, when we were devoting all our energies to the development of software systems for Medicare, we obviously didn't have enough to put on the private side. When we were expending political capital in reimbursement decisions on Medicare, we lost some opportunities to make good decisions in

terms of private payment systems. I could go on and on and describe that. I'd go back to the statement I made a moment ago that the impact on the private side was profound.

On the positive side, of course, as I mentioned earlier, Medicare gave us an opportunity to hire people, to broaden our base, to spread overheads, build buildings, pay executives more money because of increased volume, give us more presence in the provider community, and the opportunity to leverage doctors and hospitals because of the amount of money that passed through our hands. So arguments could be made on both sides.

In those years, because of my commitment to the government programs that was my responsibility, I made a number of speeches on this topic wherein I said that on balance I thought the advantage was to stay with the government market. With all the disadvantages, the pluses outweighed those. I articulated them and was quite successful in getting the Plans to stay aggressively in the government market.

Today, of course, the picture has changed significantly. I think now that whether or not we stay in the government market over the long-haul should be a business judgment, taking into account all the things we took into account before but also, today, recognizing that the government itself has lost its enthusiasm for support of the Medicare program. If the government is not enthusiastic, then the inclination will be to cut the program in significant ways and cut back capacities and capabilities to the point where it becomes a bad business decision to stay with that product and that aspect of the health delivery system.

WEEKS:

The wave of Blue Cross growth continued until 1978. When did the change

of buyer behavior become noticeable?

TRESNOWSKI:

Buyer behavior changed most significantly in the mid-1970s. Of course, the buyer was always concerned about health care costs. But one must remember that through the 1950s and 1960s and into the early 1970s, we had an economy that was growing at substantial rates. Industry was doing well. And some of the fat in the system was tolerable. In the mid-1970s, things began to tighten up a lot, largely associated with changes in the business cycle. As in any cyclical situation, people grab hold of ideas which they think are solutions to problems.

In the mid-1970s, the business community concluded two things: one, that the answer to cost containment was in bringing the individual recipient of care back into the transaction through co-payments and deductibles. That is, business felt that first dollar coverage, comprehensive benefits, insulated and isolated the beneficiary and the subscriber from the true costs of health care, and therefore they didn't have a stake in it and didn't care about it. That was important.

The second thing the businessmen found, and it's allied to the first point, is that they could cut their premium costs if they increased co-pays and deductibles substantially. And they did that. Many changes were made.

One of our major product developments at that time was comprehensive major medical and wraparound major medical, all intended to be responsive to this demand by the business community. But something very interesting happened. It didn't have the effect that it was expected to have. Costs were not contained. They continued to rise at enormous rates. Until you got to the end of the 1970s and in 1980 and 1981, when we were looking at cost

increases of twenty, twenty-two, twenty-four percent. Those trend factors hit industry precisely at the time that the economy took a nose-dive and many industries in this country were badly hurt -- particularly the hard goods industries such as steel, auto and allied manufacturing.

When that happened, corporate survival was at stake. When corporate survival depends on the health benefits structure, all sorts of things can happen. Benefit changes were broadly made, and radical moves were attempted in order to cut back. Most importantly, in the steel and auto industry management came to the bargaining table with labor and said, "We can no longer continue with the comprehensive packages we've had. We need to incorporate cost-sharing in the form of deductibles and co-pays." Labor balked. There were major strikes around that issue. Everybody was searching for a way to acquire comprehensiveness of benefits, but at an affordable price. And they discovered HMOs. Not only did they discover that HMOs gave comprehensiveness at a more affordable price, but the notion of preferred provider organizations came along, which gave them an opportunity to negotiate the price and utilization constraints.

So the HMO and PPO movement began to take hold. More recently, the concepts of ambulatory surgery, second opinion, all the things intended to constrain utilization, and some benefit options such as home health care, hospice care, and so on have emerged. Those were the major changes which occurred in the business community.

WEEKS:

Did the FEP lead the way in asking for options?

TRESNOWSKI:

Well, I wouldn't say that FEP did. The Federal Employee Program has

always been characterized by multiple choice of a government-wide service benefit program, a government-wide indemnity plan, and then a whole series of HMOs. A lot of people pointed to the Federal Employee Program as a kind of model of multiple choice. But even the multiple choice model of FEP didn't have the cost containment aspects that one would have expected.

I think what happened was not so much that FEP was looked to as a series of things that happened in the early 1980s, like the PPO movement out of California and a few other places, and the further development of HMOs, and the concept of managed care. Those were ideas whose time had arrived. They were made available, and they took hold, and they showed results. As a matter of fact, the Federal Employee Program is lagging behind. It's just now coming around to the point of view that it will have to change its basic structure to take advantage of the so-called informed choice or the triple option type of opportunity.

WEEKS:

Was the Blue Cross loss of business mainly in national accounts at this time?

TRESNOWSKI:

No. As a matter of fact our greatest losses were in local business. There were losses in local business, and there were losses in national accounts, but the reasons were different. The losses in local business were largely price related. We were trying to catch up with trend factors, as I indicated a moment ago, of twenty, twenty-two and twenty-four percent. When you are presenting accounts with rate increases of those dimensions, they look elsewhere. So we lost a lot of business from local groups on the basis of price.

National accounts were less a matter of price and more a matter of delivery. National accounts were increasingly looking for greater uniformity of benefit delivery, taking advantage of price opportunities with providers, and we struggled in order to deliver that. Because our performance suffered in that aspect, we lost national accounts. The net effect was that we lost business across the board.

The only line of business that grew over that period was HMOs. We not only increased the number of Blue Cross and Blue Shield sponsored HMOs but enjoyed significant enrollment gains of about twenty-two percent a year over a period of two or three years.

WEEKS:

Were losses of business due to focusing on other problems?

TRESNOWSKI:

No. I don't think so. I think, as I said a moment ago, we got caught up in the price spiral, and because we had not prepared ourselves, because of the distraction of the government programs, we were not in a position from an operational standpoint to deliver in as efficient a manner as the marketplace was demanding.

Witness where we are today. We have recovered very nicely financially and we are able to give rebates, and reduce rates, and the local market shows that. We are now beginning to gain enrollment in local markets. But we have not solved the national account market delivery problem and continue to suffer losses there.

WEEKS:

Did BCA overextend at 676 North St. Clair?

TRESNOWSKI:

You mean did we take over too much room? That's interesting when one looks back in time. The Blue Cross Association, particularly after the Blue Cross Association and Blue Shield Association staffs merged, had grandiose notions of the role of the Association. We were going to do everything and be everything to everybody. We were going to move aggressively into product development. We were going to move extensively into marketing and new markets. We were going to do great things in terms of our operational capability. We were going to design payment systems; and on and on and on. Those grandiose notions of who we were, what we are, and what we were going to do carried over in terms of our commitment to the people at the Association.

There was a time when we were up to 1300 employees and growing. We took lots of space at 676 St. Clair to accommodate that capability, anticipating that we would grow beyond that. Of course, those were foolhardy plans -- foolhardy in the sense that you can bite off more than you can chew. We spread ourselves too thin. We had trouble setting priorities, and because of that the results were not achieved. There were some major defaults in our abilities, and all of those came home to roost.

WEEKS:

Then do you think you were overextended in your data processing facilities also?

TRESNOWSKI:

The thing we were overextended was the systems development. That in itself is a long story. We had begun a systems application development program some eight years prior to moving to 676. It was called the long-range systems plan, LRSP. It is a complex story that is difficult to translate in a

shorthand way, but simply put, again we were trying to develop a membership system, a claims system, and the various supporting systems to satisfy the needs of all the Plans. It became cumbersome. It took a lot of time in development and had enormous implementation costs associated with it. People began to lose confidence in its objectives and in its products. It was a source of significant controversy and disappointment, broadly, throughout the system.

Back to the question, if one were to say that we overextended ourselves, I don't know whether it was so much a matter of overextending or whether we set a process in motion that was not achievable. Hindsight's a wonderful thing. But in the context of hindsight, we would have been welladvised to have taken what we were setting out to do in terms of the development of a national system, and to have handed it over to a subsidiary corporation, outside the framework of the political structure of the Association, with a specific charge and responsibility, and let them go do the job. Give them a budget, and get it done. Some argued for that and obviously were not successful. As it turned out, we expended a lot of resources, dollar and human. There were prices to be paid for the failures involved.

WEEKS:

Would you say that BCA was overstaffed even before the merger?

TRESNOWSKI:

No. But one could argue that perhaps we were. We were not a lean organization. We were still living off the largess of the government contracts and the confidence that the Plans had and the dues support, on a broad scale. The chickens came home to roost in the late 1970s, when deliverables were not met, results were not achieved, and people began to put

dollar values on those failures and were quite concerned.

WEEKS:

Now I would like to discuss the merger. When did the movement toward a merger begin?

TRESNOWSKI:

The merger of the Blue Cross Association and the Blue Shield Association? That began many, many years ago and there were a number of aborted attempts. In a shorthand way, I would say that the merger of the two staffs of the Association is a classic example of an idea whose time had arrived. There were task forces, joint committees, that were created over the past fifteen years. I remember one headed by Art Handley, who was the president of the Rhode Island Plan. They came through and did a careful, detailed analysis and concluded that there should be a merger of the two Associations. It was an idea that was not acceptable; people found all sorts of reasons why that was bad logic, and it was killed.

Then came the so-called McConnell Committee, chaired by Ed McConnell, then president of the Kentucky Plan. Their solution to the problem of two organizations was to create three to leave the two associations in place and create a third service corporation to serve both associations. That also was an idea that was not readily acceptable, because of the separation of policy from operations. Although a lot of energy went into that, it also was killed.

The interesting thing about that was that the McConnell Committee report was presented to the annual meeting of Blue Cross Association and Blue Shield Association in May of 1977. It was a very professional presentation with slides and audio-visuals and so on, but it was defeated. I mention that to you because it was May of 1977; it was at that annual meeting when I was

appointed the Executive Vice President of the Blue Cross Association. Being very much into myself as a result of that appointment, I began to work hard at trying to sort out and organize where the Blue Cross Association was going to go administratively. I spent many hours late into the night, weekends, thinking through the administrative program that I would put in place for the Blue Cross Association. I met extensively with Walt McNerney, who was then president, and convinced him of the worth of the ideas that I had put together.

We were then prepared to go to a meeting of the Blue Cross Association Executive Committee in July of 1977, two months after I had been named Executive Vice President. The agenda of that meeting was going to be totally devoted to my presentation of the reorganization and the plan of action, the priorities for the Blue Cross Association. Little did I know, or did McNerney know, that when we got to that meeting in July -- it was at the Century Plaza Hotel in Los Angeles, that other members of the executive committee had convinced themselves that even though the McConnell idea was killed in May, it was absolutely essential that we merge the Blue Cross and Blue Shield Associations. So that meeting in July in Los Angeles did not discuss my plan of organization for the BCA. It was totally devoted to developing a strategy for merging with the Blue Shield Association.

Following that meeting, in July, a meeting of the executive committees of the Blue Cross Association and the Blue Shield Association was convened. Both agreed with the objective of a merger and appointed a series of task forces to formulate the ideas to accomplish that. We referred to it as the "long, hot summer of 1977," when these task forces worked long and hard to formulate a set of recommendations that could be brought back to a meeting of the Plans in

October, wherein a vote would be taken to accomplish the merger.

An interesting set of dynamics occurred over those summer months. Even though there was a lot of political infighting around leverage, and how it would be done, merger was now an idea whose time had arrived. There was a lot of momentum behind it to get it accomplished. The two critical actors and the two events that caused it to take place and caused the idea to ripen were the merger of the Blue Cross and Blue Shield Plans in New York City and the merger of the Blue Cross and Blue Shield Plans in Michigan. They were now single corporations, and they wanted this to happen and made it happen. And indeed it did happen, in October.

An interesting side note that became a major consideration in the merger was the struggle between organized medicine, or the doctor influence on Blue Shield, and those on the Blue Cross side. Because the doctors who held positions of prominence and control in the Blue Shield apparatus were threatened by this merger, a series of backfires was created by selected individuals. A surgeon in Kansas City comes to mind, and others. But when it came down to the eleventh hour, a couple of Blue Shield Plans, very large ones, Massachusetts and Pennsylvania, with strong doctor influence, agreed that the merger was essential, and they carried the day. The vote was taken, and the merger passed.

WEEKS:

You have mentioned factors and persons favoring the merger and the doctors who were against the merger. Were there any other factions or persons either for or against?

TRESNOWSKI:

There were many aspects to the merger. There were people who had

personal stakes in terms of their own jobs and their own careers. There were questions of individual control. Whenever you merge two organizations, you wind up with two of everything, not just people but everything. That has to be all sorted out.

As I look back over my career, not only here but my entire career, the period from July, 1977, until the end of 1978, not only the development of the idea but the action of the Plans and the administrative implementation of the merger, was the most difficult that I ever lived through. It was difficult because we were dealing with people's lives. As I say, we had two of everything.

It started right off the bat with the question of who would be the president. Bill Ryan was president of the Blue Shield Association, McNerney was president of the Blue Cross Association. That decision was made in January of 1978. But following that decision, a whole lot of other decisions had to flow. Who would be the executive vice president? Who would be the senior officers? Who would be the managers? Then a myriad of questions — fringe benefits programs, and so on.

During that period of time, I took the point of view that I was a young man with a lot of my career ahead of me, no matter what happened, so I kept myself above the fray, trying to do the right thing and to make decisions in a supportive way, notwithstanding the impact on me personally, because I just didn't feel that it had any. My feeling was that if I didn't survive in the dynamics that took place, I would go elsewhere. I was young enough and wasn't concerned.

That was not true of a lot of other people. In fact, it wasn't true of most other people, because their careers and their lives depended on these

decisions. The interesting thing about that was that I became the one person in the whole scheme of things that everybody trusted, because I kept myself out of the political infighting, and therefore they looked to me to make these critical decisions. And I had to make them in terms of people. They were not easy. But we made them.

After Walt was named president, he named me executive vice president and Bill Ryan senior executive vice president. Between the three of us we set about to make a lot of decisions, and we did.

WEEKS:

Was Walt one of the prime movers in bringing about the merger?

TRESNOWSKI:

To answer that question, one would have to know more about Walt and his motivations. One of the major concerns about Walt by his constituency over the years was what his agenda was. I have a lot of respect for Walt. He contributed an immense amount to the success of Blue Cross and, eventually, Blue Shield. But nobody ever really knew what his agenda was and what his motives were. And he never shared them much with other people. As close as I was to Walt, I was never clear on what he wanted to accomplish. In answer specifically to the question, I would say that he was supportive and wanted to see the merger of Blue Cross and Blue Shield. But he would have stopped short of seeing that happen if he felt that, by virtue of that, certain larger matters would not have been resolved. For example, if he felt that it was necessary to maintain physician cooperation, then he would have been moved perhaps in a different direction. Of course, one has always to recognize that he had his own personal situation. Although Walt had great confidence in himself and felt that he could do almost anything, this was a critical time in

his career. He had nurtured the Blue Cross Association over many years. This was a critical turning point in the direction of the organization, and he felt challenged by the merger and wanted to do it. He wanted to do it in a way in which he remained in control. He knew that when it happened he would lose some of his personal leverage over the system. He knew, for example, that he would no longer be chairman of the board, which he had been in the Blue Cross structure, and that concerned him. He knew that he would have a different set of actors to deal with in the framework of the joint executive committee, and so on and on. So to say that he was unequivocally in support of this, I don't think would be fair. On the other hand, I would say that he thought it was the right thing to do.

WEEKS:

How was McNerney chosen as president?

TRESNOWSKI:

There was a search committee appointed shortly after the decision in October of 1977. That search committee -- I don't know what they did -- they got into a room and held hands, I suppose, and stared at the ceiling and waited for a sign. Walt was a controversial personality in the Blue Cross structure. On the other hand, when compared with Bill Ryan, they knew that Walt had outstanding leadership capabilities, great intellect, great national reputation. When it came right down to it, when they looked around at alternatives, they had to conclude that he was the person to do it. I know, as a matter of fact, they had concerns about his administrative skills and selected him with the understanding that he would stay home and mind the store more than he had done in the past, and expected him to do that.

WEEKS:

You mentioned Bill Ryan, who were the other candidates?

TRESNOWSKI:

I don't know. I don't know that I recall. Those two were the principal ones. My guess is that there weren't any other serious candidates. The committee pretty much concluded that they would stay with one or the other.

WEEKS:

After the question was settled, was there bitterness or ill feeling?

TRESNOWSKI:

That's always hard to tell. Bill Ryan was disappointed twice. Not only when he lost out to McNerney, but eventually when he lost out to me, because he was a candidate to replace Walt when Walt left. But in both instances — I am, of course, more familiar with the second — Bill Ryan was an outstanding human being. After the decision was made to select me as president, he got up and congratulated the board on their decision and said he always liked a horse race and he thought the best man won. He was a real statesman. Although I know down deep he was hurt badly. Anybody would be. Bill wanted the job both times. But when McNerney won he came back in and worked hard and when I won he worked for me and worked very hard. It's hard to know what's in a person's heart. But he was not bitter. That will always be to his credit.

WEEKS:

Now I'd like to talk about your position. You were vice president and chief operating officer at BCA before the merger and then became executive vice president of the new organization. The merger occurred as the business reached a peak which was followed by a sharp decline in reserves. Do you want to talk about your new responsibilities?

TRESNOWSKI:

I took over in December of 1981, during a particularly dark period. The system of Plans had sustained losses of approximately \$450 million in 1980 and again in 1981. After growth throughout our history, market share began to dip beginning about 1978, 1979. We had lost about five or six points of market share by the time I took over. We were suffering financial losses and market losses. The Association was in difficult financial straits as a result of some capital decisions and the overextension that we talked about earlier.

Even though I had been executive vice president, there were two of us -- Bill Ryan and myself. My responsibilities were fairly narrow at the time. But working for a guy like Walt McNerney who was a strong CEO and who felt deeply the need to demonstrate his administrative skills, I had very little opportunity to influence events. But there I was in December of 1981, and now the problems were mine.

I had a lot of confidence. I felt I knew the organization and I knew what was required to bring it back. I concluded that the first thing I had to do was to streamline the organization internally, make it leaner, give it greater focus, select priorities, make commitments and be able to deliver on commitments. That was extremely important. I had to enhance the credibility of the organization.

The second thing I needed to do was to gain the support of the constituency. In other words, not only did we have to project our credibility in terms of our performance but I had to communicate it, and I concentrated on both those as very high priorities of mine.

We reorganized the staff, we streamlined our plans, set our priorities, communicated extensively. I traveled the country, visiting with Plans, CEOs,

their top staffs, talked to their boards. I used those opportunities as much to gain my own insights as to convey any information. And that paid off.

The credibility of the Association went up, we restored our financial position nicely and established our own credibility by virtue of communication techniques with the Plans. And, fortuitously I suppose I would have to say honestly, the business cycle turned around. Cost trends leveled off, we began to make money, the markets turned around. All those things taken together added up to a much better performance by the organization. It's not to say that we haven't got a lot of problems today and that when one looks ahead to the next five years, unless we make some decisions today we'll be back in jeopardy again. But we've been fortunate, I've been fortunate since I took over.

WEEKS:

Was the financial slippage due to the confusion of merging the two organizations?

TRESNOWSKI:

I think the problem was not being on top of what it is we were doing, not understanding what it is we hoped to accomplish, in terms of our objectives, our plans, and what the price tags were for all of that. An organization takes on a certain momentum and unless it's controlled in terms of what it's doing and what it costs to do that -- and when I say controlled, I mean really controlled, day in and day out -- it'll get away from you. And that's what had happened. I'm a great believer in delegation and participative management and all those wonderful managerial concepts, but if the CEO loses control of the organization because he lacks management information or fails to hold people accountable, very clearly, then he'll be in trouble. And that's what

had happened.

WEEKS:

When executive decisions had to be made about how to merge the two organizations in respect to duties and staff assignments, what became of the Blue Shield CEO, Ned Parrish?

TRESNOWSKI:

Ned Parrish retired before these things took place so he was not a factor. There were other people, people like Jim Knebel, who was executive vice president of the Blue Shield Association, who went off to Nevada to become a Plan president, which didn't turn out very well. But he was expendable. There were others. Some people who held senior officer positions were moved down the line to lesser positions. Some were simply told that they didn't have jobs. That's tough at any stage of the organization. But for those who spent their whole lives building their careers to then reach the point of significant achievement, and then to be told they didn't have jobs, it was particularly traumatic. That's why I said earlier that that period was probably the most difficult in my entire career, because of those decisions.

WEEKS:

What second-level changes were made?

TRESNOWSKI:

Managerial changes? One of the problems with the merger and one of the reasons that we got into trouble was that we made a number of political compromises, kept a lot of people on in jobs, gave out a bunch of titles in order to satisfy certain needs. The one lesson I learned from that is that putting those individuals in positions of importance is not wise. You've got to confront the tough decisions, you've got to make them, because they'll come

back to haunt you sooner or later.

WEEKS:

Did you make reductions at some fixed rate across the board or did you analyze the structure unit by unit?

TRESNOWSKI:

It was very detailed analyzing. Individual Plans were looked at, organizational structures were examined on a section by section basis. And this was all done in a fairly short period of time, so I would not argue that it was done with a lot of precision. But a lot of people put a lot of time and energy into trying to make good and rational decisions.

WEEKS:

How were the Plans affected by the new organization?

TRESNOWSKI:

I think the Plans were less concerned in those early years about the productivity of the Association than they were about getting rid of two separate organizations. They didn't want to deal with two organizations. It was very inefficient. First of all, it cost them more money than they wanted to spend, for support of the two organizations. But they found themselves duplicating their efforts. They would go to one annual meeting and then to another annual meeting. They would go to this conference and they'd go to that conference. There were different cultures, different philosophies, different objectives. And yet these Plans were of a single mind.

So in those early years, their major objective was to get the two organizations merged. Whatever good came from that in terms of specific Plan services and so on was a plus. But they didn't have great expectations on that score. The expectations came after the first two years. Then they felt

that the Association had enough time to get through its growing pains and the trauma of merger and get down seriously to the business of picking its priorities and focusing its objectives and getting things done. When it didn't happen then, they began to get concerned. That, of course, hit about the same time as the turn around in the business cycle, with financial losses and market losses.

WEEKS:

One of the reasons for the merger was to effect economies and to reduce the overlap in administrative functions and personnel. How did you cut costs other than through reduction in staff?

TRESNOWSKI:

Of course in a labor intensive organization like this, that's what it is. There isn't very much opportunity beyond that. With staff come other reductions like space costs and travel costs, and that sort of thing. Pension decisions, fringe benefit costs, were minimal. It really was manpower.

WEEKS:

What did the merger and the economy drive do to personnel morale?

TRESNOWSKI:

Oh, gosh. It would be difficult for me to answer what the morale was like, because we assiduously avoided taking the temperature, knowing that probably it was pretty bad. In fact it was. It was bad because of the decisions that had to be made about people. When the financial situation turned sour, we began to get into layoffs. Whenever you lose control of your finances, you compromise your ability to make rational business decisions, you are confronted with crisis -- you've got to cut here, cut there. Those are not always good decisions. They are not made rationally and with a great deal

of prudence. And that message is not lost on the troops. They look at the organization and they see all that scurrying about, waiting for the next Friday memo to come out and see who was fired. You can just imagine what the morale was like. It was up for grabs, and the ability to produce was significantly hampered.

One of the things I had to do early on when I took over was not only to restore our financial situation, but to communicate to the employees that we were in sound financial shape, we were going to be tougher in terms of what we expected of them, but my sense of employees is that they want to be treated that way. They want to know what's expected of them and that things are going to get accomplished. They don't like sitting around wasting time. There was a lot of that going on. That's not to say that the morale is so much better today than it was then, but I think it is somewhat better.

WEEKS:

Did the confusion and the competition between Cross and Shield factions bring about an impossible situation for McNerney?

TRESNOWSKI:

I don't think so. I really don't. I don't think there was a conflict between Cross and Shield. After a short time one couldn't distinguish between them. The doctor issue was much overplayed. As I watched the doctors' influence on the board, it was minimal. In most cases it was very constructive. The real difficulties came from the Blue Cross side in the sense that the strongest personalities came from that side. Walt had made some enemies, and they were constantly nipping at his heels. So it wasn't so much Cross and Shield as it was some long-standing concerns about key representatives from Blue Cross.

I'm a great believer that if a chief executive officer is well liked and respected by his constituency, the people who hire and fire him, he can sustain any setbacks, whether they be financial, market, whatever, because he can demonstrate that many of those things are beyond his control, and often they are. If they are not, if there is a fairly direct correlation between the performance of the CEO and those things, then everybody knows that, even the CEO himself, and he should be the first to stand up and say, "I made some bad business decisions and here's my letter of resignation." But that wasn't the case here. The Association has not got that much control over events in the market or in the Plans' finances. It really came down more to a question of a struggle for power and attitudes about Walt on the part of key individuals. They used various things like the down-turn in finances and in the market, and some of the defaults in LRSP and a few other things that people wanted to point to and say, "You haven't done your job."

WEEKS:

How did the turnabout come after the heavy losses of 1980-1982?

TRESNOWSKI:

Well, the turnabout came, as I say, fortuitously, because the cost trend turned down. There is always a lag period. We had rated for twenty and twenty-two percent trends and the trends turned down, and we began to restore our finances. When we restored our finances, we were in a better position then to price our products. We also made a lot of investments in product development, HMO, PPO, and moved aggressively into those markets. It was fortuitous in the sense of the business cycle, but fortuitous events can be ignored and lost. They represent opportunities. These opportunities were exploited, and the Plans came back, as did the Association.

WEEKS:

How did you hold the big national accounts such as GM, Ford, U.S. Steel, FEP and CHAMPUS?

TRESNOWSKI:

Every one of those is a separate story. FEP we didn't hold. We lost market share. When I came to the Association we enjoyed a 60% market share, and today we are down to 37%. CHAMPUS was not a particularly competitive market. There is not a lot of money to be made in CHAMPUS. We moved into it because we had learned to do that kind of business through Medicare. So that's not any big story. The auto and the steel industries, we always concentrated on those. They were very important customers and we sustained ourselves because we put a lot of time and energy into it. We lost some, though. We lost DuPont in that period, and some other major national accounts.

WEEKS:

What have you done to regain the national accounts that you did lose after 1978?

TRESNOWSKI:

In the last two years, we have devoted more time and energy to resolving the problem of national account delivery than at any time in my memory. Not only has there been time and energy devoted to it, but more sophisticated analysis of the problem, and a clear delineation of what needs to be done to solve the problem. There are now some actions on the horizon that I hope will solve the problem. We haven't solved it yet. We continue to lose market share in national accounts. I'm hoping that the ideas being refined and carried to implementation will position us well in the national account

market.

WEEKS:

You did better with local business than with national accounts. Was this because they were smaller accounts?

TRESNOWSKI:

No, not necessarily. Going back to what I said earlier, we lost a lot of local business, but the local business was a function of price and national accounts were a function of operations. That's oversimplification, but in general that's what it was.

When the trend factors turned around we were in better position to quote more competitive prices in the local market and turned it around. I hate to oversimplify because, in most of these cases it is more complicated than that. A lot of other things were going on at the same time -- like improvements in delivery at the local business and a lot of other things. But when you sort it all out, price became the critical factor.

WEEKS:

Was there less pressure from unions in this group?

TRESNOWSKI:

No, I don't think so. I don't think labor has been a big factor in the market for some time.

WEEKS:

Was tradition a factor in local business?

TRESNOWSKI:

Tradition in the sense of understanding Blue Cross and Blue Shield and being wedded to it? I suppose we still enjoy a brand identification which is thought of generally as positive, and if we can deliver a good product, good

operations, attractive price, we'll always have a good chance of getting business.

WEEKS:

You still have a large portion of the FEP business and all of CHAMPUS. Will you discuss how you secured this business and what you will have to do in the future to hold CHAMPUS and to hold and increase FEP?

TRESNOWSKI:

We'll hold CHAMPUS because nobody else wants it. It's as simple as that. You don't make any money on it and you're in it for all the reasons I cited earlier, to share some overhead and to continue a presence. FEP has not been totally negative. We are doing very well financially in that program, but we have lost market share. Because of the multiple choice situation, we are in adverse selection spiral. The future of FEP is going to be in the change of the product -- away from the so-called high option and standard option to a product that is geared to the managed care ideas. That whole analysis is under way at the moment, and I expect that within the next year we would be looking to amend the law or change our product offerings in FEP to recognize what's gone on.

And I think, because of our generally strong financial position and the fact that we still enjoy a good reputation among federal workers, if we can come up with a product that is comprehensive and affordable, we'll recover nicely in FEP.

WEEKS:

You are the biggest in the business. With Blue Cross and Blue Shield, FEP, CHAMPUS, Medicare, and Medicaid you serve about 105 million Americans. What service are you likely to emphasize next?

TRESNOWSKI:

The real change in product is the move to what we now call the new health care. That's the managed care concept, managed care in HMO the context, managed care in PPO, or case management in our traditional benefits. That's what the marketplace is demanding. We'll never go back to the easygoing product. It'll be multiple choice, consumer oriented, with a managed care aspect to it. The difficult decision we have to make is the transition from where we are now, where most of our business is with traditional products, to this new health care and this new set of ideas, trying to manage the existing product, create the new product which is extremely challenging administratively, and moving through a period of two to three or four years while that transition takes place.

Keeping your wits about you while you are doing that is going to be a real challenge.

WEEKS:

Do you expect the separate HMO units to become more uniform in ownership, management and functions?

TRESNOWSKI:

Absolutely. I don't think that the HMO business can continue with the disparity that exists across the country in individual communities. The HMOs don't have enough of a critical mass, they are hanging on by the skin of their teeth, they lack portability from community to community. There will be fewer, in larger organizations, chains. Our own HMO-USA has the potential for putting together a national Blue Cross and Blue Shield HMO product. I think you are going to see a lot of sorting out in the HMO business over the next five years.

WEEKS:

Do you expect the HMOs to own facilities such as hospitals and clinics?

TRESNOWSKI:

I don't think so. I think it's hard to tell what a lot of them will do. In the case of Blue Cross and Blue Shield, I would argue against that. I think you are better off contracting, because you can be selective and you can always cancel contracts, based on performance. I don't think that it's wise for an insurance carrier to get into the hospital business. That's why I think organizations like Humana and HCA and a few of those who were in the hospital business and have gotten into the insurance business are doomed. I think there is a fundamental conflict of interest and business objectives.

WEEKS:

Are all Blue Cross and Blue Shield HMOs' premiums on a capitation basis?

TRESNOWSKI:

They have to be. They are all premiums for an individual. So, whether or not Blue Cross turns around and contracts for the delivery of health care on a capitation basis, there is a lot of that going on, but it's relatively small.

WEEKS:

With HMOs growing steadily, will this have an effect on fee-for-service?

TRESNOWSKI:

Yes. I think fee-for-service as we have known it in the past is over with. I think you are dealing with a controlled fee-for-service through managed care, negotiation of fees, negotiation of utilization constraints -- whole set of incentives built into delivering care differently.

WEEKS:

I understand that the HMO market percentage held by HMO-USA is about fifteen percent and increasing. Would you comment on expected growth rate and number of units and percentage of market?

TRESNOWSKI:

We have those objectives laid out somewhere. I think by 1990 we expect to grow to twenty-five percent market share.

WEEKS:

The role of the investor-owned chains may be changing somewhat. Dr. Thomas F. Frist, Jr., CEO of Hospital Corporation of America, made a statement recently that his company would buy fewer hospitals in the coming year and would stress their insurance operations and other business interests. Do you look upon the investor-owned companies getting into your field as a serious threat?

TRESNOWSKI:

I think it's another set of competitors, and I think they have to be taken seriously. But I don't think they are a serious threat because as I said a moment ago, I think they are in a fundamental business conflict. I am surprised that the financial communities have accepted HCA's strategy for restoring earnings -- that is, to get into the insurance business. I think they are going to lose their shirt before it's over with.

WEEKS:

Is it true that about 30% of the health insurance purchased by employers has some element of self-insurance?

TRESNOWSKI:

Actually, I think the amount of self-insurance is higher than that,

depending on what definition you use. There is a variety of definitions. There are cost-plus, so-called ASO arrangements, varying degrees of self-insurance. Some use Blue Cross, some don't. Some take on the total risk, some reinsure with the Plan for part of the risk. But if you take all those definitions, I think the percent that fall into that clarification is more like fifty to sixty percent.

The interesting part of it, is that in the last five years it is probably both the fastest growing aspect of our business and one of our greatest competitors. That is because the people who leave Blue Cross and Blue Shield to self insure hire a third party administrator.

WEEKS:

DRGs. How is the Medicare perspective payment system working out now that we are in the second year?

TRESNOWSKI:

I don't think anybody really knows. There are a couple of things that there is probably unanimous agreement on, and then there are a whole lot of things that nobody really knows the right answer to. What people would generally agree on is that the DRG, that is the per case method of payment, placed in motion a set of incentives that changed the behavior of hospitals in terms of cost incurrence. I think nobody would deny that. People would argue about what the effect of that is in terms of a more efficient and effective delivery of services versus whether the quality has been impaired, whether people are sent home too early. But generally everybody would agree that the incentives have changed and, although it certainly is not the only factor, it is probably an important factor in the significant drop in hospital utilization that has occurred, at least in the last two years. So I think one

would have to look at the DRG payment system as having accomplished the purpose of changing the incentives and the way people behave.

What is the long-term effect of the DRG? I would say that unless the DRG system is linked to physician payment and to the full spell of illness, not just the hospital stay itself but the period prior to hospitalization and the post-hospitalization period, whether it be in a hospice or a home health agency or some other follow up modality, unless the DRG covers the full spell of illness, then it will have a limited effect. Let's face it, hospital administrators will be imaginative, and they will find ways to debundle, and they have already done that. There is also pretty solid evidence today that certain surgical procedures done on an ambulatory basis are priced at twice what they would be if they were admitted to the hospital. So there is a lot of imagination running rampant on how to beat the system.

By putting the case on an all-inclusive DRG amount, to pay both physicians and hospitals, and other modalities as well, you are in fact putting the same set of incentives across the board. I am very much a supporter of prospective payment as probably the most effective vehicle for the payment for care because it turns the incentives inward and influences the behavior of those who deliver care. I would quickly add, however, that accepting prospective payment as the vehicle requires that it be very sensitively applied. I don't agree, for example, that there should be a national DRG rate. However legitimate they may be, variations in practice are cultural and reflect what goes on in various parts of the country. I think there are also variations in populations and illness, epidemiology, that influence the incidence of disease in various parts of the country. So I think there is a lot of work that has to be done to perfect the per case

method. But basically I think it's the right way to go. It's got the right kind of incentives.

WEEKS:

How many Blue Cross and Blue Shield Plans are using the DRG concept for non-Medicare patients?

TRESNOWSKI:

There are six. Others have it under investigation at the present time. The first one to adopt it, in fact I think they had it perfected before Medicare, is the Kansas Plan. They had a distinct advantage because they had been in the business of gathering clinical data for about ten years as a kind of CPHA of Kansas. Kansas City followed, Arizona, Oklahoma and several other plans. If you think of the geography, you will note these are plans that are not in the midwest or the northeast, and, they are Plans that had not enjoyed a provider differential, and so the prospective payment scheme not only set in motion a different set of incentives but it gave the Plan an opportunity to negotiate the price, if you will, on a per case basis. Something they had not enjoyed prior to this time.

The reason you would not see a lot more Plans moving in that direction is because they already enjoy either favorable reimbursement relationships or different kinds of incentives to accomplish the same purpose.

I think rather than prospective payment, what the Plans have done is move to preferred provider arrangements wherein they negotiate prices and they can negotiate all kinds of different ways to pay, whether it be on a per-case basis, some capitation arrangement, some negotiated fee schedule — a whole variety of techniques.

All that adds up to the principle that was enunciated by the Blue Cross

Association some years ago, which I deeply believe in, that there is no single reimbursement method that is applicable across the United States. I think the pluralism of our society and the variations that exist out there clearly dictate that a payment system should be tailored to the characteristics of each community. That's precisely what has happened.

WEEKS:

Let's talk of malpractice insurance. The increase in malpractice insurance rates for doctors has been alarming. Has this caused doctors to practice defensive medicine?

TRESNOWSKI:

There is a lot of speculation about that, and I suppose to some degree it's true. I don't know whether doctors practice defensive medicine as much as a lot of them just don't practice medicine. In other words, they will shy away from rendering care in those high risk situations. The most talked about one today, of course, is obstetrics.

There was an excellent article in the paper recently that talked about the increasing difficulty pregnant women have finding obstetricians, because most of the obstetrician/gynecologists have given up their obstetric practice. The malpractice premiums are too high. The risks are too great. The criticism is rampant, and they just take the point of view that, "Who needs it?" So they shy away from it. Neurosurgeons are another example, and there are others.

WEEKS:

There seems to be a great variation in premiums in different regions of the country, even in the same specialty. Could you comment on that?

TRESNOWSKI:

Don't know the exact reason for that. I think really it has to do with the variations in medical practice. And the litigious nature of a community; in New York City the rate of individuals who complain is twice to three times what it is in Atlanta, for example. I think there are some places where people walk around with a chip on their shoulder -- both among those who receive care and those who deliver care. I'm not impressed, for example, by doctors who claim that the economic intrusion in medical practice has caused dissatisfaction on the part of patients with the professionalism of the physician. I think that is nonsense. Doctors are doctors, and they relate to their patients based on their personalities. I don't think economics has a lot to do with it. Some doctors keep you waiting in their waiting rooms whether there is money to be paid or not. They're insensitive when diagnoses are given, they won't tell you about a diagnosis until you get a bill in the mail. Then you spend forty-eight hours worrying before you can get hold of the doctor to explain. There is a lot of insensitivity, and it has to do a lot with the geography and the cultural characteristics of communities. People don't sue doctors whom they feel good about. They do sue doctors who make them mad, make them wait in waiting rooms, who are insensitive to their needs, and that sort of thing. If people sue, then you get variations in the incidence of malpractice, and in the rates.

WEEKS:

Some cooperative plans such as the Hospital Association of Pennsylvania's seem to be working out, where commercial plans are withdrawing. Is Blue Cross and Blue Shield doing any cooperative work, or planning to do so?

TRESNOWSKI:

In the area of malpractice? No. We have not entered the malpractice insurance market at all, even in some of our casualty subsidiaries, either those owned by the Plans or one that the Association is deeply involved in. It's a very high risk business, and we have chosen not to do it.

WEEKS:

Are any legislative efforts being made to eliminate contingency fees for attorneys and these kinds of suits, or to have such suits heard by a panel of judges rather than leave awards to a decision of the jury?

TRESNOWSKI:

There is a whole variety of tort reforms going on at the present time, both on an administrative basis at the state level and state laws, such as in New York. Most recently, Senator Hatch has introduced a fairly comprehensive malpractice reform bill which, frankly, has a lot of good features in it, such as setting a cap on contingency fees, on pain and suffering awards, and other tort reforms. I think that it will become a general consensus, even by trial lawyers, that some tort reform is inevitable, and it will be moderated.

The real trick is to provide a balance between the legitimate filing of a grievance and compensation for injury, as against frivolous actions on behalf of consumers. That balance will continue to be debated over time. My major criticism of all the parties in this is that we spend a lot of time worrying and talking about the economics of the situation, about appropriate tort reform, but meanwhile we don't spend enough time and attention on eliminating and minimizing the risk. There's a full range of initiatives that could be included in that, such as tightening licensure of professionals, risk analysis in institutions, facing up by the medical profession to the fact that there

are impaired physicians and the profession ought to take some action to protect the public against them.

WEEKS:

How can the higher physician fees caused by this malpractice insurance be absorbed?

TRESNOWSKI:

Well the answer to that is very simple. It's that they are absorbed by just tacking them on to the fees. That's a simple answer, and in many ways it's as simple as that. Except when you are in a highly competitive environment, as we are today, just tacking an additional factor onto a fee to cover malpractice premiums may not be feasible, because then you disadvantaged yourself competitively. So there would have to be variations on based on what the community practice is and what the cost buildup of any physician might be.

WEEKS:

The next topic is PROs. How complete is the system of PROs?

TRESNOWSKI:

The last time I looked at it, every state that was supposed to had a PRO designated. The problem at the moment is that a number of those PROs are failing, either because they haven't carried out their responsibility or because they disagree with the instructions given to them by the federal government. So within the last three or four months, there have been three or four PROs that have been either dropped or replaced by some other organization.

WEEKS:

What groups are forming PROs?

TRESNOWSKI:

I suppose the most prevalent group are the remnants of the PSROs that began some years ago. Other active participants are the medical societies that were allowed to participate as PROs. And of course there are others. There are insurance carriers, Blue Cross and Blue Shield Plans. As a matter of fact, at the moment one of the Blue Cross and Blue Shield Plans is the PRO in the state of Idaho. A number of the PROs are about ready to lose their contracts and the only viable alternative would be assigning the responsibility to a Blue Cross and Blue Shield Plan. I think many of the medical societies that have gotten involved have become disenchanted with the heavy dose of regulation that followed and the criteria to be applied, with less concern for the quality of care and more in terms of the cost. Not that they are opposed to measuring cost but they would have thought that the PRO was there to watch and be a surveillance mechanism for the quality of care under DRGs. Some of them have found that it doesn't work that way.

WEEKS:

Do you feel that there is effective utilization review?

TRESNOWSKI:

Utilization review has been around as long as anyone can remember, and various levels of emphasis. I remember the first real initiatives had to do with so-called admitting and discharge committees of hospitals. Those were replaced by utilization review committees.

When Medicare first started, the committees were the front-line of utilization control. They were phased out by the PSROs, and prepayment claims review by carriers and intermediaries, and some post-payment review. It went through an evolutionary cycle.

Today we are probably best positioned to do the kind of effective utilization review needed through the vehicle of pre-admission certification, concurrent review while in the hospital, and discharge planning to facilitate leaving the hospital. The data bases are much better, in terms of diagnostic-specific criteria for what constitutes admission, length of stay and the intensity of service associated with the diagnosis. Not only is the technology much better, but the courage of the non-medical people involved, like carriers, intermediaries, PROs, and major buyers, has improved to the point where they don't care what the doctors say anymore. That's an overstatement, but they are prepared to take the findings these data techniques give them and demand that questions be answered -- and in many cases simply not pay for care when it exceeds the criteria.

WEEKS:

Are freestanding clinics covered by PROs?

TRESNOWSKI:

Not at the present time. That's one of the additional responsibilities on the horizon, but yet to be negotiated.

WEEKS:

Overall, are PROs helping to maintain quality and contain costs?

TRESNOWSKI:

I don't know that anybody can answer that question at present. A contract was awarded about three months ago to something called a super-PRO. That contract was awarded to a consulting agency with the primary responsibility to evaluate the whole program and attempt to answer the question you ask.

WEEKS:

The next topic is coalitions. I would like you to comment on how

coalitions work, what they have accomplished, and then comment on your experience with the Dunlop Group.

TRESNOWSKI:

Coalitions work and are a function of an increasing awareness on the part of the business community that the problems of health care, the cost of health care, access to health care, the quality of health care, are best understood, determined, and influenced at the community level. That's contrasted with the belief that the way to deal with those matters is through some kind of legislative or regulatory approach. We went through that period in the 1970s with the comprehensive health planning law, PSRO laws, the ill-conceived Carter caps on reimbursement. The business community generally concluded, number one, that government couldn't do the job. Number two, it was self-serving. If laws and regulation did anything they were really going to protect the government and the Medicare program. What they would do would be to shift costs to the private sector rather than to resolve the basic problem.

Add to that the fact that the business community, particularly in 1980 and 1981 in the midst of a severe economic recession, was faced with cost trends of twenty to twenty-five percent. Their competitive position in international markets, their fundamental survival, was dependent on solving the health benefits component of their cost. So they took it very seriously. The decision-making moved from the personnel manager or the human resources manager up to the financial division of the corporation, and on up to the CEO and the board in many cases.

While they were doing that, they were sensitive to the fact that the decisions they made about health benefits fundamentally were community decisions, and therefore they should be shared across the business interests

of the community. Thus the notion of coalition was created. Most of the coalitions were created as business coalitions. Only in the last three or four years have they been enlarged to include doctor groups and hospitals and insurers and labor. That's the origin and that's what they've been about. The first order of business was getting to know one another. A lot of sharing of information and a lot of dialogue took place. Then they saw that better data were needed for them to understand what's going on, so the accumulation of data, the profiling of information, was another order of business. That gave them a little more structure organizationally. They hired staff, they created budgets, and formalized the coalition activity around the purpose of gathering data so they could better understand what was going on in the community.

After that, they began to take some very specific initiatives. If they felt utilization rates were too high, they would focus on that. If there was too much capacity, they would focus on down-sizing. So the sequence of actions that they have taken at the community level was based on the assessment of what the major problems were. Which makes eminent sense. That was the thing to do.

What has been the effect of the Dunlop Group on all this? The Dunlop Group was conceived as a national coalition of all the parties at interest — business, labor, hospitals, doctors, insurers -- for the express purpose of nourishing and supporting community-based coalitions. In other words, the Dunlop Group would engage in dialogue at the national level about matters of concern at the community level and at the same time project to the community-based coalitions support and encouragement and enthusiasm for what they were doing. And I think it's worked.

I was recently in Tulsa, Oklahoma, on a site visit for the Robert Wood Johnson Foundation, under the Community Programs on Affordable Health Care. I sat for a day and a half and talked to key members of the business community in Tulsa, labor, hospitals, doctors, and so on. I came away from Tulsa extremely impressed. Mostly with the business community, which I found very sophisticated, very knowledgeable, and very committed to changing the fundamental behavior of the health care system. I don't think that's atypical. If it is typical, that's good news.

WEEKS:

The next subject is imaging. Has Blue Cross and Blue Shield developed guidelines for the use of magnetic resonance imaging, CAT, and other new technologies?

TRESNOWSKI:

Yes. The imaging guidelines derived out of our medical necessity project. I think it was our fourth or fifth major initiative, following guidelines concerning respiratory care, laboratory services, and others. The imaging guidelines deal with a whole range of imaging modalities. They gave specific instructions to the Plans on the questions that would have to be asked for claims filed on various imaging techniques.

We commissioned a study of the nuclear magnetic resonance technology that was completed by a highly respected group at Harvard University. That study in effect cautioned, put up some red flags, in the application of the nuclear magnetic resonance and its application to specific diagnoses.

Interestingly enough, within the last twenty-four hours we have received some further information about the advance of that technology and its applicability, and we are now in a position to encourage its use and payment,

more than we were six months or a year ago.

WEEKS:

Have you been able to adjust insurance rates to cover these new technologies?

TRESNOWSKI:

The rating process is not specific as to whether CAT scans or NMRs are used. Rates follow a fairly standard procedure, based more on the characteristic of the population being served than on the services provided. For example, take the whole notion of organ transplants. There is not an economic consideration in organ transplants because it doesn't affect the rate all that much, and I don't think it does in the case of imaging.

Less important than how it affects the rate is whether it constitutes good and appropriate medical practice. Whether it affects the rate or not, you don't want to pay for something that is inconsistent with good medical practice, quality being the overriding consideration.

WEEKS:

You must get requests to include extended coverage in your contracts. Is there any change in coverage of such things as mental health care, alcohol and drug abuse, maternity care for single women, care by chiropractors, services of psychologists, transplants, and so on?

TRESNOWSKI:

There are all kinds of changes in the way health care is practiced in the United States. We like to think that we pay for all reasonable and necessary services, and I think we do. There is, on the other hand, a lot of controversy that surrounds some of these issues, like chiropractors. Without getting into detail, I'd simply say that unless the Plan is mandated to pay,

through some state or federal statute, we would tend to resist those forms of treatment and care that are out of the mainstream of medical practice. Some of the mandated benefits, things like obstetric coverage for single women, for example, I don't think is debatable. There is nothing either from the rating standpoint or otherwise that would preclude providing those kinds of benefits. I think most of the Plans do.

WEEKS:

Let's talk in more detail about transplants. Organ transplantation is rapidly becoming common. In 1984, the government reports, there were: 346 heart transplants at costs of \$57,000 to \$110,000; 6,968 kidneys at \$25,000 to \$30,000 cost. Patients undergoing this kind of surgery had about a 90% one year survival rate. In addition, there were 24,000 cornea transplants at a cost of \$4,000 to \$7,000 each, with a 90% success rate. Not so successful were 308 liver transplants at a cost of \$135,000 to \$238,000 with a one year survival rate of 65%, and 87 pancreas transplantations at \$30,000 with a 35 to 40% one year survival rate. The cost per operation is very high for the average person to pay, but as an insurance statistic is the cost of 346 heart transplants at \$100,000 each spread over a population of 240 million a minor statistic?

TRESNOWSKI:

The answer to that is yes, it is. Organ transplants, as I say, are not a major economic consideration. More important is what is the efficacy of the transplant? What is the medical necessity of doing the transplants? The major controlling factor in organ transplants is not the dollar availability, it's the organ availability. Somebody said we will have to perfect our techniques for harvesting organs before it becomes a very serious economic consideration.

My sense of it is, and I am certainly not expert in the technology, but my sense of it is that in organ transplants over the next five to ten years the technology will have improved to the point where it will become practically automatic to replace organs -- and quite effectively and efficiently so. The prices will come down, and it will be very much a part of medical practice to do that. I don't think the same is true of artificial organs, like heart, but transplantation will become very much a part of it. I don't see anything wrong with that. And I don't think there are any serious economic consequences that flow from that -- any more so than there would be from an outbreak of AIDS in the population, or from neonatal care of premature infants. A premature infant born at a pound and a half to two pounds will cost anywhere from \$200,000 to \$300,000 to care for it until the baby can survive on its own. And there are more and more premature births all the time.

So when you talk about economics, there are things that are not as popular or as talked about as organ transplants -- things that cost a lot more money that are being paid for. So I don't see the organ transplants as a critical economic decision.

WEEKS:

Are medical centers approved for transplantation, i.e., some approved for kidney but not for heart, liver, or pancreas?

TRESNOWSKI:

Yes. That, again, is another controlling factor. It isn't so much whether you pay for them. It's a question of whether you are paying for care that is effective, efficient, and appropriate. It's like many other things in our society, the more that's done, the better the procedure is. You look to

those institutions that have the skills and the talents on their staffs and have the volumes in order to perfect their techniques and thereby improve their results. In most cases Plans have structured their benefits to entail delivery in approved transplant centers.

WEEKS:

Are there specifics in your insurance coverage as to type of transplant, age of patient, etc.?

TRESNOWSKI:

No, there are not.

WEEKS:

Is Blue Cross and Blue Shield able to do anything about coverage of the uninsured or underinsured, regionally or nationally?

TRESNOWSKI:

That's a very large question. Access to care by the uninsured and the underinsured has always been a major public policy consideration. Depending on certain dynamics of the industry, it ebbs and flows. At the moment it is emerging as the most serious public policy issue that we face. It's going to push aside the question of cost, and we'll be back to the question of access. It becomes a critical question because of the competitiveness of the industry. Competitors tend to do market segmentation. They pick off the better risks. It leaves out individual coverages and small groups, because they don't fit the principle of insurance. So you have an increasing segment of the population that is uninsured or underinsured. That's a subject a lot of people are talking about today. But as so often happens, a lot of people are talking about it, but nobody seems to be doing much.

Historically, it was a mission of the Blue Cross and Blue Shield

organization, both to justify our tax-exempt status and also to extract differentials from hospitals and doctors. We agreed to take care of individuals, the smaller groups and high risk situations, and thereby serve a community purpose as community organizations. But Blue Cross is disadvantaged today. Our competitors don't do it, and the Congress is debating a decision to take away our tax-exempt status. Ostensibly that's to raise revenues, but it also sets in motion a fundamental change in public policy. That is, to change our business practices.

WEEKS:

Some areas, I believe, are trying to give reduced rates to the unemployed, but this isn't much help to those who have exhausted their unemployment insurance. Do you have any further comments on this?

TRESNOWSKI:

I think a lot of work has been done on how to take care of the unemployed, who clearly need health benefit coverage as much or more than the rest of the population. A series of product initiatives have been taken along these lines in Pittsburgh, here in Illinois, in Michigan, and in other places, to design and develop a set of benefits, minimal in scope, but significant in lessening the financial burden on the individual, and to have those available at very reasonable rates, largely through agreements among the insurers and hospitals and doctors to subsidize those risks at reduced amounts.

The critical question is the one you suggested. Where you are dealing with people who are unemployed, without any money, how can they afford it? That's why you tie those, to the extent you can, into workers' compensation arrangements so that even the nominal premiums can be paid and the protection afforded.

We've had, I would say, limited success with that initiative, limited success because everybody talks about it, but, as I said recently, everybody's concern becomes nobody's responsibility. There has been no real follow-through to deal with the issue.

WEEKS:

On the subject of cost containment, what is the present state of the effort to reduce costs?

TRESNOWSKI:

The present state is very good. If by costs you mean the combination of price and utilization, then costs have come down very dramatically over the last eighteen months, driven largely by the drop in hospital utilization. Whereas we were looking at trend factors of over twenty percent in 1980 and 1981, today the trend is as low as four to six percent. That's very good news indeed.

WEEKS:

On the subject of mutual corporations, the Michigan Plan is now attempting to get permission to convert to a mutual not-for-profit insurance company because it might make Michigan Blue Cross and Blue Shield more competitive. Are the other Plans striving to do similar things?

TRESNOWSKI:

There have been a number of moves by Plans to mutualization. The most recent was here in Illinois. The Florida Plan, the Connecticut Plan. The objective in moving to mutualization was to get out from under the unique treatment of Blue Cross and Blue Shield by the insurance departments in the respective states. Unique treatment are kind words to describe what most people would call unfair treatment or discriminatory treatment vis-a-vis

competitors. The move to become mutual is simply to put ourselves on a level playing field competitively. I think that that is clearly an acceptable objective. However, my understanding is that a lot of the Plans have been disappointed. Even after they have become mutual insurance companies, they are not out from under the rigors of regulation.

WEEKS:

I believe you said earlier that under the new GM contract the Blues will be assuming risk over the three-year span. Isn't this different from the early days when in some Plans hospitals had to assume risks if the Plan was in the red?

TRESNOWSKI:

The nature of the risk assumption under the GM contract is different from the original guarantee contracts that the Plans signed with hospitals. The commitment in the GM contract is for a 10% reduction in the premium over the three-year period. That's placing the Plan in the position of exercising greater cost containment constraints with the objective of reducing premiums by 10%. The guarantees with the hospitals were that the Plan would do its best to price and underwrite various risks, but that part of that risk-sharing would be from the institutions themselves. They were really two different concepts.

WEEKS:

Are there any other areas in which Blue Cross and Blue Shield assumes risk in the insurance operation?

TRESNOWSKI:

That's what insurance is all about -- accepting the risk. The problem today is that there isn't much insurance left, if you've got an administrative

service only or a self-insured program.

In experience-rated contracts, the risk is defined by the experience of the group. In other words, it's almost a cost plus kind of contract. The true risk is usually in the individual and the small group. Even in those instances, there is a lot of cross-subsidization that goes on from large groups to those smaller groups. So there isn't much risk involved in so-called health insurance any more; health insurance is probably a misnomer.

WEEKS:

On the subject of frauds. How successful have fraud audits been, and will they continue?

TRESNOWSKI:

In the last ten years, the development of fraud and abuse control units by Blue Cross and Blue Shield Plans has been expanded significantly. They have been extremely successful, mostly because of the sentinel effect -- the existence of the fraud unit, and the occasional letter and questioning that goes on. Also, when a true fraud is determined there is active prosecution of the fraud, and lots of publicity associated with it. I don't have the data readily at hand, but the savings have been quite significant -- the explicit savings. The implicit savings are probably worth ten times the amount of the explicit.

WEEKS:

I would like to ask a few questions about the future. I think you suggested at least that you foresee, HMO-USA in every state. Will the Kaiser-Permanente pattern of physician partnership under capitation be the prevailing one in HMOs in general?

TRESNOWSKI:

We hope to have a network of HMOs traveling under the HMO-USA banner. We've got a lot of changes that we want to make in that product. Right now it is essentially a loose network of existing HMOs with local benefit arrangements and local pricing. Our eventual hope is that there will be options available to the account, either to go to local benefit and local pricing, or to a national product and a national price, national membership files. There is a demand for that product, and it has to be delivered.

As part of the strategy in developing HMO-USA, we hope to have broadened the geographical distribution so that every major community in the United States is served by an HMO that is a member of HMO-USA. The analogy to Kaiser-Permanente is a good one except that we would probably not rely solely on the staff-model HMO, which is what Permanente is. We would include staff-model HMOs, IPAs, and variations. Under all circumstances, it makes no sense to pay other than on a capitation basis. The success of the HMO is that the providers are at risk in the capitation. The incentives have to be there for cost-effective delivery of services. I don't know any better way to do that than under capitation payment.

WEEKS:

I believe Paul Ellwood predicted that eventually there will be two national chains of HMOs. I suggest that there will be three or four: Kaiser-Permanente, HMO-USA, a commercial insurance company, and possibly an investor-owned chain. Would you care to predict?

TRESNOWSKI:

I think the HMO market is going to shakeout substantially. There are large capital requirements in an HMO, there are great opportunities for

adverse selection, and there are great opportunities for failure. If all that is true, and I believe it is, then you are into a survival of the fittest phenomenon, which is what Paul Ellwood talks about when he says, "After the dust settles, there will be four that remain."

I believe that if you think about it on a national basis, his suggested four may be appropriate. Beyond that, I believe there are going to be some locally based HMOs that will remain strong, serving local markets. Whether those local HMOs will be captured at one point or another by the big four -- the opportunity is always there. But there are some HMOs that have very strong community roots. The Group Health cooperative of Puget Sound is a good example, a strong organization. There are several in the Twin Cities of Minnesota that have performed their job very competently, and there are several others around the country.

So whereas you may have two, three, or four, large, strong, national HMOs, I think there will be, representative organizations that will do very well in various communities across the country.

WEEKS:

Someone has predicted that HMOs will be more durable than PPOs and will gradually take over much of the PPO market. Would you comment on that?

TRESNOWSKI:

I think in this sense the PPO is a transition idea. The PPO arose because the buyer wanted broader access to the delivery system than could be afforded through the HMO, yet wanted the managed care components of the HMO. So the PPO is a logical alternative to the HMO and to the traditional benefit program. I think what will happen though is that the PPO will fade as a viable product and in its stead will be essentially two products tied to the

delivery system. One is the HMO and the other is the so-called managed care product, with broad access to the delivery system.

Both will be reasonably cost-effective. It will be a matter of what the public wants. Do they want restricted access and whatever advantages flow from it, or do they want unlimited access and be willing to pay premiums to achieve that?

WEEKS:

What will the physician population of 600,000 to 700,000 do to health care?

TRESNOWSKI:

The supply of physicians, in my judgment, is probably the most important of all the factors that are influencing the way health care is delivered, now and into the next decade. Whatever the factors are that has dropped hospital utilization, the supply of doctors has set into motion a set of so-called supply-side incentives to change the location of receipt of health care, whether it is ambulatory surgery, or increasing care in the doctor's office, or development of alternative delivery systems, HMOs, IPAs or whatever. The supply of doctors against a diminishing demand for health care services means increasing competition for the provision of services. That set of supply-side incentives will dramatically change the way medicine is delivered.

WEEKS:

Some specific questions concerning the physician population. Will physicians' fees be higher? Will physicians schedule more appointments for a patient? Will salaried positions be more attractive? Will prepaid group practice be more popular? Will physicians make fewer referrals? Will an inflated physician population affect the Blue Plans?

TRESNOWSKI:

I think the answer to all of the questions is yes. Well, not all: Fees will not be higher, because physicians will be more amenable to negotiating prices. They will want to negotiate prices in order to keep volume up. So I think the price will be subject to considerable negotiation and downturn in the presence of opportunities to increase volume. But the other questions I would say yes to.

When you consider how the physician supply affects Blue Cross and Blue Shield, it has already begun to have its affect, and that is the increase in the participating physician percentage. Doctors want to participate in some form of financial arrangement whether it be Blue Shield or an HMO or IPA, or something whereby they can present themselves to the public as having a financing mechanism, and have a fairly secure channel of patients within the framework of that mechanism. If you have, for example, a strong Blue Shield Plan with good enrollment of major accounts, it is very advantageous for a physician to be a participating Blue Shield physician in the context of oversupply. Any physician who is not Blue Shield is disadvantaged when it comes to the number of patients.

WEEKS:

On the subject of women in medicine, the number of female medical students has risen dramatically in the past few years. How will this affect the practice of medicine in the future? Will women like salaried positions with regular hours more than men do? Will women be likely to take a few years out, as nurses have, to raise their children? Will women physicians be more interested in the sociological and environmental aspects of medicine than men?

TRESNOWSKI:

I wish I knew the answers to all those important questions. I have little empirical information -- in fact I have none. What anecdotal information I have is that clearly women are more attracted to HMOs because of the greater predictability of their time commitments. Therefore the quality of medical practice in HMOs will go up, because now that form of practice is being selected for convenience. I think the opportunity for salaried practice is greater, for a variety of reasons. But that's really anecdotal.

My guess would be, and this is instinctive more than anything else, that the increasing presence of women in the delivery of medical care will influence emphasis on the caring aspect of medicine. I don't mean to say that men don't care. I think that women, instinctively, would care more for human beings, would be more concerned about the whole person, rather than just the disease process. I may be dead wrong on that; it is just a guess.

WEEKS:

Walter McNerney, fifteen years ago, talked about possible moves by Blue Cross and Blue Shield in the future to help the aged in areas of housing, nursing homes, and retail stores. Do you have any such vision of the future?

TRESNOWSKI:

I think the only growth market we have is the aged population. Whether it should be the kinds of things Walt McNerney talked about fifteen years ago, I don't know. I do know that we have had under development for the last three years a long-term care product. Long-term care is clearly a need of the aging population. We think it's a good market opportunity because from age 65 to age 75, increasingly the population is healthy, vigorous, involved, in many cases working -- and often at the peak of their asset development, so there is

a market that can afford a long-term care product. They are receptive to a long-term care product, because they know they are within a decade of perhaps using that service themselves, so they would in effect be prepaying, anticipating the day they need a long-term product.

Yes, the elderly market is an important market for us. The major product is long-term care, but there are other opportunities, as Walt described them some time ago.

WEEKS:

On the subject of tax caps. As we know, there has been talk about taxing a part of the fringe benefits and health insurance premiums paid by the employer. A similar step has already been taken by making part of Social Security payments to upper income individuals subject to federal income tax. Would you care to comment?

TRESNOWSKI:

It has been a principle in our society not to tax sickness. That principle, going way back in time, plus the fact that the Congress wanted to encourage broader access to health care services, is the reason health benefits were exempt from federal taxation. The philosophy of the country has changed, and indeed the philosophy of politics has changed. The pendulum swung too far in the direction of broad access, and there is a desire now to bring the pendulum back in the other direction. Also there are those who believe that by involving the subscriber in the financial transaction by paying taxes for health benefits, or reducing the benefits below a cap through deductibles and co-pay, that will have a salutary effect on the demand and the cost of care. Those are not particularly solid arguments; they are subject to substantial rebuttal. But the argument that's being used now is that we

have, in effect, an inequitable situation where there are many employees who do not receive their benefits through their employment, and they pay for health benefits with after-tax dollars, and that represents an inequity that should not exist.

What it all comes down to is that you can build arguments to support either view. At the moment, there is a strong feeling that employees are too heavily burdened with taxes and that the real reason for taxation of health benefits, or any fringe benefit, is to raise revenues. It's a hidden tax, and that's the way it's being viewed.

WEEKS:

On the subject of selective contracts with hospitals.

HMOs and PPOs contract with some of the hospitals of an area to furnish services at a discounted rate. HMOs and PPOs owned by Blue Plans do the same, but do Blue Cross Plans contract with selected hospitals to furnish the standard services at a reduced price? The key word is selective and the only example I think of is Northeast Ohio. Are selective contracts allowed in most states?

TRESNOWSKI:

Selective contracting is the history of Blue Cross. It used to be called participating Blue Cross hospitals, participating because they met certain criteria and standards for participation. It had more to do with commitment to areawide planning, to responsible medical record techniques, to the appropriate transfer of patients from one facility to another, and so on. There was less concern for price negotiation, but nonetheless, one of the criteria was a contract that spelled out the basis of reimbursement. So selective contracting was always very much a part of Blue Cross philosophy.

In the 1950s and early 1960s, states began to enact laws requiring Blue Cross to contract with any licensed institution. Those were usually laws politically contrived because one or more institutions were denied the opportunity to become Blue Cross hospitals. That pendulum has now swung back in the other direction, because the selectivity affords the carrier the opportunity to negotiate price and require utilization constraints. All this is justified on the basis of effective cost containment. The irony is that we have now come full circle. We are back where we started from. State laws are being amended to allow that to happen. The problem is that when you make these massive changes in public policy, you are dealing with an industry that has been accommodated and accustomed to a different set of constraints over a fairly long period of time. So, obviously, hospitals feel the tension and are outraged when they are not selected by Blue Cross and Blue Shield. And the tensions rise.

But the notion of selective contracting is very much with us and will stay with us for some time to come.

WEEKS:

You mentioned previously that there were several Blue Cross and Blue Shield subsidiaries. Will you name those that exist (or did exist) and what they do specifically? Do you anticipate the forming of others in the future?

TRESNOWSKI:

There are several subsidiaries at the national level. There is the BCS Financial Corporation, which is a holding company that includes a series of corporations. One is a life company, BCS Life, and one a casualty company, BCS Casualty. BCS also has an ownership interest in Dental Network of America, with a dental capitation product. There is also a reinsurance

corporation within the framework of BCS Financial Corporation.

Another recently created subsidiary is a financial management corporation, the name of which is Plan Capital Services Corporation which is a cooperative for purposes of investment performance, so Plans can leverage greater returns and yields through combining their investment portfolios. The other function of this corporation will be to go to the money markets with Blue Cross and Blue Shield commercial paper for purposes of borrowing to carry out business objectives.

In addition to those subsidiaries, currently being discussed is the creation of a Blue Cross and Blue Shield Plan services corporation which would be a national operating capability to deliver national accounts. That corporation would have broadened authority for some of the functions now carried on by the national Association, such as the telecommunications network and the interPlan data record system.

The matter of corporate structure, organization, holding companies, subsidiaries, is still being debated. It's important to keep in mind that the structure flows from the business strategy. You don't create structures and then think about what you are going to do with them. You've got to have some concept of business strategy. That strategy is still being debated extensively. Business strategy in the sense of what is our product portfolio, and what is going to be our marketing, our distribution system? All those matters are under discussion. I would guess that as they are resolved, there will be further changes in organizational structure.

WEEKS:

What kinds of research, if any, do you expect the Association or the Plans to engage in?

TRESNOWSKI:

The research agenda has changed a lot. At one point the research agenda was focused almost totally on matters of health care delivery. Today the agenda is more on marketing research. What are the right products? To what extent is consumer choice a viable alternative? How do consumers react when presented with a variety of products? So we have moved into more of a market research environment.

WEEKS:

What kind of educational plans for the staffs of the Association and the Plans do you have in mind?

TRESNOWSKI:

The education programs are focusing on several aspects. One, of course, is market education. We have had an extensive marketing education program leading up to awarding a Certified Health Consultant Certificate. That's been an excellent program, well received, and very well attended. There are also educational programs in Medicare audit techniques, and we have always conducted fairly high level education programs on strategy development and understanding the health care environment.

We have not gone beyond that in education or training. I think the whole matter of human resource development and training has been sorely neglected in Blue Cross and Blue Shield and is a matter of high priority in my own thinking.

WEEKS:

In conclusion, is Blue Cross and Blue Shield still a social movement?

TRESNOWSKI:

Yes, I believe it is and more importantly, I believe it always will be.

It has been and always will be a social movement for very important business reasons rather than any maudlin commitment to some idealistic social philosophy. The business reasons are simply that in order to succeed in a competitive environment, one must differentiate oneself --product differentiation, business practices. I think what Blue Cross and Blue Shield has represented in the minds of the American public, in its business practices, has helped us to acquire enrollment. Therefore it has been a good business decision as well as a good social philosophy. I still believe that's the case. I think it needs to be looked at and modified from time to time, but nonetheless I would dread the day that we ever began to just look like and imitate our competitors. I think we need to remain different for business reasons, and if one wants to conclude that those are social purposes, I wouldn't argue with that.

WEEKS:

What will become of the first day, first dollar service contract?

TRESNOWSKI:

I think it will always be there. I think the American public wants comprehensiveness of benefits, but more important, they want it at affordable price. If you cannot deliver comprehensiveness at affordable price, then co-pays and deductibles and major medical techniques will be substituted. But give the public comprehensiveness of benefits, with an affordable price such as in an HMO or a PPO or managed care, that's what they want, and that will always be popular.

WEEKS:

Is national health insurance, federally supported, now moribund if not dead?

TRESNOWSKI:

The concept of universal health insurance I think is dead, simply because the nation can't afford it. One of the major public policy issues today is the size of the federal debt. A major contributor to the federal debt are the entitlement programs, such as Medicare and Medicaid, which are in a sense national health insurance programs. So I think as long as this country struggles with economic problems, the national debt, I don't think the subject of national health insurance will come back. I do believe, though, that as more and more people become uninsured or underinsured, the Congress will have to pay attention to the financing needs of that segment of the population. You may get some form of national health insurance through the back door for the 40 to 50 to 60 million people included in that category.

An Interview with Bernard Tresnowski

Chicago

August 28, 1985

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