Blue Cross plans to expand consumer role

All 74 Blue Cross plans in the U.S. must have a majority of consumers on their governing boards by Jan. 1, 1975.

The recent action of the Blue Cross Assn., taken at a special meeting of member plans, mandated a position taken by the BCA board of governors in 1971, when it originally endorsed the principle of majority consumer representation on plan boards.

The BCA listed seven guidelines for selection of consumer board members. They are:

- Membership should reflect the social, economic, ethnic, and geographic characteristics of the population served.
- Nominees should not be eligible if they derive incomes from delivery or administration of health services.
- The majority of those entitled to nominate and elect governing board members should be Blue Cross subscribers and representatives of the public. The composition of the nominating committee should be structured to reflect adequately subscriber and public interests.
- Consideration should be given to permitting nominations from the floor or by petition.
- Membership on the board of a few non-public members (physicians, hospital administrators, and other deriving income from the administration or delivery of health services) is desirable as a safeguard against preoccupation with cost at the expense of quality. However, their participation in negotiations with providers of services should be avoided.
- To avoid self-perpetuation of the board, members and corporate members should not be the same person. Limits should be imposed on the number of consecutive terms served by a board director and/or minimum waiting periods between terms should be established.
- The board should have no more than 25 members, with meaningful representation of serious interests. If a larger board is deemed necessary, consideration should be given to the use of a smaller executive committee which could meet on a monthly basis.

Some plans already have consumer majorities on their boards. In Vermont, for example, 70% of board members are consumers.

At times, the BCA has interchanged the words "consumer" and "public representative" in its pronouncements.

In taking previously approved principles and making them plan requirements, the BCA is now saying that "a public member shall not be an employee of or shall have a financial interest in a health care facility, or be a member of a profession which provides health care services."

TO EFFECT THE recently approved national standards, five plans must seek to change state laws stipulating that plan boards should include equal numbers of hospital administrators, physicians, and public representatives.

As of mid-1973, 48 plans, with 74% of total enrollment, had a majority of public representatives on their governing boards, up from 31 plans and 53% of enrollment in mid-1972.

In another action, the BCA board of governors approved a policy statement providing that cost effectiveness and quality should be determining factors in a plan's decision on whether it should contract with a particular health care institution.

BCA also announced plans to develop a manual to promote effective areawide planning in various localities. The manual will describe the type of problems encountered in developing community health plans and methods for dealing with them and with the complexities of multiple, conflicting goals.