6

In the Beginning of Blue Cross

Blue Cross is the term the average person associates with hospital insurance. From a few hundred in 1929, the number of Blue Cross subscribers has grown to more than 80 million. Blue Cross has been a social movement rather than just a means of insuring oneself and one's family against the costs of hospital care. The key has been the concept of prepayment for services.

Prepayment for hospital services was as attractive an idea as Social Security, and it drew the patient, the family, and the community hospital into a mutually secure relationship. This was true for the Dallas school teachers in 1929 paying 50¢ a month for up to 14 days of hospital care at Baylor University Hospital.

Prepaid health services were also available in 1933 for 5,000 workers building an aqueduct, canals, and dams to bring water across the desert of Southern California to Los Angeles. This plan cost 10¢ per worker per day–5¢ a day from a commercial insurance carrier to cover accidents on the job, and 5¢ a day from the worker himself to cover illness off the job. The prepayment money for the aqueduct project was paid to a young physician named Sidney Garfield,[1] who was able to operate a small hospital on the desert job site and furnish hospital and medical care to the workers.

Thus early experiments with prepayment were generally localized and community-oriented.

Later, of course, under the Blue Cross plans, this changed. In the ensuing years, consumer demands forced the movement to spread from care at one hospital to several or all of the hospitals in a community, area, or state. Even national coverage was arranged eventually to accommodate travelers and employees of businesses operating in several communities throughout the country. Garfield's prepayment plan worked in the desert, it worked for employees and their families at Grand Coulee dam in the state of Washington, and it worked for employees in the Kaiser shipyards in California. Of all the prepayment mechanisms, however, the Blue Cross plans provided more people financial access to hospital services than any other system.

Blue Cross was not originally visualized as insurance. It was perceived as prepayment for hospital services rather than a cash benefit, as a communal approach to budgeting for the expenses of hospital care. Even today the Blue Cross approach to financing and paying for hospital care does not neatly fit the insurance mode. In many respects it is still an evolving social movement, struggling to adapt its fundamental principles to a changing political and economic environment.

There are many ways to tell the Blue Cross story. Perhaps the best, at least for our purposes, is to go directly to the sources and let them tell the story in their own words. In this and the following chapters in part II, the Blue Cross movement is told from the perspective of the people whose minds created it and whose hands shaped it.

To explain how Blue Cross started, what it is, its underlying philosophy, and its essential characteristics as a business entity, we turned to C. Rufus Rorem.[2] Rorem was the director of the AHA's Hospital Services Plan Commission in 1937. This commission evolved into the Blue Cross Commission, which Rorem headed until 1947.

In reviewing Rorem's reminiscences, the reader should note the continuity as well as the progression of his thinking from the days of his work on the Committee on the Costs of Medical Care (see chapter 2). Also, the close relationship between Blue Cross plans and hospitals should be recognized. To add flavor to this last point, the words of George Bugbee, Kenneth Williamson, James Hague, and John Mannix are included. Finally, to provide a sense of Rorem as a person, the observations of Maurice Norby and Robert Sigmond are included.

ROREM:[3]

In 1931, after about two years with the Committee on the Costs of Medical Care, I came back to Chicago to join the staff of the Julius Rosenwald Fund. Prior to joining the committee, I had been on the faculty of the University of Chicago.

I went to the committee to work on a specific study, funded by the Rockefeller

Foundation, with Michael Davis. Michael was the director of medical services for the Rosenwald Fund. I came back to Chicago to work under Michael, as the associate director of medical services.

I remained with the Julius Rosenwald Fund until December 1936, when the trustees of the fund liquidated their program in medical economics. During the five years [in] which I was on the staff of the fund, I conducted some research, but most of my time was devoted to the promotion of uniform accounting among hospitals, the development of clinical group practices, the development of group practice by physicians and at hospitals, and the development of "group hospitalization," which was the name originally given to the Blue Cross movement for the group payment of hospital and medical services. As you can see, much of my work was an outgrowth of the directions set by the Committee on the Costs of Medical Care. [See chapter 2 for a discussion of the Committee on the Costs of Medical Care.]

During this time, as you know from the committee's Minority Report Number One and the American Medical Association's response to the committee's final report, organized medicine was reluctant to accept group hospitalization. Their reluctance was grounded in the general principle that group hospitalization would result in socialized medicine and the removal of medical practice from control by the doctors.

Any sort of unified, explicit resistance, however, was relatively shortlived. The first formal recognition of group hospitalization by a medical group came from the American College of Surgeons in 1934. Surgeons, by that time, were providing almost all their services in hospitals. As a result, they saw in the Blue Cross movement a device by which they could either collect larger fees or find it easier to collect all of their fees, because there would be no hospital bills to compete for payment with, or perhaps take precedence over, the surgeon's charge.

The Creation of Blue Cross

Let me explain more carefully what group hospitalization–i.e., hospital care prepayment or hospital insurance–was thought to mean or be and how it came about.

Hospital care insurance originated as a device by which an individual hospital would be guaranteed specified revenue and would in turn assume responsibility for specific services for groups of people who paid money to the institution. These people–beneficiaries–were eligible to receive specified care at that institution without having to pay any extra fees at the time of their illness and use of the hospital.

The most publicized of the early hospital insurance programs was the one initiated in Dallas, Texas, by the Baylor University Hospital.

Many individually sponsored insurance programs had been established before. Baylor, however, was probably the first to start a program of health service benefits, as opposed to one of cash indemnities toward the hospital bill. The services benefit principle is the feature, and probably the only distinctive characteristic, which explains the rapid growth of the insurance principle in paying for hospital care.

One weakness of the Baylor Hospital plan was that the benefits were available in only one hospital, a Baptist hospital. Therefore, the plan was not widely acceptable to people of other religious beliefs.

During the time that Baylor Hospital was expanding its coverage from approximately 1,600 to 6,000 beneficiaries in the city of Dallas, two other hospitals established similar and competing programs. One was a Catholic hospital, the other a Methodist institution. Both of these hospitals ultimately enrolled approximately 5,000 beneficiaries. These beneficiaries paid 75 a month, through a promoter, for the same benefits as Baylor offered for 50¢ a month.

The hospitals received 50¢– of the total 75¢ monthly fee–for each person enrolled by the promoter. The enrollment in the Methodist and Catholic programs was not, however, deterred by the fact that their fee was $9.00 a year while the Baylor program was available at only $6.00 per year. Reluctance to participate, or at least what reluctance there was, arose from disbelief in these programs in their entirety, not from their price.

For example, I found out later, when interviewing business executives about enrollment of employees, that none of them objected on the grounds that family coverage was not worth, at that time, $24.00 a year. They doubted whether the contract was worth anything. They just did not believe in the program at all.

As originally organized, people were required to choose one hospital at the time they joined a group hospitalization plan. It soon became apparent that it was necessary to allow people to choose their hospital at the time of illness rather than at the time of enrollment. This meant, of course, that effective group insurance for hospital care should allow free choice among several alternative institutions. Interestingly, while being among the first to recognize the importance of group hospitalization, the state of Texas was among the last areas of the country to recognize and implement a free-choice, areawide plan. Ultimately, the single-hospital plans which had been formed in Dallas, Houston, and Fort Worth were merged into one plan, the Hospital Services Association of Texas.

The earliest plan to provide service benefits in several institutions appeared in New Orleans. There the Baptist Memorial Hospital joined with the Touro Infirmary to establish

a citywide program with service benefits at the two institutions. Modest cash benefits were also provided for services in other hospitals.

The first full-blown, communitywide, free-choice, service benefit plan was developed in Newark, New Jersey. It was introduced in 1933 by Frank Van Dyk, who later moved to New York (1935) to become director of the New York City Plan. In Newark the areawide plan covered about 12 hospitals, each of which agreed to provide stated benefits for a stated amount expressed in terms of dollars per day.

Another important early citywide plan was developed in 1934 in St. Paul, Minnesota. Here Mr. E.A. van Steenwyk, a 29-year-old former real estate operator, conceived the idea of free-choice benefits among all the institutions in St. Paul. He also introduced for the first time the option of dependents' benefits. Up to that point, benefit coverage had emphasized just employed persons. No coverage was available for the wife or children of the employed individual. Van Steenwyk's idea was that, for an additional monthly premium charge, coverage could be purchased for that person's dependents.

As a footnote to van Steenwyk's idea, it's interesting to remember that initially it was the practice to charge an additional premium for each dependent who was covered. Within a few years, however, the data showed that it would be practicable, from a statistical point of view, to have a standard family rate, regardless of the size of the family. In other words, one rate for a one-person family, male or female, and one rate for a family of two or more persons, regardless of the number of dependents. So in time, pricing practices changed over to essentially what they are today.

John Mannix was a contemporary of Rorem's, both in time and in his involvement in Blue Cross. Mannix describes the energy and spontaneity which characterized the beginning of the Blue Cross movement.

MANNIX:[4]

The Blue Cross plan in Cleveland was started in 1934 and has been very successful. An interesting aspect to me when I review the history of Blue Cross is that I have always thought of several plans starting at about the same time: one in Newark, New Jersey; one in Washington, D.C.; the Cleveland plan; the St. Paul plan; and the plan at Sacramento, California. These plans were all started within about 18 months of each other. While I later got to know all of the individuals who took the leadership of these plans, none of us knew each other at that time. That was a perfect demonstration of an idea whose time had come.

I think the report of the Committee on the Costs of Medical Care accelerated this, but all of us were working on the idea without any particular knowledge of what the

committee was doing or what they were likely to recommend. I do not believe that the people who were interested in developing these various initiatives had any more knowledge of the earlier history than I did. We all thought we had come up with a new, logical, and sound idea by independent actions in widely separated parts of the country.

ROREM:[5]

During this early period of Blue Cross' development, I was with the fund. My interest, however, was in this area. So, upon request, I visited over the course of several years at least 40 of the communities where prepaid, group hospitalization plans were being established. For several of these plans I had the opportunity to recommend the people who became the executive director of the plans. These directors were recruited from many fields: finance, industry, accounting, sales, hospital administration, social work, and education.

As I mentioned, the Rosenwald Fund decided in 1936 to discontinue its program in medical economics. I can only speculate as to the impetus for this decision. It was clear, however, that some board members of the fund were embarrassed by personal criticisms from their family physicians, who objected to changes in medical service organization which were being discussed and even taking place. As a result, early in 1936 they decided that the medical economics section of the fund should be discontinued at the end of the year.

The Rosenwald Fund faced the problem of what should become of the medical economics staff, Michael M. Davis and me. Their decision was to allocate, in effect, transition grants of $150,000 for Davis and $100,000 for me. These grants were to be paid out over four years in equal installments. The problem then was to find an organization which would accept and could receive these grants, since the fund was required to restrict its donations to eligible nonprofit organizations.

Michael decided to move to New York City. There he established a nonprofit corporation called the Committee for Research in Medical Economics. It was headquartered in New York City for several years, until he moved to Washington, D.C., to continue his interest in health economics on a personal basis.

My grant was offered to several agencies. My first suggestion was that the money be granted to the Twentieth Century Fund, which had an interest in medical economics. The Twentieth Century Fund decided not to accept the grant, since it would mean the addition of a "stranger" to their division of medical economics.

I then made the suggestion that the National Association of Community Chests might consider a program of this type. The director of that organization, however, considered

this program as outside its sphere of interest, which was charity and public services to be financed by donations from individuals and groups. He recognized, quite accurately, that group hospitalization was a way by which people collected their own money for services for themselves. Furthermore, he foresaw that such programs could become areawide or even statewide and would not fit into the programs of local community chests and their charitable activities.

The third offer was made to the American Hospital Association, which promptly accepted the grant. The AHA, however, accepted the grant with the understanding that, while I would become a part of their staff, I would be paid from the money from the Rosenwald Fund.

Blue Cross and the AHA

The acceptance of the grant from the Rosenwald Fund was part of the AHA's continuing interest in hospital prepayment insurance.

In 1933 the AHA decided to undertake a special study of the trend toward hospital care insurance, with a view to recommending standards for insurance programs should they develop throughout the country. The AHA warned against the indiscriminate development of plans as panaceas for either the individual's problem of obtaining hospital services or the hospital's problem of securing adequate income. It officially endorsed the insurance principle for the purchase of hospital care.

The AHA and the hospital field's interest in hospital insurance continued, and in 1935, at its annual convention, the AHA passed the following resolution:

> Be it resolved that hospitals contemplating the establishment of, or in, group hospitalization plans bear in mind the recommendations of the Association and, before any active participation in such plans, consult with the officers of the Association for information and advice concerning individuals or agencies sponsoring periodic payment plans for the payment of hospital care.

Rorem continues his account of how he happened to join the AHA and to bring with him the grant from the Julius Rosenwald Fund.

ROREM:[6]

So beginning January 1, 1937, I moved my offices from the Julius Rosenwald Fund to the AHA headquarters at 18 East Division Street in Chicago. I became the third male employee of the AHA. The others were Dr. Bert W.

of the AHA and executive secretary of the committee on hospital services of the AHA.

I assumed no duties or responsibilities for the activities of the association as a whole; I was not invited to the meetings of the AHA's board of trustees and was not dependent on the association for supporting travel expenses or any other costs of the committee on hospital services.

The committee on hospital services had two primary objectives. The first was improvement of hospitals through the development of uniform accounting. The emphasis of this effort was on promoting a standard program of uniform accounting. This program had been developed in 1933-1935 by a committee which I chaired while I was still with the Rosenwald Fund. The second objective was to continue the development of group hospital insurance for the payment of hospital bills on a community, state, and national basis.

I stayed at the AHA for ten years (January 1937 to December 1946). During this time the committee on hospital services changed its character in several ways.

During the second year (1938) an approval program for group hospitalization plans was developed, based on standards I had drafted. [See Appendixes I and J.] Also during the second year the name of the committee was changed to the Hospital Services Plan Commission. Later the term Blue Cross was introduced, and the committee was known as the Blue Cross Plan Commission. The commission was the forerunner of the Blue Cross Association.

As an historical anecdote, it might be of interest to comment on the origin of the term "Blue Cross," which was used to identify nonprofit hospital service plans which had gained the approval of the AHA. The term "Blue Cross" was first introduced by E.A. van Steenwyk, who used this title to identify his plan in St. Paul, both as a design on the literature and as a term to describe the organization, which was registered by the State of Minnesota not as an insurance organization, but as a hospital service plan association.

The Blue Cross name and mark were widely adopted, with or without permission, by various plans being formed throughout the United States. In the spring of 1949, a list of approved plans was issued. These plans were allowed to identify themselves by a blue cross on which the seal of the AHA was superimposed. This granting of the seal to indicate approval by AHA came about through formal action of the AHA's trustees, approved by the association's house of delegates and membership.

The relationship of the Blue Cross plans to the AHA also involved the plans' being members of the association. Each approved plan paid annual dues to the AHA based on the number of subscribers in the plan at the end of the calendar year. Each approved

plan then became an associate member of the AHA. The dues paid by the plans were used in the main to support the activities and expenses of the Blue Cross Plan Commission.

Blue Cross, the AHA, and Hospitals: A Changing Relationship

Up to this point, the Blue Cross plans and the AHA had a close and productive relationship. In fact, in many instances it was hospitals that had the major role in both creating Blue Cross plans and in maintaining the early fiscal solvency of those plans. Many early Blue Cross plan-hospital contracts contained provisions requiring that the participating hospitals share in the plan's losses or guarantee the provision of services to the plan's subscribers, or both. The closeness of the plan-hospital relationship is illustrated by the following comments from two hospital leaders–George Bugbee and Kenneth Williamson. Bugbee was the executive director of the AHA from 1943 to 1954. Prior to that he was the chief executive of Cleveland City Hospital. Williamson was the executive director of the Association of California Hospitals and the Association of Western Hospitals. Later he was director of the AHA's Washington Service Bureau. In the late 1930s, however, he was the assistant director of the hospital service plan (Blue Cross) of Southern California.

BUGBEE:[7]

The connection between hospitals and Blue Cross has always been hand in glove.

Every so often I read that hospitals supported Blue Cross because it was a time of the Great Depression and people couldn't pay their bills. Well, I always thought that that was nonsense. Blue Cross went so slowly at first that it paid few bills in the depression.

I prefer a much more altruisitc description of the reason. I think in some degree it's true. In fact, for the people who went through it, I think it is true. They thought people ought to have protection against high-cost bills.

I think there was a great deal done to help Blue Cross get off the ground. Blue Cross needed hospital support. Hospitals were told it was a good thing by their leadership, over and over again.

The Blue Cross pioneers made a special point of being hand in glove with hospital leadership.

WILLIAMSON:[8]

I was appointed as the assistant director of the Blue Cross plan.

The experience was important to me because I went to every hospital in Southern

California and met with their boards to sell them on the idea of joining Blue Cross. It was great experience, and it was a great test of whether I could put across ideas. These boards had to be willing to put up a kitty of $8.00 a bed and sign a contract that would make them responsible for guaranteeing services to the Blue Cross subscribers. Blue Cross was nothing but an idea with some hope and a lot of risk for hospitals.

The importance, in terms of their ongoing relationship, of hospitals' sharing the risk with their Blue Cross plan should not be underestimated. This risk sharing was the glue that held the two together, making voluntary hospitals and voluntary payment two sides of the same coin.

Over time, as the risk-sharing contract provisions fell by the wayside, it is understandable that Blue Cross and hospitals should drift apart. This separation becomes most obvious in the demands and expectations by hospitals that Blue Cross pay them at the same rate as any other private payer.

Rorem comments on the separation of the two voluntary movements.

ROREM:[9]

The change was probably inevitable as each side, Blue Cross and hospitals, organizationally and economically matured.

In my opinion the most important thing that happened in the relationships of the Blue Cross Association and the Blue Cross plans to the providers–hospitals and doctors–was the separation of BCA from AHA. I think it was long overdue.

The separation was a healthy thing. It wasn't a sign of anything bad. It wasn't going from bad to worse. I think they [AHA and BCAII were just recognizing human nature and the practice of medicine as it both was and was likely to continue.

It is unreal to assume that over the long run a buyer and a seller can act as partners in a capitalistic society.

SIGMOND:[10]

It was necessary for them [AHA and BCA] to separate, but I think it was poorly handled.

The concept was, let's separate so that we can have a more effective working relationship. Let's separate so that we can pursue our common goals and objectives better. I say it was poorly handled, partly because the separation occurred just before the death

of Edwin Crosby, executive director of the AHA.

As a result, I think the emphasis became, let's separate because we're too close. The positive aspects of it were never gotten at. The original documents, which were worked out between Ed Crosby and Walt McNerney, president of the Blue Cross Association, were interpreted as reflecting AHA and BCA moving away from each other, towards an adversary relationship. That was not the intention. However, that point was not communicated effectively, either among hospitals and Blue Cross plans or within the AHA.

MANNIX:[11]

There always were several plans that were not comfortable under the banner of the American Hospital Association. I always felt that their concerns were not justified and took a stand for a very strong AHA relationship. I felt that the plans were offering hospital services to the public on a monthly payment basis, and the success of this type of program necessitated cooperation between the plans and the hospitals.

In the very early 1940s, a group of plan leaders were interested in complete separation from the AHA. That resulted in a weekend meeting in about 1941 at the headquarters of the AHA. Nearly all the plan executives were present, along with a large representation from the AHA. The result of this meeting was a decision on the part of plans to continue under the aegis of the American Hospital Association, and probably a stronger interest than ever on the part of the AHA in prepayment for hospital care.

However, there continued among plan executives an interest in having their own separate organization and in having more autonomy. Actually, in my opinion the individual plans were separate corporations and had complete autonomy. The American Hospital Association activity was primarily strong support of the plans without any dictation about their operation.

Further discussions resulted in the establishment of a new type of AHA membership, called type IV. Types I, II, and III were institutional and personal memberships. Type IV membership was for Blue Cross plans.

Concern again flared up in the late 1960s and early 1970s regarding the AHA-Blue Cross relationship. This resulted in the establishment of the Blue Cross Association as a separate corporation: i.e., elimination of the interlocking board with AHA. This was promoted on the basis of a partnership between the Blue Cross Association and the American Hospital Association. Even though the term "partnership" was continually used, it meant further separation of the plans from the AHA, although the Blue Cross Association continued to occupy space in the AHA headquarters building until 1980, when BCA acquired separate building space.[12]

I always felt the Blue Cross program of financing hospital care would be much more

effective with a strong AHA relationship. While my background was in the hospital field, I do not think this had anything to do with the way I felt.

A corollary to this is that I have always felt that the American Medical Association would have been wise to maintain a strong relationship with the Blue Shield plans. At one time the headquarters of the Blue Shield plans was in the AMA building.

In the last few years people have raised antitrust questions in connection with this relationship, but I have always believed that a maximum degree of cooperation between Blue Cross and Blue Shield, on one hand, and hospitals and the medical profession, on the other, was in the public interest. I agree that there could be certain dangers in this, but after watching the development of Blue Cross and Blue Shield for 50 years I think these programs have been operating in the public interest, and the record shows that.

HAGUE:[13]

I thought Blue Cross divorced itself from the AHA because people were complaining about the appearances of Blue Cross and hospitals being in each other's back pockets. I didn't think they were. There was enough evidence to indicate that they weren't. It seemed to me that the combination of a very close working relationship between the purse and the provider was very good for the patient. I don't think any one of the insurance commissioners or politicians has ever proven any evil results.

Anyone who believes in the voluntary aspects of society could not say anything but that the relationship between hospitals and Blue Cross contributed significantly to the success of the Blue Cross movement and its benefits to the American people. I don't think that's a very arguable point of view. If this were the result, and I believe it was, then before you divorce yourself, before you sunder that relationship, it seems to me you have to show some malignancy, some malevolence. I have never been persuaded that any such showing was ever made.

In spite of the differences of opinion about the Blue Cross-AHA relationship, it is important to recognize that hospitals had a major role in both founding many Blue Cross plans and in maintaining the early fiscal solvency of those plans. Many early Blue Cross-hospital contracts contained provisions requiring that the participating hospitals share in plan losses and/or guarantee the provision of services to plan subscribers. The importance, in terms of their ongoing relationship, of hospitals' sharing risk with plans should not be underemphasized.

Over time, as these contract provisions have been eliminated, it is also understandable that hospitals and plans, from a business perspective, would drift apart. This drift becomes more obvious in the demands–expectations by hospitals that Blue Cross pay

them at the same rate as other private payers do.

Moving On

Rorem stayed with the Blue Cross Plan Commission until 1947. During his tenure tremendous accomplishments were achieved (Appendix K), yet, when the group hospitalization movement was about to reap the benefits of his pioneering work, he moved on to another position outside of Blue Cross. Rorem comments on his leaving.

ROREM:[14]

In January of 1947 I resigned from the Blue Cross Plan Commission to accept the job of executive director of the Hospital Council of Greater Philadelphia.

Possibly I haven't explained well enough why I decided at that point in time to leave.

The first reason was to stop traveling a hundred nights a year all over the United States. The second was that I had an offer of a job which sounded interesting. The offer came from a place that would allow me to work in one neighborhood and sleep in my own bed every night. Also, I felt the battle for health insurance was over. It was just a question of when it was going to come, and in what form, and how broadly it would be expanded. The concept, the principle was not debatable any more.

There was still much work to be done in the coordination of care: in planning for hospitals, in group practice of medicine, and in the development of ambulatory care throughout the communities–now called primary care. In working along those lines, I thought the new job would be more interesting.

So, I left. I left essentially to take on what I felt would be a new and exciting challenge. A challenge as exciting as the one I had taken on in 1936.

To help complete a picture of Rorem, the following anecdotes are provided by two of his former staff members, Maurice Norby and Robert Sigmond. Norby worked with Rorem in the 1930s and 1940s. Sigmond worked with him in Philadelphia in the 1940s.

NORBY:[15]

Rufus once brought me a manuscript of a speech he was to make some place soon and asked me to edit it for him. I read it and thought this was just fine, just great. I may have taken out a word or two, not more than ten from this whole 20-minute speech. I brought it back to him.

I still remember. He said, "I wanted you to edit it."

I said, "I did. It's great. It is just fine."

"Oh, OK."

He took it and went through the whole thing again. I finally saw the secretary typing it again. I could hardly find the original words in it.

In a week or so I had to make a speech some place. So I had my speech typed up. I thought out of courtesy I would give it to Rufus.

I said, "How about editing mine for me?"

It came back just black. I read it and it did sound a lot better.

I went back in to Rufus' office and said, "I think I had better leave."

He said, "What's the matter?"

I said, "Obviously I can't meet the quality of work that you are used to and that you demand."

He said, "What's the matter?"

I said, "The speech I gave you."

He said, "You had some good ideas in there."

"But," I said, "they are lost."

"No, no. Every idea is there. All I did was change the words around."

That's the kind of fellow he was. He didn't mean to hurt you at all.

* * *

As time went on, there was a lot of nitpicking among the Blue Cross plans. There was infighting to become members of the Blue Cross Commission. It was done by election of the peers. There was a lot of twisting and struggling. Rufus didn't care for that, but he was forced into managing it. He wasn't too good a political manager. He was direct. He said exactly what he meant and wanted to say. I think he finally decided that life was too short to fight political situations.

SIGMOND:[16]

I went to work for Rufus at the Hospital Council of Philadelphia. Rufus had just left the Blue Cross Plan Commission. He decided that that job had gotten beyond the promotional stage, it was a management job. He wanted to work at the community level and he thought the Philadelphia position would be a good opportunity.

Rufus has been the single strongest influence in the health field on my life–still is. I talk to him at least twice a week, and I think I probably have all my life from the time I went to work for him. If you're interested in some anecdotes, I could probably give you an hour or two.

Matter of fact, just yesterday I was talking to him and he says, "You know, when it comes to this HMO idea it looks like all these folks are rediscovering the wheel." He said, "You know, if they lost it, there's nothing wrong with them rediscovering it." That's kind of a typical Roremism.

* * *

I think that I've come to appreciate the impact that Rufus had on me in those early days more as I've thought about it. I mean, it wasn't something I was glorying in, I was just doing my job. As a matter of fact, I'll never forget an event that happened the second or third week I was working for him. Some issue had come up: the organization was very new and they were forming a retirement plan. As it was getting developed, it looked like the secretaries were going to be left out. I thought that was wrong. We were having a little staff meeting–there were only four of us–and I spoke up pretty vigorously. Rufus was obviously upset about how aggressive I was being on this point, so a couple of weeks later he called me into his office and he said, "You know, I really want to sit down and talk to you because I was surprised at your behavior in that discussion the other day. I always thought I'd like to have an organization that was a nice, big, happy family. Let's talk about that. It didn't seem to me you were behaving like a member of a happy family."

I said to Rufus, "I don't know very much about your family, but I was behaving just like I do with my happy family. If there's some kind of issue, we're screaming and shouting."

Then he sat back and laughed. "You're right," he said, "you're right. In a Quaker family you don't do things that way."

I said, "Well, in a Jewish family that's the way you do things." We were both agreeing that we ought to be a good, happy family, it's just a whole different cultural background.

Working for Rufus I think gave me maybe three things. First, he gave me appreciation of the potential of the hospital as a community institution. He didn't believe that everything that hospitals did was right, but he gave me a sense of the importance of the organizational form that the hospital represents in American society. Secondly, he gave me a sense of the importance of keeping the financing as close to the management as possible at the community level. And third, he really hooked me on Blue Cross. It's important to recognize that, when Rufus left the Blue Cross Plan Commission, there was no strong leadership at the commission or its successor organization [BCA] until Walt McNerney came along 15 years later.

Immediately after Rufus left the Blue Cross Commission, if there was an individual running one of the plans who wanted to talk to somebody about a basic issue, a basic problem, he had always called Rufus, and so he did. Of course Rufus helped most of those folks not only to get their job, but to get organized.

I would say, in the early days when I went to work for Rufus, he was quite free in giving advice to Blue Cross people–and I mean literally free. He didn't set up a consulting business, and the office was involved with whatever Rufus was doing. So I got involved. In effect, we were running an unofficial, informal Blue Cross Plan Commission.

So I got to know a lot of those Blue Cross folks and their problems. Rufus wasn't doing anything that could be interpreted as undermining the Blue Cross Commission. He just tried to help people.

Notes

(Transcripts of the oral histories cited here are housed in the library of the American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 60611. The Oral History Collection is a joint project of the Hospital Research and Educational Trust and the AHA.)

1. Until his death in December 1984, Sidney Garfield was an administrator of the Total Health Program of the Permanente Medical Group in Oakland, California.

2. See Profiles of Participants, in the center of this book, for biographical information.

3. *C. Rufus Rorem, In the First Person: An Oral History.*

4. *John R. Mannix, In the First Person: An Oral History.* See Profiles of Participants for biographical information.

5. *Rorem, Oral History.*

6. *Rorem, Oral History.*

7. *George Bugbee, In the First Person: An Oral History.* See Profiles of Participants for biographical information.

8. *Kenneth Williamson, In the First Person: An Oral History.* See Profiles of Participants for biographical information.

9. *Rorem, Oral History.*

10. *Robert M. Sigmond, In the First Person:* An Oral History. See Profiles of Participants for biographical information.

11. *Mannix, Oral History.*

12. Robert M. Sigmond, on this point, mentioned that the BCA was originally set up by some of the plans in New York City to help in national marketing and that it was always separate from AHA and the Blue Cross Commission. The Blue Cross Commission and the AHA merged in 1961, when McNerney became president of the Blue Cross Association.

13. *James E. Hague, In the First Person: An Oral History.* See Profiles of Participants for biographical information.

14. *Rorem, Oral History.*

15. *Maurice J. Norby, In the First Person: An Oral History.* See Profiles of Participants for biographical information about Mr. Norby.

16. *Sigmond, Oral History.*