

HOSPITAL
ADMINISTRATION
ORAL HISTORY
COLLECTION

Lewis E. Weeks Series

David W. Stewart

DAVID W. STEWART

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
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David W. Stewart

CHRONOLOGY

- 1920 Born in New York City, March 2
- 1941 University of Rochester, B.A.
- 1941-1949 L. Bamberger & Co.
- 1942-1946 United States Army
- 1949-1955 Blue Cross of the Rochester Area, Public Relations, Personnel,
Office Manager, Assistant to the Managing Director
- 1955-1976 Blue Cross of the Rochester Area, Managing Director (CEO)
- 1975 Genesee Valley Group Health Association (HMO)
Executive Director
- 1976-1984 Blue Cross of the Rochester Area, President (CEO)
- 1984-1985 Blue Cross and Blue Shield of the Rochester Area,
Chairman (CEO)

MEMBERSHIPS & AFFILIATIONS

Administrative Management Society, Member

American Health Planning Association, Member of the Board and
Current President

American Hospital Association Council on Finance, Member

American Hospital Association Special Committee on Comprehensive
Delivery Systems, Member

Beta Phi Foundation, Treasurer

Blue Cross Association, Member of the Board

Blue Cross Association/Blue Shield Association National Cost Containment
Committee, Member

Blue Cross Commission, Member of the Board

Blue Cross and Blue Shield Association, Member of the Board

Citizens' Planning Committee of Monroe County, Member of the Board

Columbia University, Lecturer in Public Health and Preventive Medicine

Community Planning Committee for Nursing, Member

Comprehensive Health Planning Council, Member of the Board

Council of Social Agencies, Executive Committee

Finger Lakes Health Systems Agency, Member of Board, Executive Committee

First Presbyterian Church, Pittsford, NY, Trustee

Genesee Region Health Planning Council, Member

Genesee Region Home Care Association, Member of Board, Past President

Government Research Corporation, Advisor

GYRO International, Rochester Chapter, Member, Past President

Health Computer Center, Member of Board, Past Chairman

MEMBERSHIPS and AFFILIATIONS (Continued)

Home Care Association of New York State, Member of Board, Executive Committee

New York State Business Council, Member of Health Committee

New York State Coalition on Malpractice, Member

New York State Conference on Blue Cross and Blue Shield Plans, Past President

New York State Homemaker - Home Health Aide Association, Past President

New York State Public Health Association, Member, Current President of
the Rochester Area

Patient Care Planning Council, Inc., Member of the Board

Pittsford Central School, Citizens' Committee, Member

Rochester Memorial Art Gallery Finance Committee, Member

Rochester Neighborhood Health Centers, Member of the Board

Rochester Regional Hospital Association, Member of the Board

Rochester Regional Medical Program, Member of the Board

Rochester, University of, Medical School, Clinical Associate

Rochester, University of, Men's Alumni Association, Past President

Rotary Club of Pittsford, Past President

United Community Chest of Greater Rochester, Member of Board, Past Chairman

United Fund Review Committee for New Agencies, Member

Visiting Nurse Service of Rochester and Monroe County, Member of the Board

ROCHESTER BLUE CROSS INNOVATIONS: NATIONAL FIRSTS

Blue Cross linked with community facility planning, 1955

Blue Cross stand against further hospital bed expansion, 1956

Hospital outpatient surgical benefits, 1959

Pre-admission testing covered, 1958

Physician-run Hospital Utilization Committee established, 1959

Hospital-level areawide home care corporation established, 1960

Diagnostic inpatient admissions covered, 1960

Hemophilia blood and ambulatory care covered, 1961

Hospital relations team of nurses established, 1962

Psychiatric benefits made equal to other inpatient benefits, 1963

Complex diagnostic tests covered on outpatient basis, 1965

Basic contract benefits made available in chronic, rehabilitative, and
state mental hospitals, 1966

Rochester Blue Cross the catalyst for creating three HMOs, 1970-1973

Highest Medicare Part A productivity in the nation, 1974

Selected by DHEW and the Blue Cross Association as the site for a major
test of the ability of the private sector to establish a new system of
hospital reimbursement, linked with planning, and providing incentives
for economy, 1977

One day maternity program with home care, 1977

Areawide Home Hospice program created, 1978

Credit card concept created for comprehensive contracts, 1982

HMO/IPA organized and opened with 48,000 members, January 1985

AWARDS and HONORS

American Hospital Association

Justin Ford Kimball Award for Achievement, 1985

Folsom Family

Award for Innovation

Genesee Region Home Care Association

Distinguished Service Award

National Hemophilia Foundation

Pioneer Award

New York State Home Care Association

Ruth F. Wilson Award

New York State Public Health Association

Goler Award

Rochester Hemophilia Center

Innovation Award

University of Rochester

Hutchison Medal for Distinguished Public Service

WEEKS:

In my notes I have the fact that you were born in New York City in 1920 and that you are a graduate of the University of Rochester in 1941. Your first job was at Bambergers? Are they a retail establishment?

STEWART:

They are. They are a wholly owned subsidiary of R.H. Macy. I originally was hired out of college as a member of what they called the Macy training squad. They used to hire 25 men and 25 women from the northeastern colleges. Rochester and Buffalo was about as far west as they went. They would then take 14 and put them in Bambergers. I was one of those.

WEEKS:

Did you rotate in different departments?

STEWART:

They had a nationally famous training program created in 1937 which was highly competitive for entrance and continuation. They had a rotation system interspersed with classes, discussion groups, and that sort of thing. It was really unusual for its time.

WEEKS:

The reasons I ask these questions: I was working for a discount department store in Detroit at the time of World War II. I remember going to New York and going to Macy's and talking with people in training. I was amazed at how, for instance, in the prescription department, the man who was managing that had come there from the luggage department or some other unrelated place, on a rotation.

STEWART:

That's right. The Macy concept was that management skills were

transferable, that you did not have to have a deep knowledge of the particular merchandise with which you were involved.

WEEKS:

This is what they told us. At the time it seemed strange. Being in retailing I thought you had to know your particular department real well.

Your Bamberger experience was then interrupted by the World War II.

STEWART:

Yes. I was in the army four years. The army eventually sent me to the Yale Chinese language school after which I served under General Stilwell during the creation of the Chinese new First Army in India. Following a successful campaign in Burma we went on into China over the Burma Road.

WEEKS:

That must have been quite an experience.

STEWART:

It was fascinating.

WEEKS:

Did you pick up some fluency in Chinese?

STEWART:

Yes. I went to the army language program at Yale which had an accelerated program in conversational Chinese.

WEEKS:

There are so many dialects.

STEWART:

There are four or five primary dialects that most Chinese speak. We were taught the Peking dialect. It's very close to the new common dialect. Chinese writing is the same regardless of dialect, because of its pictographic

nature so if you can write and read you can communicate regardless of dialect.

WEEKS:

You returned to Bambergers for three years after the war? How did you decide to leave Bambergers?

STEWART:

I decided to leave Bambergers because I was unhappy in a detailed personnel job without any interesting prospects and they urged me to go elsewhere.

I had a young family with two children. We lived out in New Jersey. I was leaving home at 7:15 and I was returning at 7:30 at night. They say experience is what you get when you don't get what you wanted. Subsequently I contacted everyone I knew primarily in Rochester where my wife and I had gone to college and where my wife had relatives, and in Niagara Falls, which was my parents' home. I ended up with an offer of a job at the Rochester Blue Cross Plan. It is ironical because the job opening was created by the resignation of Bill Sandow who eventually returned to Blue Cross and went on to become head of the South Carolina Plans in 1955. If he hadn't quit, I probably would have gone on to another career some place else. Fortunately, my wife's aunt was a faculty widow with a wide circle of influential friends, one of whom was involved with the selection process for the Blue Cross job.

I was hired as supervisor of personnel and public relations by the president of the board of directors. Back then almost all the Blue Plans were very small and nobody would ever conceive of a grandiose title like president being associated with a Blue Cross or Blue Shield Plan. The highest title to which you could aspire was managing director. In the '60s we still had a lot of Blue Shield Plans whose CEOs were still executive secretaries, holdovers

from the structures of county medical societies.

My boss, who was Sherman D. Meech, was the head of both Blue Cross and Blue Shield which had started in 1935 and 1947. All the upstate Plans had followed similar patterns of Blue Cross founding and operating Blue Shield Plans.

Rochester Blue Cross was started by Dr. Nathaniel Faxon, who at the time was administrator of Strong Memorial Hospital. I believe he was an AHA president in the '30s. On the month the Plan opened for business in June of 1935, Dr. Faxon became the administrator of Mass General, where he stayed until he retired to his home in West Falmouth on Cape Cod. Dr. Basil MacLean was appointed to succeed Dr. Faxon. Dr. MacLean had a very strong, outgoing personality that did not tolerate fools pleasantly. He had a tongue like a bull whip. He never drew his university pay, but he made a handsome living doing consulting.

By 1949 Mr. Meech's health had been failing. Members of the board of directors clearly were interested in bringing in new blood. I was employed when I was 28. That was young blood, young and new.

WEEKS:

What was the Plan like when you came there -- in size and so on?

STEWART:

We had 105 employees and about two hundred thousand members. We were the second largest Plan upstate. It is hard to remember the premium income. It was almost four million dollars -- less than one-hundredth of today.

The Blue Shield Plan had just been started two years before. It was one of these strange things. Blue Shield Plan in Rochester was a surgical Plan only. It had a fee schedule that was graded from \$1 to \$100. A \$100 benefit

was for a craniotomy; \$1 was for some kind of suture in some not very significant site. You look back on it and you marvel that we were able to sell the program at all.

The whole history of health care in Rochester from the 1930s on is an account of the interweaving of the communities' highly organized and participatory power structure. The primary conductor of this symphony was Marion Folsom at Eastman Kodak. Folsom had extraordinary influence with George Eastman. Interestingly, Folsom was the first academician Eastman ever employed.

WEEKS:

I didn't realize he taught.

STEWART:

Folsom was a member of the graduate school of business at MIT. You may remember that Eastman gave some extraordinary beneficences to MIT. On one of his many visits down there he decided he would try one of these college types, for which he had no particular admiration in the business sense. He certainly admired academicians in research but the translation of an academician into the business community was very far from George Eastman's concept of a career ladder.

At any rate, he employed this quiet, prescient man from Georgia, who to the end of his days talked like he had a mouthful of hot potatoes.

WEEKS:

Is that right? I never met him.

STEWART:

When he became tired or excited, it became so thick that, if you hadn't heard it over a long period of time, you would have real trouble making out

what he was saying. I have gone to talks that Folsom gave and, inevitably people next to me would say, "What did he say?" They couldn't hear a consonant from beginning to end.

WEEKS:

He must have had the ear of Mr. Eastman.

STEWART:

He turned out to be a marvelous pick. He brought humanism to Eastman Kodak. his achievements deserve a book. To my understanding he created an unemployment insurance fund in Rochester business and industry in the early thirties before this was ever heard of as a government activity. He was responsible for setting up a whole set of rules that Rochester business and industry followed during the Depression which in this day and age sounds like they were issued by a suspicious dictator or a marine colonel.

For example, in the early '30s if one member of a family had a job, Rochester industry would not give a job to a second member of the family. Because in the depth of the Depression's grip things were so hard and so difficult, they took the posture that this was not time for anybody to be affluent. It was a time for survival, and it worked.

As I said, it created a whole series of rules, one of which was that the major industrial firms would not advertise for help in the paper. They created their own job agency. They did this in order to prevent raiding between each other. If one of them expanded the work force, Bausch & Lomb didn't want to steal people from Kodak or the steel company, or Garlock's or Todd or whoever. Of course, they wanted to keep the skilled people. Even today, for example, if you buy a Rochester paper you will never see in there any advertising of any jobs with the major industries.

WEEKS:

Even for special skills?

STEWART:

Even today.

WEEKS:

Was this an expression of George Eastman? Was he a rugged individualist?

STEWART:

George Eastman was. All of those marvelously successful men were.

WEEKS:

I suppose a lot of camera companies sprang up in the Rochester area on the coat-tails of Eastman, is that right?

STEWART:

There is only one camera company that survived in the Rochester area. There were two kinds of cameras. You either had a Kodak or you had a Graflex. As I recall, Graflex started in Rochester and was split off from Kodak because of a lawsuit.

WEEKS:

That was the old newspaperman's camera.

STEWART:

Right.

Back to Eastman and Folsom.

One of the things few people realize is that Eastman was never president of Eastman Kodak Company. Somebody else was always president. He was treasurer. Folsom succeeded Eastman as treasurer after Eastman's suicide.

WEEKS:

The moneybags are where the power is.

STEWART:

Right. That gives you a feeling of the presence of Marion Folsom at the highest level of Eastman Kodak and of his extraordinary effectiveness. Anyway, Folsom was one of the original architects of the Social Security Act. He became deeply interested in community organizations in the early thirties.

Appearing at the University of Rochester in the early thirties was a young, brilliant, energetic professor by the name of Luther Fry who was made the head of the then tiny department of sociology.

Also, Fry was sort of a galvanizer of community action. He focused the primary efforts of the department of sociology on practical sociology of community organizations. Fry was adopted and sponsored by Marion Folsom. Out of this was generated a whole series of other studies. We had Yalies and Harvards in to study the organization of health care. Even today those books make interesting reading: the way health care is organized, the use of health care, the organization of the hospital system. All of these things are all laid out in the studies that were done essentially from about a period from 1935 to 1939. That formed the foundation for the difference in Rochester's health care system.

Folsom and Fry and these studies made the basic assumption that this was a community health care system and they had to treat it as a system.

If you were to look for the one distinguishing characteristic that separates Rochester from all the other metropolitan areas of the nation, it's that. They treated it as a system and while this was imperfectly observed over the decades, it largely meant that no single hospital received a plethora of blessings at the expense of others. I can remember people from Ohio coming to Rochester to find out how we obtained both economy and high quality in

hospital care. We made the point that you have to treat the hospitals as a system. One of those executives said, "Well, we couldn't do that because our chairman is the chairman of the board of so-and-so hospital and he believes it is his duty to God to favor that hospital above all others."

We have never had that extreme partisanship within industry in the community. Our community's industrial trade association currently has a rule which forbids any broad, public solicitation in the community for any one hospital. This rule is in place today, and it works. The stance of industry has been that if we are going to have a public solicitation for a massive gathering of funds, it is going to be for all of the hospitals. They will all participate together, and they will all share in the fund drive as determined by the health planning organization.

WEEKS:

You have a regional hospital association, don't you?

STEWART:

Yes, and a very fine one. Of course, all of these things have gone through various deaths and rebirths. Back in the old days of the thirties, we had a version of a hospital council. As a result of the studies we discussed, there came recommendations for a stronger entity. By the middle forties, the Rochester Hospital Council had received significant grant funds from the Commonwealth Foundation and had been made a model for the nation by Dr. Lembcke.

WEEKS:

Who sold the providers on the idea that it was best to cooperate?

STEWART:

The structured decisions made between 1940 and 1970 were largely

orchestrated by Folsom. There was absolutely no one in that community that was about to argue with him.

WEEKS:

They follow the leader.

STEWART:

As Marion Folsom was organizing on the social and health side of the community, George Eastman was also organizing the industrial side of the community into a league of industrialists to keep out unions and to keep everything going the way they said.

WEEKS:

Sounds like Henry Ford.

STEWART:

Eastman organized the community to the point where every major manufacturer joined his Industrial Management Council then stuck by the decisions involving many community facets. Everyone doesn't understand how different things were.

WEEKS:

That's right. Everyone doesn't have that perspective.

Without their blessing Blue Cross would not have been possible?

STEWART:

It would have had the modest level of growth that it had in other communities. But from day one, Rochester Blue Cross was supported by the university, including its powerful board of trustees, and by business and industry at large. The boom never stopped. At the end of its second year, Rochester Blue Cross was the second largest plan in the nation. We were bigger than New York City Plan which started two or three months ahead of us.

As one senior hospital trustee told me, "Dave, back in the early thirties in our hospital (about 150 beds at the time) they used to pass around the position of treasurer. The fellow who was treasurer that year wrote a check for the hospital's deficit. As the thirties rolled on the deficits started to grow. It wasn't as if all of these people were impoverished, but they thought they were, and they didn't want to do that anymore."

When this idea of Blue Cross came along -- remember this isn't all Christian charity and beneficence that caused the sweep into Blue Cross -- they realized this as a chance to get out from under of personally financing deficits while strengthening their hospital and improving access on the part of workers.

They simply took a dollar and a half a month out of all of their employees' pockets. It turned out to be a great scheme they all supported and they made sure their employees were encouraged to "volunteer."

WEEKS:

This brings up a point. At that time the employee paid the premium.

STEWART:

Lew, there wasn't any employer contribution towards the premium as far as I know anywhere in the nation until World War II -- seven years later.

WEEKS:

I have heard from some of the persons I have interviewed that the unions were not in favor of the employer paying anything. In the beginning.

STEWART:

I don't know. I didn't arrive on the scene until '49.

WEEKS:

The attitude of the UAW here has usually been they don't want the

employer to pay anything voluntarily. They want to take it away from him through union negotiations.

STEWART:

I do know what Walter Reuther did for Blue Cross when he took that case to the U.S. Supreme Court. It put fringe benefits outside the wage freeze. That blew Blue Cross and Blue Shield enrollment into the stratosphere.

WEEKS:

I want to ask you: Were there community ratings in those days?

STEWART:

There wasn't anything but community ratings. The first great breach in the wall of community ratings was created by the state and federal government insisting on experience rating for their employees. For example, in the state of New York, with a very high penetration of Blue Cross enrollment the word "experience" was never even mentioned until the state said we don't want a community rate, we want a special rate of our own. That was the beginning. General Motors was the first industry to follow suit. This was in the 1950s.

WEEKS:

Was the rating lower than the community rating?

STEWART:

The way it worked out for the state employees under experience rating was that the premium for the people in Albany and the New York City area was down; and the premium for everybody of Albany went way up. New York was above average in cost but Albany was a very, very high cost area. West of Albany you had, and still have, a remarkably low cost health care system. As a matter of fact, health insurance premiums for groups in New York City are way below most all other huge cities. Even today, people become badly confused by

comparing the cost of New York's Medicaid with that of other states. Medicaid is one thing -- and it is totally different from the level of health insurance premiums for employees.

WEEKS:

You were talking about the fund raising.

STEWART:

Fund raising and so forth?

We can go back to that. I said that one of the primary distinguishing characteristics of Rochester was this decision by industry, led by Folsom, for a system of care and not by individual hospitals. That evolved into no independent fund drives by independent hospitals. That had a big effect, Lew.

WEEKS:

A pretty stable community.

STEWART:

A stable community and no branch offices. It was almost entirely home owned and operated, including Kodak.

When the bosses went home at night they went to their homes in Rochester. They didn't hop on a train and go to Stamford, Connecticut or some place an hour and a half away. They hopped in their car and drove 10 minutes to their house. This still existed in the forties and fifties. (And their employees didn't go to some other health area at night.)

Rochester was fortunate enough to have the leadership that took advantage of that to organize the community's cultural and health establishment. Some other communities may have focused in different directions. Rochester's focus included a remarkable emphasis on the health care side. We had this combination of strength with the philosophical direction being provided by

Folsom, who was the great guru of the philosophy of community organization.

WEEKS:

Two things I was thinking about when you talked about the community getting together on a fund drive and working as a system. One, I would assume there is some planning study behind this. Let's assume that someone thinks there is a need for a new facility here or there.

STEWART:

The original planning foundation for health care was built in the 1930s with the focusing of the University of Rochester's sociology group on the city, and Folsom's interest in embracing of this. That established an ongoing planning mechanism that was called the Health Committee of the Council of Social Agencies. It was part of a highly organized Community Chest which embraced all the social agencies. I suppose one of the reasons for the health focus was that about half of all Chest money went to the hospitals, and industry was deeply committed to the Chest dollars going into health and that focused interest on doing it better -- so it all happened.

Although I appeared on the scene in 1949, I didn't become involved in community health affairs until 1952-53 when I was appointed to some committees of the nursing council and the hospital council headed up by Charlie Royale. It was then I found out about those health planning people sitting over there in the Council of Social Agencies. They were not only great brains, but were dedicated to a path of control and change I easily embraced. They knew more about health care than I did and they became my teachers. The incumbent who developed health planning to a highly sophisticated, and eventually large, operation was Walter Wenkert. His number one cohort and expert in studies was John Hill. Wenkert, hired through Folsom, was brought from New Haven where he

was head of the TB Association.

This began the intertwining of Blue Cross with health planning. While the staff only consisted of a total of three people, they were Folsom's, and so their influence was in inverse proportion to their size. Folsom was also a strong advocate of the hospital council. He always wanted everything handled as a community enterprise. He wanted all these providers to be talking together.

We go backwards again in time into the early 1950s and the world of Blue Shield. We were sitting there with a Blue Shield Plan with a \$100 surgical fee schedule -- a not unusual situation around the country. Blue Shield had a very low enrollment compared to Blue Cross enrollment because very few employees wanted this low benefit, nor were employers interested. By 1951 we had about 70,000 members in Blue Shield. Blue Cross was already more than 300,000 and leaping upward. Blue Shield was creeping upward.

Folsom said he would not permit Blue Shield into Eastman Kodak (remember, no corporate contributions as yet) until they made available a paid-in-full contract which guaranteed payment in full for the surgical bills of the average Kodak employee making \$5,000 a year. Fortunately, we had a flexible medical society leadership who persuaded its surgeons and orthopedists to develop the first "service" contract in the East (the California relative value schedule was first). Besides Folsom was so strong and the potential reward so great they didn't have the heart for the war that broke out in other areas of the country on this issue of relativity. The medical society as a society has always had leadership that in most concepts was relatively advanced although later on they certainly agreed with the AMA that group practice programs were communistic plots created to undermine the fabric of American society.

In the face of Kodak insistence on the paid-in-full program, they set up committees and worked hard with Blue Shield for a two-year period. By 1953 or so they came up with a list of service benefits paid in full for surgery if you had single or family income of \$5000 or less.

When that came out, Folsom gave it his blessing. He participated as Blue Shield's only non-physician board member. The response was so overwhelming we couldn't handle the enrollment. Some people had to wait up to a year to get into Blue Shield.

An interesting sidelight of that gold rush was that employees knew that Blue Shield would be available with big new benefits so they saved up their elective surgery. With huge enrollment we had a run on benefits and Blue Shield ran below the legal level of reserves. The insurance department came in and threatened to close us down unless we got more reserves. A Rochester industrialist, George Todd, stepped in and signed a personal note to Blue Shield for about \$300,000 with no provision for interest or repayment. That boosted our reserves to the required amount. We paid him back within six months, but it gives you an idea of our support.

This is another example of pushing the providers ahead of themselves in time. Blue Shield was a singularly ineffective mechanism on its own. No power to change because its board was composed of physicians who didn't want to rock the boat. This was -- and still is -- the curse of Blue Shield.

Doctors still consider all the money in Blue Shield coffers as theirs. I always regard it as the community's pot to pay for physicians' care. There is a big difference in how you are going to use that money, depending upon which of those views you use.

Rochester then became the first place in the United States to convert its

entire Blue Shield membership to a paid-in-full plan. Every single time the premium went up the service benefit was moved up proportionately. So the \$5000 went to \$5500 and to \$6000, and so forth. Today \$5000 is close to \$35,000. Guaranteed and paid-in-full just like it was in 1953.

However, Lew, as the supply of doctors has increased so fast that some physicians are not making all of the money that they feel they are entitled to, they have started charging above the schedule for over income members or a la carting their care. Up until 1985, 88% of the physicians' services covered by the program were paid-in-full regardless of income. If you are a vice president of Kodak and you have a coronary bypass done at the university teaching hospital, Strong Memorial Hospital, next week, Lew, and you have Blue Shield, you will not have to pay a cent for that operation.

WEEKS:

That's marvelous.

STEWART:

It still exists today.

WEEKS:

When you were talking about the community health system and the hospitals working together...

STEWART:

Mind you, a lot of these people are dragged into this kicking and screaming.

What Folsom wanted was for the hospitals to be drawn closer together and to have an ever increasing number of what you could call common bases. He always was trying to get the hospitals' financial statements to be comparable. He never achieved it. Nevertheless, under his urging the hospital council

became a formidable operation. As time went on they obtained the franchise, for the administration of Hill-Burton funds. They competed with and beat the health planners in this. I think this was because hospital councils had more political clout at the federal level -- and they still do. Certainly the hospitals had a lot more confidence in their own mechanisms for administering Hill-Burton than they did in a bunch of strangers who might not be so generous. So, the hospital council administered Hill-Burton which, to a certain degree was a parceling out procedure, with everyone lined up in order of clout.

WEEKS:

If the community could come up with the rest of it...

STEWART:

The last great community-wide effort in capital fund raising occurred in about 1960. One or two of the hospitals came in to the Community Chest -- we have a community process so if some Chest supported organization wants to have a public fund drive they have to request and obtain permission from the Chest. One or two hospitals came in requesting big sums of money. That was instantly followed by the others. So each hospital put on a full court press to get their request put first -- so there were some \$25 million requested for multiple fund drives.

About this time Marion Folsom was returning from his tour as Secretary of HEW under Eisenhower. Some shrewd persons in the community must have said that this was a can of snakes and that they would give it to Folsom because he was just back and "He does that health stuff."

Before long he was asked to take the chairmanship of this whole mess.

Folsom agreed but stipulated that first there must be a determination of

need and appropriateness by a committee which he would establish.

Who is going to say no to that? It turned out that Marion Folsom's idea of need and the hospitals' idea of need had considerable differences. Folsom had come back from his tour as Secretary of HEW absolutely rock hard convinced that expanding the hospital system did not improve the accessibility, the cost, or the quality of care. In the fifties and sixties and seventies what the hospitals wanted was more beds, and more beds, and more beds. Folsom now was the community czar of the hospitals, sitting there in charge of the whole thing and he said, "No." Not only that but he felt they should merge at least two of the existing hospitals.

It was not by sheer coincidence that the community committee that Folsom appointed studied the issues and came to the same conclusions. Not only that but they put a cap on the total dollars to be raised, and allocated that sum among the individual facilities.

In 1961 we ran a community-wide fund drive for \$13.5 million. It was oversubscribed. Well, \$13.5 million in 1961 would translate into what now?

WEEKS:

Probably fifty.

STEWART:

This was the real beginning of modern health planning in this country. It was so compellingly logical it was gradually turned into state and federal HSA legislation.

When you added in the Hill-Burton funds which this drive leveraged, we came up with more like \$35 million. The requested multi-hundred beds was held to about 100.

The hospitals Folsom wanted to merge were a small third class hospital to

be merged into our biggest non-university hospital. Folsom forced this merger through the hospital board all the way up to the medical staff of the big hospital. The medical staff at the big hospital voted to take all the medical staff from the small hospital but none of them would have admission privileges. Of course, the merger fell into shreds. Eventually that small hospital was picked up and was transferred west of the city to a rapidly growing suburban area. We had to give them another 90 beds. The hospital system in Rochester expanded by about 200 beds in over the past 25 years. It was pretty good.

WEEKS:

When you were talking about the system, did they ever attempt a common funding of depreciation?

STEWART:

We went through that. In 1960 I had the agreement of the president of the hospital council to pool depreciation funds. When it was taken to the council's executive committee they just blew it to shreds.

Another 1960 event impacted all the Blue Cross Plans in the state. Up until then, Blue Cross was legally limited to paying bills with a hospital letterhead. You recall how Blue Cross is routinely excoriated for "only paying hospital bills" in many academic and legislative halls. It was against the law to do otherwise. This was a product of the control exerted in the state medical society at the time of our founding. At any rate, a New York City Plan executive promised \$10,000 to the lawyer son of a powerful Republican senator to get the law broadened. It was handled in an appropriately inconspicuous manner at the close of the legislative session. In the meantime the Plan president, Garside, had retired. Colman had taken

over and the person responsible -- who hadn't told anyone else -- had left. When payment was called for, there was hell to pay but none to the son. Fortunately the senator was defeated at the next election because he was after anything Blue. But that opened the door for us all into major medical with all its variations and eventually to HMOs.

Meanwhile, back at the ranch, health planning went through several changes. Two things occurred. First, I am sure with Folsom's help and a big effort by Blue Cross, a bill was passed in the New York legislature called the Metcalf-McClosky Act.

Senator Metcalf of Auburn, chairman of the State Senate Health Committee, was a person of remarkable vision. He was also a close friend and great admirer of Marion Folsom. George authored the bill and shepherded it through.

The Metcalf-McClosky Act forced hospitals to go through a locally-based but state-mandated process. We got some state money for the planners and were on the way.

Meanwhile the Hill-Burton process was slowing down and dissatisfaction developed regarding the role of the Rochester Hospital Council. The Executive Director was very bright and very energetic but was subject to wide mood changes, like a manic depressive. He always thought somebody was trying to do him in. In the end, they were. They got rid of him.

While this was going on, the Hill-Burton thing was going down. The role of the hospital council started to diminish. The role of the health planners started to increase. Eventually the hospital council became more of a purchasing association and a branch of the Hospital Association of New York State (HANY) as contrasted to the dominant force in health care organization and management that it occupied in many ways with the hospitals.

Backwards in time: Following Lembcke, the next head of the hospital council was Charlie Royale. He was a very personable, politically skilled and savvy person who kept building the hospital council. Very skillful at that. He eventually became the head of HANY, the Hospital Association of New York State and built that into the powerful mechanism it is today. So the Rochester Hospital Council had, you see, some very strong support and leadership that got it started during and after the war.

In the meantime, health planning was rising from the ground. The planners were strongly supported by Folsom. By 1970 Folsom is retired but everyone still turned to him in health care affairs of the community. The things that he had put in place with the industrial-management council were still being carried on. In the early 1970s the industrial-management council had new leadership in the form of a fellow named Jack Hostutler who is still there. He became a very active member of the Blue Cross board. He was really sold on health planning and the economics it could bring to business. He made sure, if you will, that the industrial-management council supported planning. In other words, the industrial-management council and the health planners and Blue Cross took over the power vacuum of determining direction that was starting to occur as Folsom declined. We had sort of a tripartite made up of the industrial-management council, Blue Cross, and the health planning under Walter Wenkert. Industry had become aware that the cost of health care was something that could be controlled. They also became aware that the premiums they were paying in Rochester were way below anything they were paying in the country for comparable benefits. They liked that. We kept reminding them that the reason for the low cost was that we had control of the system and treated it as a system. By now we had the Metcalf and McClosky Act (1964) and

we also had Medicare and Medicaid, (1966). By 1970 everyone woke up to the fact that the cost of health not only in the nation but in Rochester where the cost had traditionally gone up from 5% to 9% a year, it now was going up at a rate of 15 1/2% every year. By 1965, most of industry was paying everyone's premiums in full including their retirees' and everybody in the community was on a community rate at Rochester Blue Cross. If you belonged to Rochester Blue Cross in 1965, Lew, and you hit 65, absolutely nothing happened to your premiums or benefits. Everything stayed exactly the same.

So, now by the early 1970s we had a business-dominated Blue Cross board. Blue Shield was still the doctors' plan, and separate. When I took over the Blue Cross in 1955, the doctors split Blue Shield away from the single management and made a separate president.

Blue Shield was created because of the stringent limitations placed in the original legislation. Remember the medical societies had what now seems to be incredible political power in the early 1930s. Legislators wouldn't dare do anything in health care legislation without the blessing of the state medical society.

While the medical society was defeated in its opposition to the legislation allowing the construction of Blue Cross, they were able to control the scope of Blue Cross activity.

There is a book that describes the Wisconsin Plan's history which you should be able to get from the Wisconsin Plan. They describe all the incredible emotional reactions of the medical profession to the establishment of both Blue Cross and Blue Shield. The medical society did impact the construction of the New York State legislature by inserting a stipulation that the only thing they could pay was a hospital bill. This stayed in New York

law until 1960-1961 when it was changed through the adventure already described.

You know how Blue Cross, particularly, is a favorite whipping boy of the academicians for most of our cost problems. The reason always given is that the damn Blue Cross plan would pay only hospital bills which forced folks into the hospital for treatment. I still hear it today.

The reason for that heinous act was that it was built into the law in state after state after state. In New York State Blue Cross could not offer major medical, they couldn't offer anything. Couldn't even pay for prescription drugs. Couldn't do anything except to pay for what was on the hospital letterhead, billed by a hospital, until 1960. By that time the die was cast, and we were beyond the point of return. It was too late to reconstruct the whole system. It was not ready for it, not for another 25 years.

So all of us drove onward, building Blue Cross enrollment, expanding benefits, working with everyone we could find to contain hospital expansion. We had a powerful board and they were sold on the concept of control of beds to contain cost. About 1970 business and industry became so concerned about the increase in rate of cost of health care so they formed a Rochester community committee to investigate the cost of health care. After a year of deliberations they recommended that Blue Cross and Blue Shield start HMOs. In 1973 we opened New York State's first federally qualified HMO, plus two others. What a mess.

WEEKS:

How long did you wait to receive regulations?

STEWART:

A full-fledged drawn-out battle with the people in Washington on the federal HMO creation. They didn't want Blue Cross to have control -- we wanted it as a line of business. They wanted to break loose of this "stultifying monopoly." We came to a sort of compromise by doing most of what they wanted. We set up the federal HMO as a separate corporation. Then we started another HMO as a line of business. These days you would call it an IPA, called Health Watch. It had the blessing of the Monroe County Medical Society, who now had said, "If you are going to start these damned things, we want one under our control." So we gave them control of utilization and physician payment.

At the same time I had a close affiliation with an infant network of OEO-financed neighborhood health centers called Rochester Health Network. We helped them at the board level and we made it possible for them to meet the final funding stipulation of HEW which was to put into place a community contract providing comprehensive benefits available to anyone to buy. HEW wanted to have other than the disadvantaged enrolled in the program. What Blue Cross and Blue Shield did was make available a regular HMO contract, a network contract available in all seven sites of these little neighborhood health centers.

We had the medical society supported IPA, a Kaiser mirror image, and the OEO network HMO. By this time we had also persuaded Ernie Seward to move from his position as the original medical director of Kaiser Portland to Rochester and the university where he became Associate Dean of Extramural Affairs at the University of Rochester School of Medicine.

WEEKS:

Under whose influence?

STEWART:

Marion Folsom's, Joe Wilson's and Walter Wenkert's.

WEEKS:

That I would assume.

STEWART:

They happened to be influential on the University of Rochester's Board of Trustees. We have used Saward as our architect and guru ever since. As a matter of fact, Wenkert had brought him to town earlier than that, while he was still at Kaiser, to talk to the medical society about group health so that they would see that a medical director of Kaiser Center did not have long pointed ears, sharp tail, and smell of sulfur.

WEEKS:

Dr. Saward was in Portland 20 or 25 years, wasn't he?

STEWART:

Oh, yes. He created Kaiser Portland from scratch. As a matter of fact, Ernie Saward started more HMOs than any man alive today. People forget he started them in Europe, and in South America. He has been consultant to nations, all over the world.

WEEKS:

The HMO, Genesee...

STEWART:

We started three of them: Genesee Valley Group Health, that was the Kaiser model and New York's first federally qualified HMO. We started all of those. They all opened their doors for enrolled population as of June 1,

1973.

WEEKS:

Were they all capitation plans?

STEWART:

Think of group health as being a Kaiser program with the physicians on salary. All of the care is focused in health centers, except for some specialty referrals. The OEO was salaried, the IPA fee scheduled.

WEEKS:

Genesee is the Kaiser model?

STEWART:

Yes.

WEEKS:

The physicians have a sort of a Permanente arrangement?

STEWART:

Kaiser Permanente physician reimbursements vary all over the block. They go from straight salary to capitation, to profit-sharing. They are all over the place. Ours is salary.

WEEKS:

Yours is salary?

STEWART:

That's what Portland was, and they are still in business.

WEEKS:

What about your hospital services? Do you contract for that?

STEWART:

That goes through the Blue Cross system. Group Health is an entity unto itself. It pays for hospital service under the Blue Cross hospital

reimbursement formula. It is sometimes a point of confusion that HMOs licensed in the State of New York all pay hospitals under the Blue Cross formula which is determined by the Health and Insurance departments of the State of New York. It provides for a discount of about 12% from billings.

WEEKS:

That simplifies the picture then. How about your IPAs?

STEWART:

Keep in mind we never started out to create more than one HMO. Nor did industry intend to support more than one. But the medical society in effect forced us to create a competitive IPA model, and while all of this was boiling up the OEO neighborhood health center program sprang up with big federal dollars.

The IPA called Health Watch was a sort of joint venture, if you will, with the medical society. It went bust two years later. Legally it was a line of business and so it took about three and a half million Blue Cross dollars for the funeral.

What Health Watch demonstrated was that the medical society was, at that time, incapable of controlling their members use of hospitals. This was generally true all across the country. The pattern of medical societies forming IPAs as a knee jerk reaction to a proposed closed panel HMO -- and then failing because of lack of self-control -- was endemic. All the HMOs, back in 1973, attracted what you could call an adverse selection. Among the adverse selections, our medical society IPA attracted the worst. The physicians enrolled the people in their offices. Lew, if you ever start a medical plan don't enroll people in physicians' offices. Enroll the people who aren't in the physicians' offices.

WEEKS:

You already know you have a bad risk.

STEWART:

We ended up with every leukemia, every cancer, every hemophiliac, every heart case. You could just hear the doctors say, "Do I have a plan for you. You have been paying me all this money for all these months, all you have to do is get into this program and you never will have to pay me another cent out of your own pocket." They just didn't understand. They just knew that any program they put in place would beat the closed panel devil.

The plan lasted about two years.

WEEKS:

Were they working on a fee schedule?

STEWART:

We had a marvelously effective fixed fee schedule under Blue Shield -- with service benefits. We used that.

HMOs in Rochester faced a unique obstacle to success, namely the community's low rate of hospitalization resulting from our control of beds. Our days per thousand for the under 65 Blue Cross population was about 550. This compared to Michigan's 950 and Massachusetts' 975. This meant that there was very little water to be squeezed out of the system. HMOs live on that squeeze -- the difference between the regular rate of days versus what they can establish, which is usually 300 days. This difference pays for the extra benefits. In Rochester they could only get about 250 days -- not enough to beat the Blue rates. It was very tough.

RHN, the health center network and Group Health continued on. None of the programs was self-sufficient for a decade. RHN received massive

governmental help -- millions for support. Group Health received Blue Cross and Blue Shield loans. That brought another complication. Blue Shield and Blue Cross treatment of their GVGHA child varied considerably. As it became obvious that Group Health needed loans the Blue Shield board -- make up of physicians active in the failed IPA -- decided they didn't want to loan them any more money. Business and industry wanted Group Health to continue so they voted the Blue Cross loans to be interest free and the Rochester Blue Cross and Blue Shield Plans began drifting apart. This was one of several subjects over which we were becoming more and more antagonistic. The medical society was clearly smelling blood. They wanted to kill the program, because theirs died.

We wouldn't let them go under, so I became a sort of devil incarnate to the Blue Shield board by keeping everything alive. The leadership portion of the medical profession became more and more antagonistic to me and to Blue Cross. Remember we are now into the seventies and there was a dramatic increase in the power of health planning -- another area of deep involvement by me and Blue Cross.

You know what physicians wanted hospitals to do, and you know what health planners wouldn't let them do, expand the beds. I was identified as the great public opponent of beds.

WEEKS:

How was occupancy running in Rochester?

STEWART:

We had a decade where it never ran under 90%. Things have changed. I think we have one hospital up to 90%. If you were to take out the alternate care patients, everybody would be down in the 80s. Including alternate care,

we have one of our large hospitals that is not in the 50%. We held that bed supply down to 3.4 per 1000. It was our position that lacking tough utilization controls, all we could do was control beds. And it worked.

WEEKS:

You proved your point.

STEWART:

Let's put it this way: There isn't a hospital in our entire area of the state that is even vaguely considering proposing adding beds. Of course, there are hospitals that want to add beds because of population changes, but they can't make a case that will wash. I think that we have sold, and continue to sell Rochester business and industry on the idea of how inappropriate it is for the community to add more beds in one hospital while we have two hundred empties sitting in another that you have to pay for regardless of occupancy because of capital debt.

One person I inappropriately passed over in all of this from a leadership, both philosophical and industrial, was Joe Wilson. He personally created Xerox out of this 135 employee Haloid company. Joe Wilson became the richest man in Rochester, with hundreds of millions of dollars. Joe Wilson was very interested in health care. Governor Rockefeller made him chairman of a blue ribbon health care commission which produced a report in about 1970 recommending just this: the establishment of HMOs. Nobody could create blue ribbon committees as blue as Governor Rockefeller. He had the chairmen and CEOs of gigantic corporations all headquartered in New York State. He wanted to have national impact, for obvious reasons.

What do you think would have happened if Rockefeller had been president instead of Nixon? It would have put our health system on a different track.

WEEKS:

Maybe he would have built a new capitol building.

STEWART:

Or if he had stayed on as Vice President.

WEEKS:

He was an unusual man.

STEWART:

You obviously don't have a copy of this report. This is a very important report. It had a lot of influence with a small number of people.

WEEKS:

There also was a Folsom report.

STEWART:

By 1970 Folsom was going down hill physically. He was sort of like a declining emperor. Nobody dares revolt, but they are starting to have talks in the outer halls. At this point Wilson springs forth, like Venus from the sea.

WEEKS:

This was in the seventies?

STEWART:

Late sixties and early seventies. So as Folsom declined we have this magnificent new star arising. He has all of the competence of Folsom and he has all of the power, but in a new world. Folsom's contemporaries are declining. Here is Joe Wilson who is 25 years younger, the new George Eastman in Rochester.

Ernie Saward and I were both close to Joe, for different reasons. We called on Joe Wilson in 1971 to get support for Group Health because we were

having trouble getting a site, and so forth. The primary problem was with a Kodak senior vice president plus a couple of other Kodak V.P.s who were on the Rochester General Hospital board -- where we wanted to locate -- and who opposed the idea.

We went to Joe who said, "I'll do what I can to help you out." What he did was call up the CEO of Eastman Kodak and told him we needed cooperation, and that we were having trouble with some of the Kodak officers.

The president of Eastman Kodak within a week summoned all of his officers who were on hospital boards of directors.

The story is that he reasoned with them in the Johnsonian tradition. Out of this session came the understanding on their part that Kodak strongly supported this new system. There was instant turnaround and the hospital board voted a long-term lease to GVGHA. This was the first time in its hundred year history the board had voted on a major issue without consulting with its medical staff. It resulted in a riot at a medical staff! Screaming and yelling, running up and down aisles.

WEEKS:

They really feel threatened, don't they?

STEWART:

They still don't like it.

Joe Wilson, unfortunately, died within two years, in 1972. He was down having lunch with Governor Rockefeller in his apartment in New York with a bunch of other luminaries. All of a sudden Joe gave a start, his head fell forward, and he was dead with a massive coronary.

If he hadn't died, we know he would have taken over for Folsom as the power center of health affairs which would have even further strengthened the

system of planning and change based on the need rather than the desire. Fortunately, because of the foundation that had been established by Folsom and reinforced by Wilson, we were able, between Blue Cross, and the health planners, and the hospitals, and the doctors, to hold to our course.

WEEKS:

Do you see anybody who can take Wilson's place?

STEWART:

No. There is no single dominant personality with a keen interest in the overall health scene. I think Rochester is going to have problems as time goes by because things are becoming more fragmented.

Just one more national event. In the middle seventies Walter McNerney had close contact with the Secretary of HEW. They discussed the funding of all these experiments by HEW in hospital reimbursement, in making the system better, and how come there is nothing for the Blues? So they agreed there would be funding for the creation of a hospital experimental program that would link reimbursement to affordability and to planning. They "searched" the country for a site. The choice narrowed down to Kansas City or Rochester.

In the selection process we were chosen over Kansas City. That brought in a half or three-quarters of a million. Thus began the saga of Maxi-Cap. Maxi-Cap, as you know, had a chief investigator, one Howard Berman, the V.P. of the Blue Cross Association. His assistant was David Kline.

We appointed Bob Clement as executive director. Bob was a V.P. of HANYS and had a fine record in industrial engineering. Bob took on the actual work of staffing and operations over a three year period. It was a monumental task of organization and diplomacy, including countless broadly representative community meetings. The area to be involved was reduced from nine counties to

the six counties of the Rochester Blue Cross and the job was almost done.

But at the last minute it was subverted by skillful maneuvering into reincarnation as HEPP, the Hospital Experimental Payment Program, and Dr. Jim Block took it over. He simply massaged Maxi-Cap and applied it to the Rochester metropolitan area hospitals. They formed the Rochester Area Hospital Corporation (called RAHC) to administer the payment system.

We took the rest of the Rochester Blue Cross territory and created Finger Lakes Hospital Experimental Program, or FLHEPP, in the rural area. These are still in place today and have become nationally famous.

Both HEPP and FLHEPP followed the basic rules and parameters set up by Maxi-Cap under Bob Clement with a few variations, the primary one being the control was in hospital rather than consumer hands.

The whole concept of the thing was, we would start with the 1978 costs and then we would roll these costs forward, using a series of indexes, which applied to total community cost.

So here we are in 1986, hospitals are all still being paid on an index rolled forward from 1978, an index geared to predetermined overall limits not individual hospital cost. Overall community cost is capped, as is capital expense. To oversimplify, hospitals as a group were simply placed on an allowance. Here's the total amount of money you are going to get from Blue Cross, Medicare, and Medicaid. Between the three of us, you see we had over 90% of all the hospital reimbursement. We put a whole series of limits on expansions of services, and so forth. We pooled cost for new technology. We pooled elements for new services, et cetera. There is a quarter of a percent here, and a percent there, and so forth, for capital, for new services, new technology. The hospitals, using their own RAHC, decide how to cut up the

pies between them.

It was viewed by some as suicidal. Why are the Rochester hospitals submitting themselves to this Draconian code of conduct voluntarily? The commonly heard reason was simple: It was better than the new state formula. The state mandated program punished high per diem hospitals. Rochester has always been, next to New York City, in high per diem in the state because this is a product of the low bed supply and a low rate of use. In a given population, say a million people, on location would give them 6 beds per thousand population, in another location give them 3.3 beds per thousand. You can remember how it used to be, no matter how many beds you had, they were always full. With six beds per thousand, you know the level inpatient illness was not very high, because in that area people were routinely hospitalized while in the other area the same patients routinely were treated in ambulatory units and the physician's office. While we had high per diems, we had among the country's lowest premiums.

The true cost of health care always has to be measured by dollars per capita per year. The Rochester premium for General Motors, the last figure I can remember is 1983, was half of the Michigan General Motors premium, and was a third of the southern California General Motors. A third!

In that kind of a circumstance where we had created the envy of the industrial world in health care programs from the point of view of quality, accessibility, and cost, the state formula was then going to hang these hospitals by their success, high per diem. So we leaped in with Maxi-Cap and then HEPP with marvelous cooperation. Those programs go on to this day, and they perform with great results just the way Walter told HEW they would. Since HEPP the distance in per capita cost between Rochester and the rest of

New York State and the rest of the country has grown and grown.

WEEKS:

What about the new elements of reimbursement such as DRGs?

STEWART:

We are exempted from them all and we continue to out perform the nation -- DRGs or no. The point is the hospitals work together. Today the Rochester Area Hospital Council board members, administrators, and chief financial officers know more about each other's business than any other group of hospitals in the United States. When people come to Rochester, they can't believe what they hear. They say, "You mean to say that Rochester General Hospital tells Genesee Hospital all of these financial details?"

The answer is: "Yes. Everybody's operation is an absolutely open book to everybody else. Every proposal for new services of any kind whether they are under or over the threshold for health planning, whether they are a reorganization of the administration, of the hospital structure, the medical group, everything goes before that board first for discussion and approval. Everything."

WEEKS:

In this way there is no unfair advantage.

STEWART:

It is not a magic amulet that wipes away all competitiveness, or pettiness, but it is the next best thing. Unfortunately, as soon as you move out of that metropolitan environment and into the countryside where the largest community is 20 or 30,000 most of these attitudes and enhancements disappear. If you have 200 or 300 employees in Geneva, NY, they don't go to the hospitals in Geneva, in Penn Yan, and Canandaigua. They just go to

Geneva. If you are a big employer in Canandaigua, you don't give a damn about any other hospital and so you get into all the parochialism that dominates the American hospital system today.

The reason they don't put it together is not that they can't. They won't. They won't have anything to do with these other hospitals -- an attitude of "Don't talk to us about that." That's the difference between the Rochester metropolitan area and the rest of the nation. We have handled it together as a community system.

WEEKS:

There is no question that you are a community all by yourselves.

STEWART:

I and Blue Cross never stopped preaching the gospel of a single system. Business people on hospital boards understood that if they wanted something grand, they had to pay for it. No matter what happened, it was going to come out of their pocket. We helped them understand by putting premium price tags on many proposals which greatly improved understanding.

WEEKS:

You are sort of like an oasis here. Your system is like an oasis. You are quite different.

STEWART:

Leaders from other areas have beaten a path to Rochester over the years. The most recent group came down in the corporate jet and went back saying they couldn't do it because their board chairman was married to one hospital and wouldn't consider a community system concept.

The cost of hospital care in your community in 1990 and 2000 is going to be determined by what you do now. The only way you are ever going to get at

it is the same way you get at any big corporate problem. You start now with a program and a plan in action that you modify every year just as you do with a corporate plan.

Rochester visitors just go back to their towns and cities, throw their hands up and quit. The providers -- sometimes augmented by religion -- have maintained their dominance over the minds of the business and industrial leadership and there is no motivation on the part of industrial leadership to take over a dominant role. Health care turns dynamic, powerful men to mush. They would rather complain about the cost of health care than try to do something. They seem to hope -- and even believe -- that some simplistic solution will spring forth and solve their problems without their involvement -- like DRGs.

WEEKS:

We should begin thinking about what is coming after DRGs. And what is coming after HMOs.

STEWART:

And what is happening too. What are you going to do with your hospitals in Ann Arbor? You have the university hospital. It doesn't give a damn about anything except themselves. I remember I talked with John about 15 years ago. He was doing a study about a Catholic hospital somewhere in the vicinity.

WEEKS:

Our Catholic hospital is St. Joseph's, a Sisters of Mercy hospital. It moved from the city to the suburbs. A new hospital was built. They spent about \$50 million, 400 and some beds. The university hospital was just under 1000 beds and they wanted to replace the old main building. It was about 60 years old.

STEWART:

I remember the old one.

WEEKS:

They have spent just about \$300 million. I am not sure how it will be paid for.

STEWART:

It will be paid for by people who pay premiums in this area. That's how it's going to be paid for.

WEEKS:

Just think of what it is going to cost.

STEWART:

It will cost 300 million bucks plus the financing cost which will bring it up to at least \$500 million. Nobody else is going to pay for it. The people in this area -- and I suspect they have no idea of the impact on the premiums.

WEEKS:

As an example, we have a situation in Michigan right now. The state agency that approves certificate of need as far as lithotripters at a million dollars a throw -- five hospitals ordered them before they received approval. So now the state is not allowing -- at least two or three of them to use their equipment. I don't know what is going to happen but if the state backs down on this then they are just opening the flood gates.

STEWART:

Then they will just order the stuff and go ahead. A precedent.

WEEKS:

I wanted to ask you about the Blue Cross-HMO network. Is Rochester Blue

Cross a member of that?

STEWART:

Let's not build a mountain out of a molehill. They have an agreement that if you are in an Ann Arbor HMO, come to Rochester and get sick, our HMO agrees to take care of you, that's all. That's like the old Interplan Benefit Bank.

WEEKS:

That's the way you handle the national accounts now, isn't it?

STEWART:

It's just an agreement to take care of you among a group of independent Plans. Of course, in this day and age we are anxious to have this dynamic image and the network concept is appealing to big groups and an appropriate action.

WEEKS:

There is no corporation network?

STEWART:

No.

WEEKS:

They have what; 65 or so Blue Cross HMOs?

STEWART:

Lew, they are by far the biggest network in the nation.

WEEKS:

I can see where if you are careful about the boundaries...

STEWART:

In Rochester we agreed to care for them. I didn't follow through on the strange saga of the HMOs in Rochester. We are treading on Minneapolis' tail

with the percent of population enrolled in HMOs.

WEEKS:

Are you?

STEWART:

Approaching 50% of the employed population.

WEEKS:

How about outside HMOs?

STEWART:

Remember the Blues started three HMOs in 1973. We only meant to start the one Kaiser type but ended up stuck with the other two. Because of physician resentment over the demise of their IPA in 1976 the Blue Shield board wouldn't discuss another try.

So, eventually a freestanding, independent HMO-IPA was started in Rochester and struggled along. I wanted to start a competitor but couldn't because I was married to Blue Shield in my Blue Cross position, and I couldn't start one in Blue Cross because that would have constituted invasion of Blue Shield turf. This is the curse of many Blue Cross Plans which are business oriented and want to drive on with new structures but are held under by their Blue Shield partner which is dominated by conservative physicians.

As Mark Twain said, "The man with four aces doesn't call for a new deal." Physicians who dominate Blue Shield boards are commonly well-to-do, politically powerful and always conservative. Their power of dynamic inaction often stays with them after they merge with a Blue Cross Plan.

It is really a difficult issue and the one, in my opinion, which caused the demise of Walter McNerney as our national president of BCA/BSA. You know how visionary he was. He saw, early on, you had to merge the Blues. After he

put them together, he ended up with an organization which had grafted on an adversarial trunk that did him in.

Again, it's important to remember, Blue Cross created and operated almost every Blue Shield Plan. Then the Blue Shield corporations broke away from Blue Cross as the business grew. Some of the breakups were spectacular and created guerrilla warfare that continues, in some areas, to this day.

Minnesota was one of the most spectacular breakups. At any rate, in the early 1950s in New York State we had 12 combined Plans with only 7 heads -- New York City had split. By 1960, there were 12 Plans with 11 separate heads. You can only imagine the chaos resulting from the multiplication of CEOs all battling for turf. It also fostered an isolationist attitude on the part of Blue Shield Plans whose controlling physicians didn't understand the need to respond to customers' desires. They took a "this is the way we do it here and that's what Blue Shield does" position. Unfortunately, with every area doing things differently, it made it impossible to create standard national contracts and severely damaged our relations with many major employers. It even drove McNerney bonkers. They educated me in the concept of the laws of the Medes and the Persians.

Meanwhile, back at the ranch, one day we woke up and this little freestanding HMO had 20,000 members and growing, and they all came from us. The obscure we eventually see, the obvious takes longer. Finally Blue Shield agreed to start a competitor under the Blue Cross threat that we were going to go it alone. At about the same time, Blue Shield agreed to having one CEO for both corporations, so long as it wasn't me.

At any rate, for my last big project in my last year, both Blue Cross and Blue Shield boards gave me the job of starting the HMO-IPA. From an April

start, we opened the doors January 1, 1985 with 46,000 Blue Choice members. In the first year they hit 100,000. In our metropolitan county of 700,000 we have 135,000 in the Blue Cross-Blue Shield HMO-IPA; we have 110,000 in the freestanding HMO-IPA; we have 50,000 in Group Health, the Kaiser model; we have 45,000 in RHN, the old OEO network. So, in late 1986, we have 350 going on 450 thousand HMO members in a metropolitan county of 700,000. It's what we dreamed of in 1970 when we started it all.

All across the country, HMOs, or their variants, in managed care, are having a terrific impact on the days of hospital care of the under-65 population, and the ripple effect of an HMO in a community compounds the result, especially in those areas of the country with high use. Still to be felt in most areas is the next act in the drama, namely, what happens when you enroll these over-65s in HMOs. That's where you take the days per thousand from 4,000 to 2,000 over night. The over-65s constitute about half of the hospital patient population. You can cut it in half within a year. Two thousand days is easy to hit with a good HMO. Just like every good HMO in the country hits at most 350 days for its under-65, they all hit 2,000 days for their over-65. It's going to be a delayed action bomb for community hospitals. Isn't it ironical that the feds are killing health planning when they need it the most?

We can deal a little more with the memories and reminiscences of the earlier days of Blue Cross. Thinking in terms of when I started in 1949, Rochester had sort of a national record for the high percent of population enrolled. We always tended to share this lead off and on with Rhode Island and with Allentown which was a small Blue Cross Plan right at the head of the Bethlehem Valley. When Bethlehem Steel enrolled in Blue Cross, that gave

Allentown the highest percent of population enrolled. We all ended up over 80%.

WEEKS:

Didn't the steel company want their own Blue Cross, so to speak?

STEWART:

Well, they got it.

It is difficult to remember back on things that may seem important today. You accepted things as they were. You never regarded them as unusual. In 1949 there was total independence of one Blue Cross Plan from another. We had a national headquarters, a loose trade association, trying to implement actions that would make us more effective as a system of Plans. Dick Jones, who had a newspaper and PR background was the affable, and-to-me, the helpful executive director. Tony Singsen was the real brains. A man named Smith headed up the Blue Shield Association. Dr. Paul Hawley, fresh out of the VA was made head of both, but it all blew apart after a year, thanks to Blue Shield's doctors. That's another story.

For obvious reasons all the New York State Plans established a conference of Plans (NYSCOP) to discuss common problems. When I appeared in 1949 Carl Metzger of Buffalo was the undisputed leader of the group. We wrestled with statewide issues and under Ralph Hammersly's goading employed a single law firm for dealing with the state government and the legislature. In later years Ed Werner took the mantle of leadership. Without his prescience, drive, and persuasive gift we would have been in a lot more trouble than we are -- and that's speaking nationally as well as within New York State.

Then there was the idea that membership time in one Plan would become a credit in another Plan, so that, for example you could move, as I did in 1949,

from the New Jersey Blue Cross to the Rochester Blue Cross and you didn't have to start your waiting periods all over.

Paul A. Webb of Maine, along with Singsen, was father of the Blue Cross Inter-Plan Service Benefit Bank.

We also had individual underwriting of group members whose groups didn't meet a 75% enrolled requirement. Remember there were no employer contributions then. You went out and sold one by one in employee groups. If you were unfortunate enough to be fat you couldn't become a member. If you had high blood pressure, you might become a member but you were rejected for all cardio-vascular problems. They had permanent exclusions, one, three, five year exclusions, all kinds of exclusions. Applicants all had to fill out an application form that delineated all of your visits to the doctor, the hospitals for the last God knows how many years. Then the Plan would use that to determine what your eligibility would be. For example, we moved from New Jersey to Rochester. The Rochester Blue Cross gave me credit for all the New Jersey membership. But, if at that time I had moved from Rochester to New Jersey, that Plan wouldn't have given me a minute of my Rochester membership although I had been a member for five or ten years. New Jersey didn't believe in giving anybody credit for anything except in New Jersey. There were other Plans like that. Every year, fortuitously, saw a diminishing of their numbers and a welding together.

The national Blue Cross was, pure and simple, a Blue Cross association, was headed up by Dick Jones, whom I mentioned a moment ago. Of course, it was a true trade association. What Dick Jones would do -- the staff would do -- would be to gather data, as best they could get from the various Plans in the various areas of hospital cost, use, membership, growth, and so forth. It was

pretty frugal fare, but we all regarded it as manna from heaven because it was the only information we ever received. I can remember as time went by the national association never did anything about studying wages and benefits. It was too touchy. Finally Jim Smith, the head of Toledo Blue Cross, personally started a study of salaries of Plan executives. I can remember that greatly accelerated my rate of increase in pay because I was able to show the head of the board how much more all other Plan presidents, Plans that were smaller and less aggressive than ours, were making across the country. Bless Jim Smith for that!

The boards of directors of the many Blue Cross Plans in the forties still reflected the structure of their origins. In most cases that encompassed huge numbers of people. I think our board of directors had 55 members. There wasn't any do-gooder or any important person that wasn't on the list. They had a meeting once a year. Of the 55, about 14 would show up. In the late 1940s a Kodak executive named Herb Holt was elected head of the Blue Cross board. He wanted to bring us out of the small Community Chest type of organization that Rochester and so many other Blue Cross Plans had. He was strongly seconded and in some cases led by Basil MacLean. Basil MacLean, as I mentioned very early on, had taken over as the administrator of the University of Rochester Strong Memorial Hospital. He was on the Rochester Blue Cross board. To hear Basil MacLean at a board meeting when my boss would be asking for an appropriation of \$150 or something or other, was worth the price of admission. Basil MacLean really saw the big picture. He never drew a penny of his salary for the entire time he was there from 1935 until he left in the sixties. He had an agreement that he would be allowed time off for consulting work.

While his management style was imperial, he was an extraordinary cultivator of assistants. In addition, he would bring third and fourth level with him on weekend consulting jobs. He would bully the consultee into paying this assistant some \$500 for the weekend plus expenses. I had more than one of them say, "You wouldn't believe this but thank God for what Basil MacLean did for me when I was starving to death. He took me on two or three consulting jobs."

Of course, \$500 was a huge sum of money.

Basil developed a series of extraordinarily talented people. Any one of them could take over and run that hospital without any problem. As a matter of fact, all of them did become national figures. One of them was John Law who went to a big hospital in Toronto. Another one was a physician, Sarah Hardwicke, who went on to one of the large associations. Another was Dr. George Graham who became the head of Ellis Hospital in Schenectady and subsequently was an AHA officer. When I received the Justin Ford Kimball award he was sitting three seats behind me saying, "Go get them, Dave!"

Among his other assistants and compatriots was Al Snoke who had left Rochester in the forties before I came. He went to New Haven. I always think of him as being at Grace-New Haven. He and MacLean were very close. Then there was Larry Bradley who went on to become a spectacularly successful administrator of a big Rochester hospital. They all trained under MacLean. MacLean believed in practical training. He would walk out and you were in charge. He did the same at the BCA where Harry Becker was his extraordinarily talented V.P.

This had a marvelous effect on talented, energetic, young people. They got a chance to really run it so they advanced far beyond their contemporaries

who were never given that much authority and freedom. Basil, who had already served as AHA president, went on from Rochester to become Commissioner of New York City hospitals where he closed some three thousand beds, to President-CEO of the Blue Cross Association. During the latter he suffered a series of small strokes, became disabled and died a few years later.

The association was first called the Blue Cross Commission because it was a unit of the AHA. The name was changed to the Blue Cross Association when we broke away from the AHA to show our independence and to disassociate ourselves from the inference of hospital control. Jeb Stuart was the first president.

The people who were dominant on the board of directors when I first became active at that level in 1955, were Jeb Stuart and Bill McNary. For some reason I was elected to the Blue Cross Commission's board in 1956 or so. It was quite early on in my career. I can remember that Jones, the executive director, would not start the board meeting until either Jeb Stuart or McNary was there. Both of them were very late risers because both of them were very late goers-to-bed. They loved to drink, and play poker for substantial stakes until four or five in the morning. Here was a board meeting at nine o'clock in the morning, with a dozen of us waiting and Jones is like somebody sitting in front of a piano just vamping, saying things that had no importance whatsoever and trying to keep it up for an hour or so until finally McNary or Stuart would make it downstairs. There are great stories about Jeb shanghaiing his young executives to work on his farm on weekends.

One of the things you tend to forget is the extraordinary number of Blue Cross and Blue Shield Plans. In the late forties and early fifties there must have been 150 altogether.

Plus the Blues there were nonprofit, non-Blue insurance plans. I

remember one in Bluefield, West Virginia, one in Perth Amboy, New Jersey, and one in a county just south and west of Philadelphia which ended up as being the biggest because post-World War II population moved out there.

WEEKS:

Were these plans that did not have the approval of the commission?

STEWART:

Correct, but it was because they didn't want it. In the early days you have to think of Blue Cross Plans being started like HMOs today. You wanted one, you started one. Some people started programs to help their one hospital and didn't want to move into a broader area. So they stayed independent.

WEEKS:

When states passed enabling acts did they cover these plans?

STEWART:

Yes, and that brings up the important point that the capability of Plans was determined by their individual state legislatures. You had some plans with very strict regulations. New York State, number one! The state of Delaware, never passed anything and the plan could do anything it wanted to. Harold Maybee, who headed that Plan used to kid us all about it. The Delaware Plan, finally in the 1960s, pushed a bill through the legislature to protect itself.

They tell a story that at one point Montana Plan was under the state gambling commissioner for regulation. But Bill Guy should talk about that.

At any rate, in the beginning there were dozens of very small Plans. In upstate New York, for example, there was a tiny Plan in Geneva, New York with about 4,000 members. Watertown and Jamestown weren't over 20,000. Ohio had them, West Virginia had them. Every state had them. They were all started by

local hospitals that needed cash for care. There is a striking similarity between the current HMOs and the then establishment of Blue Plans. Whoever wanted one got one. There was a gold rush of jobs for people with any Blue Cross experience. I say Blue Cross, there wasn't any Blue Shield in the thirties and forties, to speak of. So, anyone literally with three to six months experience was considered an old hand and many of them became founders of new hospital service plans, which is what they were called then.

The words "Blue Cross" didn't come into national currency until well into the fifties as a result of van Steenwyk's idea. Populations didn't stop using the words "hospital service" until well after that.

Rochester started in 1935. Men with only a few months experience went from Rochester to start the Cincinnati Plan, the Wisconsin Plan, the Geneva Plan, the Syracuse Plan, the New Haven, Connecticut Plan. It was very dynamic -- again like HMOs today.

WEEKS:

Norby went through this experience when he went to Pittsburgh. He was still wet behind the ears. He had very little experience, but he had worked with van Steenwyk a little.

STEWART:

Right.

WEEKS:

Did you meet van Steenwyk?

STEWART:

Sure. I knew him very well, we were friends.

WEEKS:

I am sorry I never got to know him.

STEWART:

He had that bizarre death.

WEEKS:

I didn't know about that.

STEWART:

His death was like a Stephen Spielberg movie. It was absolutely incredible. He caught on fire and shot himself. It was strange, like running around on fire. Sigmond should be able to give it to you. It is one of these things that nobody ever talks about anymore.

Back to the early days. Blue Plans were being started all through the thirties when things were very, very difficult. If you had had a reasonable job over here at the School of Public Health at the university and it was 1935 and somebody said, "We are going to start this new insurance plan down in Detroit, wouldn't you be interested in interviewing for the job?"

The chances are 75/25 that you would look at that and say, "Health insurance. I don't know anything about insurance. Nonprofit! If this was any good somebody would be doing it. I have a good job. I have a wife and kids. I am not going to go on a long shot thing like this!"

But if you didn't have a job, or had a really poor job, you might make a switch. We had YMCA secretaries, social workers, ministers without congregations, and newspaper deliverers who became the heads of Blue Cross Plans. It wasn't even a randomly chosen sample of males. Obviously females were not eligible. It was skewed toward the lower end of incomes. The overall level of business competence was not that great. The level of goodwill towards humanity was very high, but the ability to run a business and direct people to do things in an orderly manner -- that ability just sort

of... Let's say the Plan that attracted an executive with that ability was lucky.

Most of the Plans just grew because the hospital administrators, backed up by the captains of industry who sat on the hospital boards, supported the program and made enrollment available among their employees. So the Plans grew regardless of what you did.

In New York, Ohio, and West Virginia, where there were nine Blue Cross Plans, the Blue Shield Plans, all with subscribers in each other's areas, it was a zoo. Think of New York City with subscribers in two other states, let alone the small Ohio, West Virginia areas which were intertwined and gerrymandered. Conflict between Plans is not new.

WEEKS:

Did the big growth come during World War II when fringe benefits were allowed?

STEWART:

The great growth spurt occurred during World War II. The first spurt started simply because Blue Cross Plans were in business in the industrial centers of the northeast quadrant of the country, and they grew as employment grew.

WEEKS:

There was still the situation where the employee paid the premium?

STEWART:

No employer, to my knowledge, ever contributed anything toward health insurance until at the very earliest the late fifties. Lord Melbourne said, "What the finest minds of our time said was inevitable never happened. It was always the damned fools who were right." These damned fools in California

always led the world in health ideas and health insurance. They and the UAW started contributions by employers. Contributions didn't come to Rochester or upstate until 1960. Even then the contributions were very small. Half the single was common.

If you draw back and look at Blue Cross from a historical view it's as if almost every major thrust in American economic, political, social life, every main current stimulated Blue Cross enrollment.

Blue Cross was born of adversity, grew out of the depth of the Depression, was fostered by hospitals desperate for cash, and the industrialists who sat on their boards. They felt they couldn't single-handedly finance deficits anymore and they were strongly attracted to the idea that the problem could be handled by having their workers each pay a little into a hospital payment program. Because the hospital trustees controlled large numbers of employees, many of these new Plans had relatively quick growth. But the first huge surge came with the start of the war and the expansion of employment.

People who went to work took the programs because the boss recommended it, and they could afford the fifty cents. During the war, with wages frozen, Walter Reuther went all the way to the Supreme Court who determined that health insurance benefits stood outside of the wage freeze and could be negotiated as an employer contribution. That's where the first contributions were started. They didn't spread to Rochester for another ten years.

WEEKS:

Not adopted in your area?

STEWART:

We didn't have strong unions. After all, Walter Reuther was an

extraordinary performer in this particular area. At any rate, after the end of World War II came another boom, and then the Korean war and more expansion. The cost of care meanwhile started to climb so people were then really motivated to join. That's when employers started to contribute. With employer contributions came 100% enrollment. Lew, you are an employee where there are 150 employees and you are on your own, probably 75% of the people would join. But, if the employer is paying half of the cost, 100% join every time. You are not going to pass up that contribution. Right?

Major societal events expanded Blue Cross only to be followed by another, like Fourth of July rockets. By the early sixties the employers are paying the full shot.

WEEKS:

Was this when the commercial insurance companies changed over from indemnity to...

STEWART:

They never really changed. The commercials came on the scene via a new product, major medical. Blue Cross and Blue Shield Plans would not provide major medical programs. Remember, I told you in New York State Blue Cross couldn't and Blue Shield wouldn't. So by 1960 in the Rochester area the commercial people were already dominating the major medical field. We had an excruciatingly difficult time over a decade before we turned that around. The commercials had just fallen into it and they never let up thereafter.

Then came the advent of Medicare and Medicaid in 1966. That started a whole new world of incredible complexity. That was the first basic change in the Blue world. It split the over-65s off. The Blues had a lock monopoly on the over-65s. Nobody else would touch them with a ten foot pole. It

represented an enormous, unique service to the American people. Many Plans kept the over-65s at group rates and benefits. The advent of Medicare was for practical purposes the beginning of the demise of community rating in the Blue world. Up until this time the majority of Plans, including 100% of the Northeast community rated their local business and many Blue Shield Plans paid their doctors on relative value fee scheduling attached to service benefits.

Medicare took the over-65s out of the regular premium pool and imposed a physician payment plan based on usual, customary, and reasonable. This UCR system, which could be escalated at will, was an incredible and inexcusable blunder. It destroyed the controls of relative value, service programs that had taken Blue Shield a decade to construct. Blue Shield switched to the federally blessed UCR and in several cases, exemplified by Michigan, went almost bankrupt within two years. The physicians escalated UCR out of sight.

With the removal of the Medicare population, large employers started looking at the community rate and saying, "My employees don't use that much, so I want an experience rate. If I don't get it from you Blues (and a lot of Blues couldn't give it to them) we will go commercial. And the commercials, who didn't have to face the over-65 issue, had a field day.

Interestingly enough, with the advent of Medicare was the happy paradox that it took the pressure off the Blues premium because we had been carrying all these high users at big benefits.

With all of this, plus the task of administering Medicare resulted in an explosion of complexity for which the Plans were ill-prepared. Premiums first dropped or stabilized with the removal of the over-65s. Then costs, under the combined effect of Medicare and Medicaid -- which were simultaneously enacted -- skyrocketed at an annual compounded rate across the nation of over 16%. So

while Plans were desperately struggling with Medicare, their regular market was completely changing character.

Incidentally, many of the Blue Shield Plans simply couldn't handle the Medicare B data processing requirements and they turned to Ross Perot's EDS for help. He had started out of the Dallas Blue Plan and this was the first great spurt in the creation of his empire.

I remember when Ross Perot used to talk to small meetings of Plan office managers trying to get some business. In the meantime, McNerney was pushing hard for a system concept including trying to get computer software standardized under a program called LRSP, run by Norm de laChappelle -- Walter's answer to Perot.

The Blues didn't respond right away. The Blue Plans have a marvelous and unrelenting line of failures. There is that saying that "nothing fails like success." That has been one of the characteristics of the Blues that they could snatch defeat from the jaws of victory. We have been so damned good, so successful, that it was just impossible to visualize that anything would ever be any different. So they wouldn't change. Again this is backed up by the Blue Shield partner with the four aces, standing there saying, "You can't do that."

Isn't it amazing that with all these Plans struggling with a whole new world for which their management was not particularly prepared, premiums changing, community rating disintegrating, costs out of sight, groups leaving or insisting on standard nationwide benefits, and Walter saying it was an incomparable opportunity -- isn't it amazing the Plans survived and came back time and again? Maybe the religion part works.

Backwards in time again to the '40s and '50s. We had a large number of

little Plans, and essentially their original benefit structure. While it seemed almost anybody could start a plan but what really happened, Lew, was that when they did, they created minor images of the Plan from which they came. Almost everybody had a 21 day plan. About half of them had either full pay, fully covered benefits, or a version of a dollar from the contract holder, and two dollars for the family. No coverage for venereal disease because that was evil, and if you had it you deserved to suffer. There was no coverage for psychiatric. If you were crazy, you didn't deserve benefits.

The Plans went through a fascinating cycle in maternity. Most Plans in the 1930s, beginning Plans, had very good if not full coverage of maternity. Along about 1939 a lot of Plans needed rate increases and they cut their maternity benefits. So, by the time you were in the 1940s and early 1950s most Plans were paying flat dollar amounts for maternity, with no psychiatric and no venereal benefits.

In Rochester I became convinced as a result of my fortuitous indoctrination by Folsom and the early health planners that if we were going to hold down the supply of hospital beds, it would be equitable and appropriate to all, including the hospitals to expand the basic benefits structure. So that's the path we chose. We gave more benefits because our costs were low and then gave more to cover alternatives to acute hospital inpatient care and the cycle spiraled.

Walter Wenkert, who was the head of planning, and I got together and he said, "Look, if we want to keep winning this war of beds, we have to stimulate alternatives. Let's start a nospital-level home care program."

I guess one of the reasons, Lew, that I stayed in Rochester rather than take one of those big Plan offers was that I could make those decisions. I

could go to my board of directors with unusual -- for that time -- proposals and every time they supported because we had 80-85% of the Rochester population enrolled. When Rochester Blue Cross put it in place, Lew, it was available for the entire community, and it started with a bang. It made an impact. Everybody was community rated, everybody was able to start using the new benefit.

WEEKS:

Was this home care program a freestanding organization?

STEWART:

Yes, but it started as sort of a brokerage corporation. We did not want to start a program that would destroy our strong visiting nurse program, and our strong county health department home nursing. Unfortunately these two organizations were at each other's throats competitively and I couldn't afford to pick one over the other, and in 1960 the idea of Blue Cross going into provision of care was anathema.

So we started a nonprofit community organization which purchased the services of the county health department and the VNS, giving each an agreed upon geography. The Blue Cross full payment resulted in a magnificent permanent growth spurt for both of these organizations. There hadn't ever been such a thing, Lew, where we provided hospital level care at home with a hospital bed, all the equipment, supplies and a whole panoply of care including professional nursing and the home aide to hold the home together. If you had to go to the doctor, we would pay the taxi or the ambulance to carry you there and take you back. It was paid in full.

Dr. Roger Boulay, an enthusiastic young internist with impeccable credentials, acted as part-time medical director. He gave the program

increasing credibility with the physicians' community. In a short time, we had the support of pediatricians and orthopedists, followed by internal medicine. Over half our patients were under 55.

WEEKS:

Where did you keep your medical records?

STEWART:

They were all kept at the home care office. The nurses continually reported to the patient's physician, just as in the past. Home Care was just one of our adventures. We started preadmission lab testing in 1958 in an experiment with St. Mary's to try to cut the tonsillectomy stay. It was successful in reducing the average stay to a day. So, then we made it available to everybody in every hospital for everything. Blue Cross could make these changes on its own. We didn't get into the physician area except peripherally. In 1959 we decided to pay hospitals for a broad array of outpatient surgery. It sounds so commonplace now but back then these were considered daring. We were alone in the country. It was great.

In 1959 we obtained permission from our hospitals and were able to recruit enough physician volunteers to form hospital utilization review committees. A very imaginative, pragmatic lady, Marie Baumert, created the program which lasted about four months in each hospital — until they cited some big guns' patients as inappropriate. But we got a lot of good ideas out of the program anyway.

All of us have heard that cry that people had to be admitted to get any Blue Cross benefits. Doctors would say, "Why should I make the patient pay out of his own pocket when he is paying all this health insurance premium?"

We were determined to stop that. We put in place a comprehensive

outpatient paid-in-full surgical program. We covered the works -- even teeth extractions which previously had not been admitted.

Part of our education, courtesy of the physicians' UR committees was that there were a lot of people admitted for diagnostic testing that was prohibited in our contract. So we changed and decided to add outpatient benefits for complex diagnostic testing. With the medical society we made up a list for full payment in the outpatient department. As soon as we could identify for change, we would do it. It was a pretty dynamic place. This wasn't just Dave Stewart having flashes of inspiration. I was spending several hours a month with the industrial management council -- our big industry club -- telling them about all the things we were finding out and how to save money, and all of these ideas we had in the health planning. The head of health planning and I are scheming, concocting, meeting together to come up with ways to improve the system, to cajole, to persuade people to do one thing or another. We did have control over one thing: to expand these Blue Cross benefits by paying for appropriate, less expensive care.

Hospital beds across the country were expanding in exponential numbers. The Rochester Blue Cross board and industry felt secure in this environment of expanding benefits and establishing new services because the local bed supply was not expanding and our per capita costs were already below those of almost every other metropolitan area.

Under the prodding of Dr. John Romano we decided to expand benefits in order to cover psychiatric care the same as any other care. When we made that decision we included the big state mental hospital in Rochester. I made that decision because all they were charging people out of pocket for acute care was three dollars a day. I figured there won't be more than a couple of dozen

of our members in there and Blue Cross can afford the three dollars a day. Two months after we made the three dollars benefit available, what's the charge at the state hospital? Six bucks a day. Everybody is still paying three.

When we were trying to expand our psychiatric benefits, Governor Harriman had made an edict of no more rate increases for Blue Plans. The insurance department wouldn't even answer letters or phone calls. That also meant no new benefits.

Romano called me to his office for lunch and I found there the head of the Democratic party along with the lunch. We reviewed the problem and the party leader said, "Let's see what we can do." He picked up the phone and called New York City and, to my astonishment, asked not for the governor but for Mr. Carmine DeSapio, the Tammany boss. He was in the hospital. So the man called there, got Mr. D., explained that the community -- including labor -- wanted a rate increase and new mental health benefits. Back came, "I'll see what I can do."

When I returned to my office, there was waiting a summons from the Superintendent of Insurance. Needless to say, we got both the rate and the benefits. It was a great education in how political power enhances actuarial projections.

We established teams of nurses to do hospital relations work. I found hospitals wanted problems solved rather than a vice president meeting with the administrator. We expanded benefits to include chronic and rehab hospitals. Then came Medicare. With the new complications. We went from 150 employees to 350 to 700 to 1,000.

WEEKS:

While we are talking of HMOs, may I add something? Have you had experience with enlisting Medicare and Medicaid people in your HMOs?

STEWART:

Yes. Group Health was in HCFA's first experimental group to enroll Medicare people. The first thirteen in the country. They have proved to be champion performers. We face a very difficult environment for savings in this regard because of our low days. Rochester is probably the best example of HCFA's policy that no good deal shall go unpunished. Health insurance premiums in Rochester are very low. The Medicare cost is very low. Ellwood did a study in 1983 of the per capita cost of Medicare in a large number of metropolitan areas in the country.

WEEKS:

Did it include Rochester?

STEWART:

Yes. The highest cost area in the country was Miami. People say that, of course, it is the highest care cost, there are more old people. That doesn't have anything to do with it. Their cost was over \$2,700 a year per person. In Rochester it was about \$1,075. We were running about 76% of the national average. Remember that HCFA pays HMOs for the over-65 at 95% of the regional cost. If you, Lew, have a million dollars you want to put into a venture in starting an HMO for the over-65, are you going to start one in Rochester where the base reimbursement is 77% of the national average from which you are going to subtract 5% from which you are going to subtract another 15% for your administrative expense because they are expensive and tough to run? Or, are you going to go down to Florida where you are running

140% of the national average, and with the 5% taken out, and the 15% you are going to end up being reimbursed at 115% of the national average in an HMO? Is it any surprise? You see these full page ads in Florida papers for over-65 HMOs. This HCFA formula rewards these areas that have the nation's worst performance in health care costs.

I can tell you General Motors does not run their operations by picking the highest quality, lowest cost plants, and then penalize them. (That's HCFA's interpretation of how you run a business.) Wouldn't you think HCFA would establish a standard, a par? Then they could reward those who beat it, and keep pushing those who don't. They are going to drive the best performers out of the business. Group Health has the biggest enrollment in Rochester of the over-65, some 8,000 and has cut their days per thousand from about 3,400 to about 1,600. Only Kaiser has moved it any lower, maybe 1,500. The over-65 absolute bottom seems to be about 1,500. The bottom on under-65 seems to be about 300. The care, I guess, doesn't run right below that. But if the whole nation ran within 115% of these figures, it would close half the hospital beds in the nation. The prospect has a lot of people's grim attention. What was it Dr. Johnson said about hanging?

Meanwhile Blue Cross moved into the sixties, and the national level linkage between Blue Cross and the AHA was getting embarrassing for the Blues. They decided to take the Plans out of the AHA and create an autonomous corporation called the Blue Cross Association (BCA). I remember Jeb Stuart leading the meeting. It was held in Los Angeles. I was a board member then. It followed the last Commission meeting in Santa Barbara and we moved down to Los Angeles where we voted for the Association. I think Jeb Stuart was the first paid head. It was a good job. Stuart had it temporarily so did

Tierney. Then Basil MacLean became the permanent CEO. By this time the headquarters had been moved to New York City. MacLean had left Rochester to become Commissioner of Hospitals in New York City, where he closed all those beds. In a relatively short period his health began to fail and we were looking for a new head.

Walter McNerney had done the University of Michigan Study of the Michigan Blue Cross, a two volume report. The BCA selection committee headed up, I think, by Bill McNary had clearly made up their mind for Walter. I was one of those who believed that Tom Tierney of Colorado would make a brilliant head. He had invented the concept of enrolling governmental people into a regular Blue Cross Plan. It is one of those things that sound so obvious and routine but was an extraordinary breakthrough at the time -- one of those "Why didn't I think of that?" Think of what that did for the Plans!

WEEKS:

A couple of million people involved.

STEWART:

A breathtaking breakthrough. The first group he took on were Colorado's over-65, pensioners. Tierney, who was a lawyer with an incredible Churchillian gift of speech -- he was a pretty good tenor too -- had persuaded the government to enroll these people in Blue Cross. The state was having all kinds of problems. Tierney solved it by giving them a Blue Cross card and making them part of the regular system. It worked like a charm. The next thing he did was take on the lower income people under 65, in effect Medicaid, but years before Medicaid's invention by Congress.

At any rate Tom had started this pathfinding and I voted for him to be the BCA head. But Walter got it and he certainly proved to be an

inspirational leader with an unusual gift to see the future. His first move was back to Chicago with the headquarters into the AHA building.

Later Tom Tierney was made the first head of Medicare. He has been in government ever since. He has been buffeted about. I was always disappointed Tom wasn't offered a job as the head of one of the big Plans in the nation.

Walter latched on to Tierney. He latched on to another bright young guy, Alex McMahon, who had just been made head of the North Carolina Plan -- they combined the two Carolina Plans -- and myself. Walter held two three-day meetings for the four of us at Vail -- sort of think-tank things.

I remember talking to Alex McMahon, saying, "Alex, the way you are going to win the marketing war in North Carolina is to offer better benefits than anybody. Back then the cost difference between a mediocre package and a super package was something everybody could afford. He didn't last very long in the Plan. He soon was appointed head of AHA from which he just recently retired. He and Walter got along like Damon and Pythias.

WEEKS:

I had a nice interview with him.

STEWART:

He and Tierney were much alike in that they were both young lawyers, both talented, high class intellectuals.

The development of this whole Blue Cross was fascinating in many ways. It grew like Topsy. It grew despite incompetence, misdirection. No matter what you did, the new thrust, the new economic, and the new social thrust simply expanded blue Cross enrollment. The enrollment would go up, then level out, then something new would come along, a new energizer. If you could ever say that any business was a child of destiny, an idea whose time had come,

Blue Cross was it.

A factor that is often missed in this day of computerization is how similar each Plan was, one to the other, in the early days. Each Plan's operation was almost a mirror image of the others. Even the forms were the same size and makeup. If you knew one Plan's operations, you knew them all, because they all grew out of a central stock, like a family tree. For example, Cincinnati, Wisconsin, Buffalo, Syracuse, and New Haven were all started by Rochester people who simply lifted out systems and put them in place. Consequently, when someone came up with a new and better way, we could all apply it immediately, if we cared to.

All the systems were similar and manual. One of the first things I did when I realized this, was to start a series of trips to other Plans to see who did what best. Not only did we establish close ties with other Plans but also we came back with great ideas. The best of all came from a trip to Minnesota where, under Dick Christ and Bob Koch, they had developed a membership claims system that was extraordinary and economical. We ended up sending a whole team up and transplanting the whole system to Rochester.

It was a great success. We repeated this time and again so that by the early 1960s we had one of the best and most economical operations in the nation. The Plans these days don't seem to take advantage of this capability which still exists in operations which someone said isn't one damn thing over and over and over. Not to use others' ideas was a waste, and I was determined to be a lead dog. Otherwise the view never changes.

WEEKS:

One of the pioneers I talked with I asked, "How did you set rates in the beginning?"

"Well," he said, "we looked up some figures and it seemed that the average hospital stay was so long and that the number of days the average person spent in the hospital were so many in a year. We took the hospital rate of the highest hospital in the area...

STEWART:

...multiplied that out, divided it by the number of people and came up with a dollar or something like that.

WEEKS:

They had to add 10%...

STEWART:

...for administrative.

WEEKS:

For error, too. They made the percentage large enough so that they made a surplus.

STEWART:

Lew, they made them large enough, because most Blue Cross Plans didn't increase rates for five years at a time. Even later on in the 1940s and even the 1950s, rate calculations were pretty crude and most often determined by state politics, which even with modern sophistication and computers is still true today.

WEEKS:

When you stop to think of today's modern data banks, computer operations...

STEWART:

I can remember Alan Thompson, vice president and actuary of the New York Blue Cross, originally acted as actuary for all the New York Plans. He was so

conservative in his rate filings. The first thing I did when I was appointed head of the Rochester Plan was to change actuaries. I wanted rates that would only last two years not five. Now you couldn't afford to have a rate increase for more than a year at a time.

WEEKS:

You certainly were looking for a margin of safety there.

STEWART:

The margin of safety became a short time.

WEEKS:

I think before we go any farther we should mention some of your awards. I think this should go into the record. Your Justin Ford Kimball Award from AHA is one of the outstanding awards of your life, isn't it?

STEWART:

Oh, yes. Of course, and particularly because the Justin Ford Kimball Award was given by the AHA, not the Blue Cross Association. It stemmed out of that old Blue Cross Commission relationship. I don't know what has happened to the award this past year.

WEEKS:

Didn't you receive it recently?

STEWART:

I got it in 1985. It was the last one apparently. The national Blue Cross is establishing their own award, the Rufus Rorem Award.

WEEKS:

That should be.

STEWART:

Ed Werner will be the second to be honored. Rufus was the first and they

named it after him. He is still active, after having been in on the creation of the commission and heading it up in the thirties. Talking to him is like talking to a member of the constitutional convention of the 18th century.

WEEKS:

I am pleased to hear that the award is named after Rufus because he deserves to be remembered.

This Folsom Family Award, is this...

STEWART:

The Folsom Family Award is one the Folsom family gives occasionally, when the spirit strikes them. So somebody must have arranged for the spirit to strike the Folsom family. His son and his daughter are still in Rochester. I think his daughter-in-law was also there. They gave it to me as sort of community goodness.

WEEKS:

For innovation.

STEWART:

That's right.

WEEKS:

The Genesee Region Home Care Service Award?

STEWART:

For the home care program which we started, and which by the way now has been put under the Blue Cross corporate umbrella. The Genesee Home Care Corporation is now under the Blue Cross umbrella. That occurred just after I left. We were moving sort of closer and closer together. As you get into HMOs and all this vertical financing, home care becomes a more and more valuable instrument in that situation. They gave that award to me.

WEEKS:

I can remember in 1962 I worked with John Griffith at the McPherson Community Health Center in Howell, Michigan on a study of progressive patient care. Part of that was a hospital-based home care program. There was no visiting nurse service in that county. It was a small county. I can remember going down with two or three others to Blue Cross to get a special research benefit. Any one of their subscribers could have home care for the three year period of research. After that they made it a regular benefit. I am a very firm believer in home care.

STEWART:

The Rochester program is a big thing now -- multi-millions of dollars with over 230 patients on average daily census. Almost half are under 65. We expanded into early maternity discharge about 10 years ago. We paid the full cost of maintaining a new mother at home, for three days, if she goes home within 24 hours after delivery, two days if 48 hours.

WEEKS:

That also includes the home aide?

STEWART:

Everything.

After that we started a hospice program in about 1978. It's all part of the same system.

WEEKS:

Hospice services start about six months before expected death?

STEWART:

We required a closer approximation and accepted patients with an expectancy of about eight weeks. We pay for the works, every penny, for

everybody, for everything including the visiting health aide and bereavement counseling.

WEEKS:

You have a special service for hemophilia, don't you?

STEWART:

When I first started with Blue Cross hemophiliacs were treated sort of like people with venereal disease. They just weren't covered by any Plan, anywhere. They were regarded as freaks. I became familiar with hemophilia primarily because Dorothy White whom we employed in 1960 to start the home care program was part head of the hemophiliac center. She pushed me to provide outpatient care in the center and eventually care at home. Before this, the only way they could get care was to go into the hospital, and, even there, the blood expense wasn't covered. So, we provided paid-in-full benefits in the hemophiliac center and we paid for hemophiliac blood. This was the world's first. I couldn't believe it.

As a result, within five years our hemophilia center was a national model. It was the only one in the country with complete financing. Everything they did, we paid for. They were keeping hemophiliacs out of hospitals. We ended up having hemophilia patients move to Rochester from all over upstate New York.

The total cost to Blue Cross was a couple of hundred thousand dollars. It made such an impact on improving the care and the lives of our subscribers. After all, that's what Blue Cross is all about.

WEEKS:

If it is a social movement, it should be a social movement.

STEWART:

We were supposed to be doing something with the money. If I am like Aetna, I take the money in and then put part of the money out. But if I am Blue Cross, I take the money in and then do something to improve the care and enhance those dollars.

The first big achievement under our home care was emptying the pediatric orthopedic wards. The kids in the wards were lying there with big casts on them with iron bars between their legs, or what have you. The hospital was trying to cheer them up. The education department was trying to keep their minds from turning to mud. We moved them all home.

WEEKS:

This is where they wanted to be.

STEWART:

Think of the change in the life of a five or ten year old.

WEEKS:

This is the thing about home care for any patient. Everyone who is in the hospital wants to be home.

STEWART:

Right!

WEEKS:

If they can send them home...

STEWART:

Why not?

People say, "How much do you pay for home care?"

In 1962 I would cite figures like \$38.

They would say, "\$38! We are caring for people at home for a dollar and

a half!"

Of course, they were talking about traditional visiting nurse services. The difference was that in Rochester we were providing hospital level care in the home for maternity and the like. Patients had to meet criteria to be accepted. The best way to think of it was, without our home care you stayed in, or were admitted to, a hospital. Early on we had a prior hospital admission requirement, but got over that, and, as a result, cared for many stroke and heart patients who, because of home care, never even had to be admitted. The program covered -- still does -- all bills just as if the patient was in the hospital -- all equipment, supplies, medication, nursing, and home help.

WEEKS:

I think it is marvelous.

This Ruth F. Wilson Award, is there any relationship to Joe Wilson?

STEWART:

No relationship. That was from the statewide home care association where I was active at the board level. Rochester was always being held up as a shining example.

I was also president of the New York State Homemakers, Home Health Aide Association, which we merged with another to create the present statewide Home Care Association.

WEEKS:

You received an award from the Hemophilia Association.

STEWART:

One was national and the other local. We were the first insurer anywhere to ever pay for hemophiliac blood.

WEEKS:

The last one, you are proud of too, is the Hutchison Medal.

STEWART:

I was very proud of that. It's for what they call distinguished alumni. The top of the honors list have to be the Justin Ford Kimball Award, the Hutchison Medal, the Folsom Award, the Hemophilia, and Home Care Awards. I have told people though that I received the Justin Ford Kimball because my mother's cousin was Mrs. Justin Ford Kimball -- Annie Lou Boggess, I think her name was.

WEEKS:

I have always been amazed at the speech he was supposed to have given at the AHA meeting but was read by someone else. People went away from the meeting without realizing how important this idea was. Maurice Norby said his father came home to Minnesota very excited about it, and probably stimulated the founding of one in Minnesota.

STEWART:

According to what I've found out, Justin Ford Kimball had the ideas, but what put his name into real posterity was a fellow who worked for him who was a superb PR man. He was the guy who wrote Justin Ford Kimball's speeches, and kept the ball rolling. I am sure the reason Justin Ford didn't give some of his speeches personally was that he didn't write the speeches.

WEEKS:

Of course, all of us in the business know there were many, many types of hospital insurance before this. It's nice to have a symbol.

STEWART:

vanSteenwyk invented the Blue Cross when he was in Minnesota before he

went to Philadelphia. Carl Metzger of Buffalo invented the Blue Shield.

WEEKS:

His name is not familiar to me.

STEWART:

Carl Metzger first worked for Rochester, and then started the Buffalo Blue Cross and the Buffalo Blue Shield. He came up with the snake and the caduceus with the shield.

WEEKS:

Do you want to say something about the possible merger of Blue Cross and Blue Shield in Rochester?

It is already under way. I retired because I was unacceptable to the Blue Shield board's doctors to be the single head. But it's progressing well under Howard Berman's leadership. The Blue Cross and Blue Shield Plans must merge. We can't have as many Plans as we have although conceivably with regional operating centers the multiple Plans might be able to continue.

WEEKS:

There is some merging going on in New York State now, isn't there?

STEWART:

Syracuse Blue Cross and Blue Shield merged a couple of years ago. Utica Blue Cross and Blue Shield merged a year ago. Albany Blue Cross merged with New York City two years ago. The Albany Blue Shield has fallen on evil times and is now in the process of merging with Buffalo Blue Shield. Buffalo Blue Cross and Blue Shield are, in their mutual relations similar to Iraq and Iran.

All these problems date back to the genesis of the Blue Shield in New York. Remember, I said that Blue Cross was circumscribed in the law into a narrow corridor of hospital bills. So, in order to have a Blue Shield Plan,

you had to have a separate corporate structure. The physicians who first walled Blue Cross off from getting into the medical side then wanted one to pay the doctors. In the state of New York you could not have a single corporation pay both, so the Blue Cross people set up and ran the programs. This occurred in many places across the country. Then, in the fifties business was expanding. It was an incredible life. All over the country Blue Shield people and doctors looked at that and said, "Look at that Blue Shield business. I am going to split that off and run it." So, it became a whole new career for a lot of people and a power base for medicine in the new world of medical economics.

Eventually they will have to merge or die. The little Plans are already largely gone, not because they are not good or not because the people don't have their head screwed on right but because the businesses in a small Plan area require all kinds of complicated processing. Many are divisions of large corporations with national contracts and many sophisticated specifications. Small Plans don't have the software capabilities to meet these new complications. Systems expenses are driving the plans to mergers.

WEEKS:

Would you like to look at the future and tell me what you see down the road, not only for Blue Cross, but anything else?

STEWART:

People are going to be receiving their health care pretty much as it is. The most successful will be the Plan whose members perceive them as accessible, as responsive, as reasonable in cost and as of high quality. Those are the programs that are going to win.

WEEKS:

What is your prediction for the for-profit?

STEWART:

I think that the for-profits that combine insurance companies and hospitals are always going to have big problems. The for-profit insurance company and the for-profit hospital sitting in the same bed together are really warring camps. A lot of them apparently don't understand that. They think that the insurance carrier is going to bring a whole bunch of people and put them into the hospital which is then going to make a bundle of money. What they forget is they are going to lose their fanny in the insurance company. They don't understand that what succeeds in one is diametrically opposite to what succeeds in the other. I think what we call managed care -- that means the discipline that was invented by HMOs -- is a permanent fixture of American health care. Preadmission certification, all the rules and regulations that promote economical use of the system are going to be here forever. Utilization rates across the country are going to continue to drop. There are a lot of different managed care programs. There are HMOs, PPAs, and there is just plain managed care. I would say that if every Blue Cross Plan in the country simply said, "As of next January 1 every single Blue Cross contract will be a managed care contract" -- I would say enrollment in HMOs would grind to a halt. Grind to a halt because a managed care program can be implemented with standard benefit packages which have much greater flexibility, so far.

I don't see any particular change occurring in malpractice. There is no significant indication on the part of the courts or legislatures that they are ready to revolutionize the tort system. I think it is going to mush along as

it is. I see no way to significantly reduce it. Keep in mind, however, that closed panel HMOs have significantly lower rates of malpractice than do regular fee-for-service private practice physicians. Significantly lower rates.

Upstate New York has significantly lower rates than downstate New York, like 20%. If you regionalized by HSA area, you would find even greater variations within a single state.

The discipline of managed care programs, HMOs, and so forth, tend to diminish the cost of malpractice. HMO enrollment across the country is going to depend on how everybody, primarily the Blues, handle their regular business. If they manage it, they are going to stop the rapid growth in HMO enrollment with a package that is significantly lower in cost. So I would look forward to HMOs as having to significantly alter their benefit structure to provide deductibles and co-insurance. That is what I would be preparing for now. There are all kinds of magnificent opportunities in health care cleverly disguised as insoluble problems according to John Gardner. That's health care and I'd love to be in it. I was lucky to be in it when I was, and I still love it. I wish I was in it even more.

WEEKS:

As a last word: Will self-insurance grow?

STEWART:

Not that much.

WEEKS:

Of course this comes under many...

STEWART:

Under many guises. Self-insurance, when farmed out to claims

administrators who then apply all the rules and regulations of HMOs and managed care programs are not self-insured. They are managed care programs with a slightly different financing base. The world is going to managed care. It's got to. And employers can't run such programs -- it's too invasive.

The real thing now is: What are America's hospitals going to do now that they can see that the under-65 population is rapidly moving to 350 days of care a year, and the over-65 population is rapidly moving to 2,000 days a year. No matter where you are you come out with an incredible impact on your local hospitals.

Planning will rise again!

Interview November 6, 1986

In Ann Arbor, Michigan

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