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Building the Movement

The national growth of the Blue Cross movement resulted from hundreds–thousands–of persons contributing ideas and devoting a great deal of time, both off and on the job, to its development. Many of these ideas occurred at the same time, but independently of each other. John R. Mannix,[1] for example, worked independently developing the Cleveland plan at a time when six other plans were being developed.

Unfortunately, some of these pioneers are no longer alive to converse with. One was E.A. van Steenwyk, the ingenious young builder and financer of houses before the depression who started the St. Paul plan. Mannix, however, is available to tell his story.

MANNIX:[2]

My involvement in Blue Cross began probably before I realized it.

In July of 1932 I established an all-inclusive rate system at University Hospitals of Cleveland, eliminating all separate charges for ancillary services. We had one rate, which varied only by the type of accommodation, whether it was a private room, semiprivate, or ward accommodation. At the start, we offered the patients the choice of a daily rate plus extra ancillary service charges or the all-inclusive rate. Ninety-two percent of all patients chose the all-inclusive rate. This system was in effect at University Hospitals for close to 50 years.

In this process, I realized that we were taking the cost of all the ancillary services and

the individual patient. Recognizing this, it occurred to me that we could carry this basic idea of cost averaging even further. Instead of just taking the rate and dividing it among people hospitalized, you could average it, or divide it, among all people, whether they were hospitalized or not. This simple notion was and still is the basis of Blue Cross.

Cleveland Blue Cross

With this idea as the base, I attempted to convince the Cleveland hospitals to take some official action with respect to developing a prepayment plan. I was having difficulty making much headway. However, in November 1932, and I think only because I continued to press the issue, the Cleveland Hospital Council, which was the local association of hospitals, now known as the Greater Cleveland Hospital Association, decided to appoint a committee to study the development of a program for the prepayment of hospital care in Cleveland.

As so often happens, and as much as I argued against it, I was appointed chairman. We had a committee of three people. The other members were a Dr. Woods, who was the administrator of St. Luke's Hospital, and a Dr. Rockwood, the administrator of Mt. Sinai Hospital. The three of us worked for more than 18 months, until mid-1934, to establish a hospital care pre-payment plan–a Blue Cross plan.

Having helped to establish the plan, I thought my contribution had been made, particularly since I was viewed by some, because of my work in starting the plan, as a "Communist, out to socialize medicine." At the time, I had no intent or interest in becoming connected with Blue Cross as a paid employee. My interest was in hospital management. I thought that was where my future was.

We had the problem therefore of finding an executive for this new organization. With a large number of Americans out of work, there was no scarcity of applicants. My feeling, however, was–because this idea of prepayment was so new–that we should hire somebody who knew not only something about the hospital and health field, but someone who also had promotional ability.

At that time, John McNamara was editor of *Modern Hospital* magazine. I recommended him for the position. He ultimately accepted it, and he was very successful. In a very short time the Cleveland plan became, from an enrollment standpoint, the largest in the country. From 1934 to 1939, because I was chairman of the committee that started the plan, I was called upon by a great many people around the country, mostly hospital people, to help them develop their own Blue Cross plans. For example, I had some part

in starting all the Ohio plans: Akron, Youngstown, Toledo, Columbus, and Cincinnati. In every one of these plans, I met with key people at their request.

I also met with people in Rochester [New York], Chicago, Des Moines, and Indianapolis and had some part in the development of those plans. All during this time, I was the associate administrator at University Hospitals of Cleveland. I did all this on a gratis basis and in most cases paid my own expenses.

I ran into many interesting things in those local meetings. It was not unusual to have somebody get up in the audience and ask, "What are you getting out of this?" There was disbelief that someone would be willing to do what I was doing just because he believed in an idea.

Michigan Blue Cross

As noted, Mannix felt that his main career interest was in hospital administration. In fact, as is discussed in later chapters, he was actively involved in the 1930s in reshaping and energizing the AHA. Therefore, it was a surprise to many in the hospital field when it was learned that he had accepted the job of establishing, promoting, and directing a statewide Michigan Blue Cross Plan, with headquarters in Detroit.

MANNIX:[3]

I had been working with some of the hospital administrators in Detroit. They had contacted me sometime in the middle of 1938 because they had formed a committee to study the development of a hospital prepayment plan for Michigan. I met with their committee several times in September and October 1938.

In about November they asked me if I would be interested in becoming the executive of their plan. I said no, that my interest was in hospital administration. They made more attractive offers over the following several months.

I liked the Michigan people. Some of them were important leaders in the hospital field. I was working principally with the administrators of the Harper, Grace, and Ford hospitals. At that time Stewart Hamilton was the head of Harper Hospital; his son, J. Stewart Hamilton, later became the executive of Hartford [Connecticut] Hospital. In 1963, the son served as president of the American Hospital Association.

Warren Babcock was the administrator of Grace Hospital. He was the father of Kenneth Babcock, who was later to become the chief executive of the joint Commission on Accreditation of Hospitals. Ira Peters was the administrator of Ford Hospital.

Henry Ford, Sr., was chairman of the board of the hospital at that time.

The committee persuaded me to take the Michigan position. I was interested for two reasons. First, the Michigan plan would be a statewide program. Second, the state medical society was at the same time also very interested in developing a medical plan. At that time there was only one other medical prepayment plan in operation. California had started one in August 1939, but it was making very little headway. The Michigan State Medical Society was interested, and I was intrigued with the potential for a statewide hospital plan combined with a statewide medical plan.

So I took the job. My idea was that I would stay for two years and then go back to hospital administration.

The Michigan Blue Cross Plan began with only a $10,000 loan, a third of which was contributed by Grace Hospital, a third by Harper Hospital, and a third by Ford Hospital. Edsel Ford gave his personal check for the Ford share. He also gave the odd penny, by the way.

I arrived in Detroit in February of 1939. Almost immediately, the plan had spectacular growth. We enrolled some sizeable organizations in Detroit, including J.L. Hudson, the large department store, and Parke, Davis, the drug house. Ford Motor Company also expressed interest from the very beginning. (As I said, a third of the original financing came from Edsel Ford.) As a result, we enrolled Ford in the latter part of 1939.

There were also at the same time some dark clouds. In 1939, General Motors elected the Metropolitan Life Insurance Company's hospital plan. The General Motors decision made me wonder about the future of Blue Cross plans; here was the largest corporation in the country going with a private insurance company rather than with Blue Cross.

Metropolitan's hospital plan only provided $4 a day toward hospital care and $20 toward all ancillary services. I was convinced that the way to solve the problem of financing hospital care was not through a cash indemnity arrangement. What people needed at the time of hospitalization was service benefits, complete payment–full financial access to services. Blue Cross provided service benefits. We paid for a semiprivate room in full and for ancillary services in full.

I continued to work with General Motors. Two years later, in November 1941, General Motors changed to Blue Cross. This was a great impetus not only to Blue Cross of Michigan, but also to Blue Cross nationally, because we enrolled General Motors nationwide.

There is an interesting story in connection with the General Motors enrollment. To get ready to implement the General Motors contract, we brought together Blue Cross plan executives from all around the country for a meeting. We discussed with them the details of General Motors enrollment. Following the meeting, one of the Blue Cross

executives said to me, "That was a mighty fine thing you did [enrolling General Motors], mighty fine thing for Blue Cross, but I can't take those subscribers."

I laughed and said, "What are you talking about?"

He said, "I can't take those subscribers."

I said, "What in the world are you talking about?"

I am quoting: he said, "I've got 25,000 subscribers in my plan. I don't know what I would do with more subscribers."

There was only one thing that saved me from having a real problem. The General Motors benefit was scheduled to go into effect in Michigan on November 1, 1941. For General Motors employees in all other states, the benefit was not scheduled to go into effect until January 1, 1942. Pearl Harbor occurred in the meantime, and General Motors closed their plant in the state where the plan had said that they could not take any more subscribers. In fact, General Motors did not reopen that plant until some years later. By that time, taking on new subscribers was no problem.

The success of the program with Ford and General Motors resulted, a year or so later, in Chrysler enrolling in Blue Cross.

At the same time that we were making enrollment gains, we also made progress in other areas. For example, at the outset, we had only a hospital plan in Michigan. Ford Motor Company, however, insisted upon having coverage for both hospital care and for surgical care. This resulted in a whole series of meetings with the Wayne County Medical Society, as well as with representatives of the state medical society. In March 1940, about a year after I arrived in Detroit, the state medical society finally agreed to start a companion organization, Michigan Medical Service, to cover surgical care. The Ford Motor Company was the first participant in this joint program.

Michigan Medical Service maintained its own organization for claim payment purposes. A dual arrangement continued for many years; however, within the last few years these two organizations have merged into a single corporation.

Also during the early 1940s, the United Auto Workers developed an interest in the hospital and medical plan. The driving force behind their interest was basically a desire on their part to have a means of protecting their members from the cost of hospital and medical care.

Their position for achieving this goal was not, however, what you might guess. During the early part of the 1940s, the entire cost of hospital and medical benefit coverage was paid by the employees. There was no company contribution. The motor companies simply agreed to deduct the cost of coverage from the employee's paycheck.

Walter Reuther, president of the UAW, seemed comfortable with this approach. In fact, I can remember at one meeting with General Motors officials, the matter of company

contributions came up. Reuther made the statement that the company should give the union members the money and let them pay for the care. He actually was opposed to direct company contributions.

The movement toward direct company contributions probably, however, was inevitable. As far as I know, it started developing nationally during World War II. The reasons for this were several. One was the cost-plus basis for paying for war production. Another was the fact that there was a great labor shortage. Employers could not attract workers by raising wages, because wages were frozen by the federal government. Employers could, however, increase fringe benefits. Employers therefore became interested in paying very liberal fringe benefits, one of which was health care benefits. There also developed another situation, which still pertains today: The cost of health care for employees was tax deductible as far as the employer was concerned, and it was tax exempt to the employees.

What really changed the situation on company contributions, however, was the refusal of the steel companies in 1948 to bargain on health benefits with the United Steel Workers union. The steelworkers went into court. The case ultimately went to the United States Supreme Court. The Supreme Court decided that fringe benefits were a bargainable item. After that decision, the spread of company contributions greatly increased. Today it is a rare company of any size that is not paying at least part of the cost of health benefits.

There is an interesting sidelight in this connection. When I first went to the Michigan plan, I took the position that the cost of health care should be paid by the employee rather than the company. I made this position pretty much a rigid rule. Some people in one Michigan area, primarily county employees and school teachers, wanted the county and the school board to pay part of the costs of hospital and medical care. I would not agree to this. The county commissioners went to the state legislature and secured legislation to permit the county to make contributions. This is interesting, because many people believe organized labor took the initiative and forced contributions from employers. Historically, at least in Michigan, this was not true.

Chicago Blue Cross

The statewide Michigan Blue Cross and the payroll medical plan (now called Blue Shield) were precedent-setting organizations. Here also were the beginnings of contracts for national coverage for employees of corporations doing business and maintaining branches throughout the country. After such a sensational start-up, based on original capital of only $10,000, it seemed strange that John Mannix

would leave Detroit to become director of the Chicago plan. He explains his reasons for leaving Detroit.

MANNIX:[4]

When I took the position at the Michigan plan, I had no intention, as I said before, of staying on the operational side of Blue Cross for more than a couple of years. Not surprisingly, my plans changed. I guess I should have realized from the outset that it was more likely than not that things would change.

As it turned out, after I had been in Michigan for five years, I was approached by the trustees of the Chicago Blue Cross Plan. They wanted to know if I would be interested in being the chief executive of their plan.

I went to Chicago for several reasons. First, it was the center of health activities in the country. It had the American Medical Association and the American Hospital Association, the national Blue Cross headquarters, and the American College of Surgeons. *Hospitals* magazine was published there; *Modern Hospital* was published there. There were meetings of health groups in Chicago nearly every day in the year. Illinois was also a much more populous state than Michigan; and Chicago was a much more populous city than Detroit.

The Chicago Blue Cross Plan had been started more than two years before the Michigan plan but was only about half the size. Also, I thought it was very important in the city that was the center of health activity to have a strong Blue Cross and Blue Shield Plan. There was no Blue Shield Plan there at all, although at that time the Michigan Blue Shield Plan was five years old. By that time [1944] I had also forgotten about my two-year limit away from hospital administration.

Taken all together, the challenge and opportunity were too attractive to turn away from. So I went to Chicago.

During the 24 months I was chief executive of the Chicago plan, we increased the membership from half-a-million to a million, enrolling as many people in two years as they had in the previous seven, and had the development of the medical [the Blue Shield] plan very much under way.

Prior to Mannix's arrival as director of the Chicago Blue Cross Plan, Robert M. Cunningham, Jr.,[5] worked for the plan. Cunningham later went on to be editor and publisher of *Modern Hospital* and chairman of the editorial board of its successor, *Modern Healthcare.* In his reminiscence about his time with Blue Cross, Cunningham provides an interesting insight into the early operation of a Blue Cross plan.

CUNNINGHAM:[6]

The plan started operations in 1936. I went there full-time in 1938, doing public relations work and being the general errand boy for the plan director. I also got involved in hospital relations activities, such as they were.

We had an obvious interest in hospitals, as we were a major paying agent with maybe 10,000 to 20,000 subscribers in the Chicago metropolitan area. We represented enough revenue that the hospitals were concerned about the rate of payment. We, in turn, were concerned about setting up a sensible accounting base for payment so that it had some relationship to costs and charges.

My recollection is that our payments at that time amounted to about $6.00 per patient day. However, the director of the plan was concerned about the rather casual accounting that he observed in some of the hospitals, so he hired a certified public accountant, who had done some work for some of the hospitals, to put on a series of lectures on cost accounting through the Chicago Hospital Council.

I remember the president of the Chicago Hospital Council, who was the administrator of a respected hospital and who also was a retired clergyman, as many of the administrators were in those days, expressing himself at the end of one of the lectures. He said, "I don't know if we have to go through all these details. You are either going along all right, or you are not going along all right, and that's all there is to it." That always entertained me as an indication of the level of sophistication of accounting in hospitals at the time.

One of the organizers of the Chicago Blue Cross Plan was chairman of the board of trustees of one of the Chicago-area hospitals. He arranged for the director of the plan to come to a meeting of the medical staff of his hospital to explain what the plan was doing and what hospital prepayment was all about. As it turned out, I went along; it was part of my education.

When the director started to explain what we were doing, it began to appear that the doctors didn't want any part of it. During the question and answer period it became clear not only that they didn't want anything to do with it, but that they also thought that Blue Cross was probably Communistic. It was a very awkward situation and an angry crowd. Of course, the chairman of the board, who was there and who had arranged the whole thing, was upset about it. I was upset, but the director of the plan took it all calmly.

When the meeting was finally ended, he said, "Don't worry about that, don't worry about anything. It doesn't make any difference if those fellows don't like it. They will learn to like it. I can foresee a time when there may be as many as a million

members in hospital plans like ours all over the country."

I thought he was smoking opium.

* * *

Another episode I haven't thought of in many years happened at one of the Catholic hospitals. We had a complicated basis for payment, even in those early times.

We discovered that we had overpaid this particular hospital. As one of my miscellaneous duties, I was sent as an emissary to go out and explain to the Sisters that they had been overpaid and arrange for a settlement of the account.

It turned out that the hospital was run by an order of Eastern European nuns who had come to this country fairly recently and had a little difficulty with the language. The administrator and the business manager were both Sisters. None of us understood what we were doing very well, and also we had a little language problem. Finally, we worked our way through the accounting statement and the Sisters agreed that, yes, indeed, it was four or five hundred dollars that they had been overpaid.

I said, "You can either send us a check or we will take it out of your next payment."

She said, "Oh, no. We owe, we pay."

She dug into her habit and pulled out a roll of bills and counted out $400 or whatever it was and insisted on me taking the money in cash. I have often thought about that. "We owe, we pay" is kind of outdated. Nonetheless, it seems like a fairly sound basis for running a hospital, or any other business.

The John Marshall Insurance Company

Mannix spent two years in Chicago and rapidly expanded the enrollment there, making the plan a successful operation. After two years, he evidently felt there was something missing in the Blue Cross format that could only be corrected by establishing a single organization operating and offering benefits nationwide. The proposed organization apparently seemed beyond the scope of Blue Cross plans. When it was mentioned that his move from Chicago to found a commercial insurance company (the John Marshall Insurance Company) to offer Blue Cross-like service benefits nationwide was surprising, he explained.

MANNIX:[7]

I can't speak to the level of surprise.

Let me, however, tell you a bit about why the John Marshall Insurance Company

was created, how it was to operate, and what happened to it.

In 1939, right after I went to Michigan, I felt that there were too many separate Blue Cross corporations. I felt that there needed to be much more coordination among the plans. For example, because of the lack of coordination or the number of plans, I had encountered great difficulty in working with national employers. This started with the enrollment of Ford Motor Company, which wanted coverage for its employees throughout the country. As I mentioned, we also saw this, and saw it to a much greater degree, when General Motors enrolled.

In view of all the circumstances, I think we did a very good job in working with national employers. There was, however, much difficulty, because hardly any two Blue Cross plans in the country had the same set of benefits.

I first proposed a national organization with the chartering of local units in 1939. The head of one of the larger plans in the country nearly read me out of the Blue Cross movement as a result of this. The plan executives were concerned about their local autonomy.

In 1944, I proposed an American Blue Cross with a national charter similar to the charters of the American Red Cross or the American Legion, with chapters throughout the country. Again, there was little support.

Later, however, the executive of the Blue Cross plan in Huntington, West Virginia, approached me. He was very interested in solving some of the problems of nationwide enrollment and serving national employers. He asked me if I would be willing to consider starting an insurance company that could be licensed in all 48 states and which would then be able to solve some of these problems. I was. The result was the John Marshall Insurance Company.

Even though it was organized as a commercial insurance company, one of the things I insisted on, and had a written agreement on, was that at least 99 percent of the income would be used for hospital and medical care, or for necessary overhead, limiting corporate dividends to 1 percent of gross income. People were willing to finance this and agreeable to the 1 percent limitation on any dividends. Although I had been connected with nonprofit organizations, I felt we could afford 1 percent of the gross income for stockholders if it solved many of the other national problems.

Among other things, I was interested in extending benefits to at least 120 days. At that time, it was difficult to get many Blue Cross plans to provide a benefit period of more than 70 days. It was difficult even though (1) there was a national demand for this kind of benefit on the part of the large employers and (2) it did not cost very much. The greatest cost of hospital care, as you know, is in the earlier days of the patient's stay.

As I said, the ultimate result was the establishment of the John Marshall

Insurance Company. I began the company in July of 1946. We started with $500,000 in capital.

The $500,000 originally seemed like a great deal. It would have been more than enough, except for the fact that hospital costs increased substantially right after the war.

From the outset, I had been concerned about possible inflation and its effects on this venture. I was assured by everyone that after the war we were going to have a major deflationary period. Everybody thought that with the stopping of munitions manufacturing that there was going to be a deflationary period. Well, we were wrong. Exactly the opposite occurred; we had severe inflation.

As a result of inflation, the $500,000 in capital was not enough. We had real financial problems. Finally, we had an opportunity to sell the company to Bankers Life and Casualty, which was owned by John MacArthur. We did.

Just about the time I sold John Marshall Insurance Company to Bankers Life and Casualty, the chief executive of the Cleveland Blue Cross Plan retired. I was contacted by the trustees of the Cleveland plan as to whether I would be willing to come back.

I came back to Cleveland in August 1948 to be the chief executive of the Cleveland plan for the next 17 years. I retired early in 1965.

Few people in the Blue Cross movement could understand why Mannix lent his name to the John Marshall Insurance Company. Among his Blue Cross peers it was considered close to immoral to handle hospital care as a commercial venture, to profit on people's illness. The fact that Mannix was trying to solve the national account benefit problem, to provide a service that the confederation of Blue Cross plans could not, was given secondary consideration. Mannix was shunned by his former colleagues. It was only several years after he went back to the Cleveland plan that he was again accepted back into the movement and elected to offices in the Blue Cross Commission.

Minnesota Blue Cross

While Mannix was working on one track, there were a father and son in Minnesota who were also making significant contributions to the growth of the prepaid group hospitalization movement.

The father, Joseph G. Norby, was superintendent of Fairview Hospital in Minneapolis and one of the early leaders of the prepaid group hospitalization movement in the Minneapolis-St. Paul area. (In 1949 Joseph Norby was president of the AHA.)

The son, Maurice J. Norby,[8] was a schoolteacher in Minnesota in the earliest days of the prepaid group hospitalization movement. Norby was a valuable link between the Blue Cross movement and hospitals, working at the Blue Cross Plan Commission with C. Rufus Rorem,[9] developing and operating the Pittsburgh plan after working in the St. Paul plan under E.A. van Steenwyk, and rounding out his career with George Bugbee[10] and Dr. Edwin L. Crosby[11] on the staff of the AHA. His experience and contributions in these three settings proved invaluable.

Norby describes those days and his work with E. A. van Steenwyk.

NORBY:[12]

My awareness of what's come to be known as Blue Cross began in the early 1930s, when my father came back from an AHA convention. At that AHA meeting a paper was given–authored by Justin Ford Kimball–describing the experiment or program he had initiated in group hospitalization. It wasn't Blue Cross in those days, it was called group hospitalization.

My father was intrigued by the idea. Other hospital people also were. Whether the motivation of all these people was altruistic or more financially pragmatic–a way of helping to assure that hospitals would be paid–one can only speculate. Regardless of the motivating force, the results have been beneficial for both patients and hospitals.

My father worked diligently to get hospitals in the Minneapolis and St. Paul area to get behind a group hospitalization program. They were successful, organizing a group hospitalization plan in which the hospitals contracted with each other to provide service. Hospital A contracted with hospital B, and hospital A and hospital B contracted with hospital C. A, B, and C contracted with D. They had interhospital agency contracts. These contracts called for the hospitals collectively to guarantee performance under a prepayment plan for hospital care. In those days they were charging 75¢ a month for an individual.

If those 75¢ payments didn't stretch enough to pay the full bill, then the hospital was required to accept what money the plan had as payment for the services provided to the plan's subscribers. The hospitals in effect provided a guarantee to the subscribers. All the hospitals in Minneapolis and St. Paul were partners in this program.

My father was very influential in getting the Blue Cross plan started. He was one of the key movers in it. He was, I think, one of the first officers.

The plan was run by a man named E.A. van Steenwyk.

Van Steenwyk had gone to the University of Minnesota and gravitated to Chicago somehow. He borrowed money to build houses. He became known in the West Side of Chicago as the Boy Builder.

The way he did it, he told me, was that he would find someone who wanted a

house built and who could get money. Van Steenwyk would then dig the basement and charge the would-be owner the amount that it cost to dig the basement plus 10 percent, or some such figure. Then he would frame up the first floor and collect again for work completed to that point–and so on until the house was completed. He had little of his own money involved. In fact, he was operating on a shoestring. He kept on pyramiding until he had a number of houses being built that way.

This was before the depression. Then came the depression. Those folks who had contracted to have their basements dug couldn't make payments, and Van couldn't follow through. He had borrowed money to keep himself liquid, to keep ahead of the game. He had many holes in the ground with foundations in when he had to give up. He didn't go bankrupt, he just quit. He was even when he quit, but he had no money.

He came back to Minneapolis and got a job with a printer. He sorted the type, a menial job. They were printing primarily the *Minnesota Medical Journal* for the medical society. He got interested. He got to know them, and they got him doing some writing for the journal.

Then he heard about this group hospitalization development.

The committee that was organizing the group hospitalization plan also somehow heard about Van and got interested in him. He was a very persuasive fellow and a good thinker and honest. They hired him.

Van, one girl, and one room in the Globe building in St. Paul was how it began.

As this was going on, the public press got interested. There was much publicity about this new way to pay for hospital care. The radio station gave him free time. Van would go to the radio station, which was a block away from his office, and make his pitch to the public. He would then run back to the office to answer any phone calls that might come in. He also made a promotional movie. Even with these efforts, the plan grew fairly slowly.

In the summer of 1936, I was working on my doctorate degree. I had matriculated for summer school. One day that summer I went to the riverbank overlooking the Mississippi River and sat there thinking-I have my master's, my doctorate is practically done (I didn't have my dissertation), and I am being paid $107 a month to teach school. I sat on the riverbank thinking that my situation didn't make sense. I had to be worth more than that $107. I went back to the business office at the university and–I don't know how you would say it–"unmatriculated." I said that I had decided not to go to summer school and wanted my registration money back.

Then I went to see Mr. van Steenwyk. My Dad had told me much about him, but I had never met him. I asked him for a job. He said he was sorry, he would like to give me something to do, but he couldn't put me on the regular payroll, because my father was on the board or president or something. Finally, he did give me a job

of selling subscriptions to groups that his regular salesman had said were impossible to enroll.

Van said, "You can take those groups and try to sell them."

Blue Cross in those days was very sticky about not paying sales commissions. They didn't want to support salesmen who forced sales. They wanted low-keyed salesmen, so they paid them salaries. Van broke the rule with me a bit. He said that I could go out and try to sell those dead accounts and that he would pay me in proportion to my success.

So I did that during the summer and made an acceptable amount of money. I was a high-key operation, which Van didn't want. For example, the owner of the Minneapolis ball team, Walter Seeger, had a big manufacturing plant on the border of Minneapolis-St. Paul. He made bodies for refrigerators. They called it Body by Seeger. He was having union trouble. Management had been approached and had not permitted enrollment. The employees wanted it.

So I went to Seeger and said, "If you don't allow these folks to enroll with payroll deductions, I am hiring a calliope and I am going to run it up and down the street here with big banners on the side reading "Walter Seeger is a SOB." With the labor trouble you have now, it's going to make it worse."

I got Walter Seeger enrolled. It was a big feather in my cap. Van's hotshot salesman hadn't been able to do it. It was a group of about 400 people, a great big group. I was OK with Walter Seeger. He gave me season tickets in a box in the ball park–in his own box, I should say.

I went back to teaching school in the fall.

I was teaching in Fergus Falls, which was close to a small, rural town of Wadina, Minnesota (population 3,000-4,000). Van was interested in trying to get rural enrollment. Up to that time everybody had been working in metropolitan areas. Van knew I was near Wadina, so he asked me if I would try to get the people in the town interested in enrolling.

I went to the town and got to the chamber of commerce and got them to agree to promote a big town meeting for a certain night. As I mentioned, Van had made a motion picture called "How Pennies and Seconds Count." It showed an ambulance picking up somebody and rushing them to the hospital and so on. It was a good film. We showed that and then Abbot Fletcher, the treasurer of the plan, made a sales speech. Then I made a speech. I asked employers to take enough enrollment cards to cover their employees–a grocery store, a hardware store, a barber shop where there were two or three employees–and to find out how many of their people would enroll in this program if it was available to them. We said we needed their signatures on the enrollment cards in the event we decided to come in. Whether we could enroll them or not was a question, because we weren't allowed by the Hospital Council of Minneapolis-St. Paul to enroll outside the city bound-

aries. They said that the plan should be strictly localized to the metropolitan area.

I asked them to sign the cards and told them that I would be back the following week to collect them.

The reason Van wanted to move so fast was that the state hospital association was meeting in Rochester, Minnesota, the following week. He wanted to report on rural enrollment at that meeting. When I picked up the enrollment cards and totaled the numbers who had signed up, we had 90 percent of that town enrolled in one meeting–90 percent of the town! This was really something. This showed that the rural people wanted group hospitalization protection.

I went to the state hospital association meeting in Rochester and was on the program to report our experience in Wadina. I really was enthusiastic. There was a lot of discussion. The net result, however, was that the state hospital association voted *not* to permit group hospitalization outside the city limits of Minneapolis-St. Paul. They were afraid of allowing the Mayos and the hospitals of Rochester into the plan for fear that everyone in the state would run to the Mayos for their hospitalization. So that ended our rural enrollment efforts.

I went to work for Van that next summer again. That was about 1936. Then at Christmas 1937 I got a telephone call from Rufus Rorem in Chicago. Rufus wanted me to come down and see him.

Rufus knew Van. Van had told him about this rural enrollment experience that I'd had.

I went to Chicago to talk with Rufus. He offered me a job at twice what I was making teaching school.

Rufus wanted me to come and set up his office. (He had just left the Rosenwald Fund and had gone over to the AHA with his grant.) He said that it would take about a month. After that, he said, something would turn up. He mentioned van Steenwyk and said that he and Van got along real well.

I said OK.

I worked for Rufus for about three months. I then went back to Minnesota and worked full time for van Steenwyk.

By that time, my father had moved from Fairview Hospital to Columbia Hospital in Milwaukee. So there was no problem in my working for the Minnesota plan.

Pittsburgh Blue Cross

Shortly after I got back to Minnesota, Pennsylvania passed what they called an enabling act to govern the operation of hospital care prepayment plans. There was a fellow

in Pittsburgh by the name of Abe Oseroff, administrator of Montefiore Hospital,[13] who was very instrumental in obtaining approval of that legislative act. Prior to this time, most state legislatures had not passed enabling legislation.

The enabling act was passed, and the hospital administrators in Pittsburgh were looking for a developer and administrator for a prepayment plan. They invited van Steenwyk to come. He did not want to move from Minnesota, so he said, "Why don't you look at my man Norby?"

So I went to Pittsburgh and was interviewed by an organizing committee of hospital administrators and trustees.

Abe Oseroff, the promoter of the plan, was part of the committee. There was also the head of the Harbison-Walker Refractories, the president of Gulf Oil, an officer of the Mellon Bank, the president of U.S. Steel, and an officer of the Koppers Company. They were big names. Not only big names, but they had demonstrated their abilities. I was interviewed by them. However, I had the complete advantage, total advantage, because they knew nothing about group hospitalization and they were intrigued with the idea. Anything they got was new information, so they thought I was a fountain of knowledge in this endeavor.

I was still very young in chronological age but old in terms of experience with group hospital plans, because this was a newly developing phenomenon. I started work in Pittsburgh in the fall of 1939.

At the age of 31, I was starting a prepayment plan. I began by working on operational issues and systems. For example, I developed a very simple subscriber's contract. I wrote a contract on one page. In those days, the lawyers got to the early plan directors and put about four pages of whereases and all that kind of legal language into the subscriber contracts.

Well, I put in a simple system of operation. I insisted that all subscriptions be paid by payroll deductions. We sold hard. At the end of the first year we had grown to 100,000 subscribers–the largest first-year growth of any plan.

In 1940, I went to the American Hospital Association meeting in Cleveland. As part of the AHA's overall program there was a sectional meeting for directors of group hospitalization plans. The subject scheduled for the sectional meeting was a proposal to establish a public education program to promote the idea of group hospitalization.

Before the proposal could be debated, word came that the New York group hospitalization plan was broke and that there was big public hue and cry about possible mismanagement. Van Steenwyk recognized the real issue and said, "We don't need a public education program, we need a self-information program. We have got to know what is going on in our own plans and programs."

So they agreed that they would put money into a common fund and hire somebody who could run a program that would analyze their activities and give them facts and figures about how they were doing, statistically and actuarially and financially.

I was ready to go home at the end of the convention. My Dad was there at that meeting. He and I were having breakfast in the hotel coffee shop when Rufus came looking for me.

Rufus said, "Maurice, how would you like to go to work with me again?"

I asked, "What's going on?"

He said, "You were at the meeting. You heard the discussion and approval of the idea that the plans pay into a common fund to finance and distribute statistical information, and financial and operational information–a self–educational program."

Rufus repeated his offer, "How about doing it?"

I said, "Rufus, I don't know. I am happy where I am. Things are going well."

He said, "I have got to get somebody. You think it over. I want you in that job. It would complement my promotional work."

About one week later I got a call from Rufus.

He said, "How about this new job assignment?"

I said, "Rufus, I don't think I can really do it. I have got to keep this Pittsburgh plan going."

He said, "Think it over for another week."

I did that and sort of semi turned it down in my mind.

Then a couple of weeks later, on a Sunday morning, the telephone rang. Here was Rufus again on the phone. "Maurice, I have to know your decision right now," he said, "because the plan directors want their new program to get started. It has been delayed over a month. They want action."

I said, "I know, but how are you going to finance it?"

"They all agreed to make a payment."

"On what basis?"

"Just whatever they think is reasonable."

"How much have you actually got?"

Well, he had a couple of thousand dollars.

I said, "That isn't going to go very far–about a month–by the time I get a girl, furniture, and that stuff."

"Yes," he said, "but they will come through."

I said, "Just a minute and I'll get some advice." So I described the project and asked Judge Wasson, one of my board members who happened to be at my home when Rufus called, what he thought.

He said, "Mr. Norby, why don't you get a leave of absence for a year from here.

Then you will protect yourself and yet you might get into something that is important. A central office program is important in this kind of growing activity."

So I turned back to the phone and said, "Okay, I'll be there."

"When?" asked Rufus.

Of course he wanted me right away–the next day. I told him I couldn't come that soon, that I would be there in about two weeks. So I called a hurried-up meeting of my board. Judge Wasson led the pitch for me to get a leave of absence.

I went to Chicago.

The Blue Cross Commission

My first job when I got to Chicago was to go to New York and find out what had happened, why they had gone broke. There was a fellow named Pyle (I don't remember his first name) who, I think, had been chairman of the board. Van Dyk was the executive director of the plan. Pyle took over as the chief administrative officer. Van Dyk was still there working on the program. The main problem turned out to be the result of poor enrollment policy. They had relaxed group requirements and had been enrolling too many sick people.

Mr. Pyle and Mr. Van Dyk put in corrective measures, and the New York plan worked out its difficulties.

After the first year of making contributions to a central fund, the plans set up a permanent system of financing based on the size of the plan, the number of subscribers. A system for approving plans was also established. To be approved, a plan had to meet certain specified criteria. It would apply for approval, submitting data in support of its application, and if it met the criteria, it would be approved by the AHA. Later, only approved plans could use the Blue Cross name and the Blue Cross symbol, a blue cross with the AHA's seal in the center of it. The matter of the symbol, as Norby notes below, was a sensitive issue.

NORBY:[14]

The plans were meeting in Biloxi, Mississippi. The issue was, shall we turn the Blue Cross mark or trademark over to the American Hospital Association, shall we turn it over to the Blue Cross Commission, or shall we keep it ourselves in the individual states? A compromise was finally worked out whereby the American Hospital Association would allow its seal to be placed in the center of the blue cross. The Blue Cross plans would transfer the mark to the AHA as the administrative

agency of the mark until such time as three-fourths of the plans voted to take it back again. So the AHA actually was the administrator of the use of the Blue Cross mark and name.

It was a very emotional meeting, because some plans felt the Blue Cross mark was a valuable property. They did not want to give it to AHA. So they didn't give it. They gave the right to administer it. Subsequently, in the early 1970s, the Blue Cross plans withdrew this authority.

In the early 1970s, the AHA and the Blue Cross Association (the successor to the Blue Cross Commission) began a new era of formal organizational relationship. The approval program and the administration of the Blue Cross name and symbol were transferred from the AHA to the Blue Cross Association. Also, the representation on each other's boards was discontinued. In chapter 8, we talk more about the development of the Blue Cross Association and its separation from the AHA.

Early Benefits

Several persons have talked about rates and benefits in the beginning of Blue Cross, but it seems fitting to add a few more comments.

In the early days of Blue Cross, coverage was limited to just the employee, the worker. Later, provision was made to extend benefits to dependents. Also, coverage initially included only hospital care. Norby comments below on the development of benefits.

NORBY:[15]

The emphasis was on the employed person. In Minnesota, the employed person paid 75¢ a month for hospital care. He could enroll his family for another 75¢–all members of the family–but they would get only 50 percent of their hospital bill paid. Gradually, however, coverage of dependents became better. This was good not only for the employee, but for the whole family.

In Pittsburgh, for example, I charged $1.00 for the individual and $2.25 for the individual and the family. It was identical coverage for every person in the family.

Maternity care was not covered by some plans. Some charged an extra 25¢ a month if they included it. Mental health care was never included.

As far as medical care was concerned, there was continuous dispute for the first ten years as to whether or not X-ray, anesthesia, and laboratory should be included in the Blue Cross plan benefits. Local medical societies said that they were medical services

and that you could not include medical service in a hospital program.

In Pittsburgh, for example, when I started that plan, we moved so fast that we couldn't talk to the medical society. We said, "We will talk to you a little later." When we got to the end of our first year, we had to talk to them. They were really upset. So we said we would talk with them.

In those days we were paying hospitals $6.00 a day for hospital care. We said we would pay the hospitals $4.00 a day for hospital care and send another check for $2.00 a day for medical care administered through the hospital by whatever device, contract, or commission for the hospital uses. The doctors were happy with that arrangement, because we identified clinical laboratory and anesthesiology as medical services. They wanted them identified as medical services. The fact that we sent two checks, one for the hospital care and one for medical, pleased them in Pittsburgh. Those disputes were satisfied or overcome in many different ways.

In addition to expanding benefits locally, the plans had to find ways of making benefits available nationally. Norby comments on this.

NORBY:[16]

The director of the plan in Chicago would enroll Harvester, because Harvester had its home office there and its biggest manufacturing plants were in Illinois. Also, Harvester had plants out in California and Alabama and so on. The plans there would enroll them. The Chicago plan, the plan where you had the head office, would act as the national account control plan. Through the control plan, they would enroll the employees of the account all over the country under the same contract, a single contract–different from the local plan's contract.

A second issue with respect to national benefits was the question of out-of-area services. For example, if I belonged to the Chicago plan and became ill in San Francisco, what benefits did I get? How could San Francisco give me Chicago benefits? That wasn't what the hospitals had agreed to do. So they formed what they called the Interplan Benefit Bank. It worked like a clearinghouse of a commercial bank.

Through the Interplan Benefit Bank, I got the benefits of the plan of the community in which I was hospitalized. That was just the opposite of the national account enrollment program. In the national account program, all were enrolled under one contract. But in the Interplan Bank, as a member of the Chicago plan, I got a day of care with the benefits of the San Francisco plan if I were hospitalized there. The San Francisco member would come to

then have to take the lower benefits he got in Chicago. That was better than none. Prior to Interplan Bank, I got benefits only in the hospitals in my plan's area, not in hospitals in other plans' areas or in other states.

Notes

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

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

2. *John R. Mannix, In the First Person: An Oral History.*

3. Ibid.

4. Ibid.

5. See Profiles of Participants for biographical information.

6. *Robert M. Cunningham, Jr., In the First Person: An Oral History.*

7. *Mannix, Oral History.*

8. See Profiles of Participants for biographical information.

9. See Profiles of Participants for biographical information.

10. See Profiles of Participants for biographical information.

11. Crosby was executive director of the American Hospital Association from 1943 to 1972.

12. *Maurice J. Norby, In the First Person: An Oral History.*

13. When Norby moved from Minnesota to Pittsburgh to start a Blue Cross plan there, one of the leaders in the Pittsburgh hospital community was Abe Oseroff. Oseroff was the administrator of Montefiore Hospital. He also was a leading force in setting up the Hospital Council of Western Pennsylvania, under the auspices of the Community Chest, and in establishing the Pittsburgh Blue Cross Plan. The funding of the plan, in fact, came from a foundation grant to the hospital council.

Oseroff later served as director of the Pittsburgh Blue Cross Plan (after Norby left to rejoin Rorem in Chicago). Thus, Oseroff was head of three organizations–the council, the hospital, and the Blue Cross plan–simultaneously. In 1942, he resigned his hospital post, but he continued as head of the hospital council and the Blue Cross plan until he retired in 1955.

14. *Norby, Oral History.*

15. Ibid.

16. Ibid.