

HOWARD J. BERMAN
In First Person: An Oral History

American Hospital Association
Center for Hospital and Healthcare Administration History
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HOWARD J. BERMAN

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**Interviewed by Diane M. Howard, Ph.D.
On January 13, 2011**

Edited by Kim M. Garber

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EDITED TRANSCRIPT
Interview conducted in Chicago, Illinois

DIANE HOWARD: Good morning. Today is Thursday, January 13, 2011. My name is Diane Howard and I will be interviewing Howard J. Berman, board chairman of the Alliance for Advancing Nonprofit Health Care, retired chief executive officer of The Lifetime Healthcare Companies and retired president and CEO of Excellus, Inc., former president of the Health Research & Educational Trust and former senior vice president of the American Hospital Association. Thank you, Howard, for accepting the invitation to do your oral history.

HOWARD BERMAN: It's a pleasure Diane.

D. HOWARD: Could you please describe your early years in Chicago and your family background?

H. BERMAN: I was born in Chicago at Michael Reese Hospital. At the time, my father was in Europe during World War II, so I came home to my grandmother's home. Some months later my father came back. We grew up on the west side and I went to Austin High School, arguably the worst high school in the country. Chicago was at one time alleged to have the worst school system in the country and Austin was supposed to be the worst high school in that school system. So, I presume that I went to the worst high school in the country. But, it was a wonderful place and a nice jumping off point.

My mother ran a settlement house. My father was a civil engineer. He did subways, bridges, dams, foundations, and substructures. When she was in her '50s, my mother finished her undergraduate degree and then went on to graduate school and got a master's degree in social work. I come from a family where community service was a high honor, not a punishment. I'm the older of two children. My brother is a public administrator with a master's degree in public administration from Roosevelt University – he works for the City of Chicago. I went to undergraduate and some graduate school at the University of Illinois, graduate school in hospital management at the University of Michigan, and then began trying to make a difference.

D. HOWARD: What was your undergraduate major at the University of Illinois? What activities did you participate in?

H. BERMAN: After some fits and starts, mostly to avoid having to take a language, I ended up in the College of Commerce. I started in accountancy and got about halfway through that and then decided that auditing wasn't for me – that to spend one's life trying to sort out other people's distrust was nothing I wanted to get involved in. Along the way I discovered finance. Finance just seemed like applied economics. It had a degree of elegance with its models and the math. It made sense to me. So, I have an undergraduate degree in finance and part of a graduate degree in finance. At the University of Illinois, I was a James Scholar. I was president of my fraternity house, president of the Hillel Foundation, and was in academic honorary fraternities. I did reasonably well as an undergrad. This was fortunate because my father died when I was 19. I never realized it, but while our family wasn't poor, we didn't have a lot of money. So, it was important to get through college, and to get through college well, to set up the base for graduate school and beyond.

D. HOWARD: Could you describe your decision process for matriculating at the University of Michigan and describe your experiences in Ann Arbor?

H. BERMAN: I've been fortunate in high school, in college, and then in graduate school that I've always had at least one great teacher. Of those, John Griffith¹ was probably the best. No matter what I could say about John, I would not be able to fully express the gratitude and fondness I have for him.

I had an advisor at Illinois named John Pike who said that given my lack of family connections and wealth, being a merchant banker was probably not a good career decision. I wrote away to graduate schools and got graduate catalogs. Every night I'd read one of these catalogs. I read about the certificate program in hospital administration at Duke. I recall throwing it in a drawer and then coming back to it and thinking, *this makes lots of sense*. It was a combination of community service and business and making a difference and it just felt right.

I then began a process of exploring where there were health administration programs in the United States. In the '60s, there were a little more than two handfuls. There were, I think, two in Canada, there was one at St. Louis University where they were training religious, there was one at Baylor where they were training military. There was Minnesota, Chicago, UCLA, Michigan, Columbia, Yale, and several others. I went back to my advisor, Pike, and said, "What do you think?" I told him I thought I wanted to live in the Midwest and he said, "You ought to focus on Chicago, Minnesota, Michigan, and St. Louis."

I didn't have a lot of money, so I couldn't apply to all of them. But I applied to Michigan and got a call saying they'd reviewed my application and they'd like to invite me for an interview. I said, "That would be terrific. I would love to have an interview!" They said, "When are you in Ann Arbor?" I said, "I'm at University of Illinois, in Champaign, when are you here?" They said, "We're not." To get from Champaign to Ann Arbor had a degree of expense and difficulty, so we agreed that we'd meet in Chicago. I had an interview with this guy Griffith. I showed up on a Saturday and didn't realize it was the American College's annual meeting.² I met him and we went up to his room and we had a conversation. It was an interesting and challenging discussion. I tried to hold my ground. Later I realized that this was the beginning of a career's worth of him yelling at me! The sequel of all that was that I was accepted at Michigan and offered a Public Health Service traineeship. So, off I went to Michigan.

Marilyn, my future wife, was finishing her senior year at Illinois. I went to Michigan; she stayed at Illinois to finish her senior year. I was going to be at Michigan for a year and ended up living with two other guys. We were all engaged and we'd play a game every month to see whose phone bill was largest. The person with the largest phone bill was then taken to dinner by the other two. One guy was Al Baxter, whose father was a Pentecostal minister. Baxter would go out every Sunday to the Pentecostal church in Ann Arbor and we wouldn't see him. But he'd get fed and we were jealous of that! The other guy was also Jewish and we spent an interesting year together. I got

¹ John R. Griffith (b. 1934) is the Andrew Pattullo Collegiate Professor Emeritus at the University of Michigan. His oral history: Garber, K.M. (ed.) *John R. Griffith in First Person: An Oral History*. Chicago: American Hospital Association and the Health Research & Educational Trust, 2010, can be found here: www.aha.org/chhah

² The American College of Hospital Administrators, now known as the American College of Healthcare Executives, has an annual Congress in Chicago.

exposed to lifelong friends in terms of John Griffith, Steve Loeb, Bill Dowling and Lew Weeks, just terrific folks.³

D. HOWARD: You've been described as a quantitative guy with a keen eye for finance. Can you reflect on that statement and share your reactions to it?

H. BERMAN: I've met quantitative guys. I'm no quantitative guy. I'm not afraid of numbers, but good quantitative people have an understanding of number patterns beyond mine.

I view numbers as labels and signs for describing underlying phenomena. I need to understand the underlying phenomena and how things push and pull on each other. I need to understand that if 'the accounts receivables are up, cash is going to be down.' So, they're signals. I used to tell my students that they just have to understand the shape of a right answer, not all the way to the fourth decimal point. The quantitative guys can look at numbers and see patterns. I look at numbers and I see vectors and the way forces interact with one another. I've never thought of myself as a quantitative guy. If I disappoint anybody with that, I apologize!

D. HOWARD: Can you talk about your first job out of graduate school and why you selected that particular opportunity?

H. BERMAN: For some people, jobs seem to come to them. For whatever the reason, I never thought I was one of those people. I always had to go look for a job. Given the times and the opportunities, the job at the University of Michigan, which I took right after finishing my residency in New York, was the most challenging job I could wheedle my way into.

I loved working for the Department of Hospitals in New York, but they were going to go through some changes as they went from being a city department to the Health and Hospital Corporation. It was a difficult time in the country. What Michigan was trying to do in its initiative to move from a one-year to a two-year academic program was to assemble a faculty that was going to try to create a rigorous discipline around health services management and hospital operations. It was a terrific opportunity. So they were willing to take a chance on me and I was just delighted to have the opportunity.

Walt McNerney⁴ once gave me some advice. He said, "Howard you don't plan a career. You do what's interesting until you can find something that's more interesting. Then you go do what's more interesting and at the end, it's a career." What Michigan was beginning to do was remarkably interesting to me. In the back of my mind, I wasn't sure whether or not I wanted to pursue a doctorate. This would give me a chance to work my way through that decision.

³ Stephen F. Loeb, Ph.D. is professor emeritus and former chair of the Division of Health Services Management at Ohio State University. William L. Dowling, Ph.D. (b. 1937) became an associate professor at Michigan in 1966 and moved on to become professor at the University of Washington in 1978. Lewis E. Weeks, Jr., Ph.D. (b. 1907) was the editor of this oral history series from 1978 to 1989 and co-author with Howard Berman of several books.

⁴ Walter J. McNerney (1925-2005) was the founding director of the Program in Hospital Administration at the University of Michigan. His oral history: Weeks, L.E., ed. *Walter McNerney in First Person: An Oral History*. Chicago, IL: American Hospital Association and the Hospital Research and Educational Trust, 1983, is in the collection of the American Hospital Association Resource Center.

D. HOWARD: You have a history of recruiting talented people who have remained very loyal to you over the years. Could you describe some of these relationships and how you've been so successful in sustaining those mentor-mentee relationships?

H. BERMAN: To answer that question, I have to share some background. Just as I've had throughout my life remarkably good teachers, I've had terrific mentors: John Griffith, Barney Tresnowski, Gene Sibery, Walt McNerney, Alex McMahan, Gail Warden, and Bob Sigmond – all just terrific people.⁵ At one point I went to Gene Sibery and said, “How can I ever thank you for what you've done for me?” He said, “Howard, whatever you think I've done for you, you do for somebody else.” So my relationship with David Klein and Cleve Killingsworth, and Bruce McPherson⁶ and a number of other terrific people, like Myles Lash⁷, is my trying to repay and model what Gene Sibery did for me. What I've done is try to let them do their thing.

I like working with smart people because smart people do terrific things. I've concluded that working with smart people is like working with thoroughbreds, not draft horses. You can't get them in an eight-hitched team and have them go in a straight line. All you can do is point them in the direction and periodically keep them moving, and then run around with a safety net so that everything's fail safe.

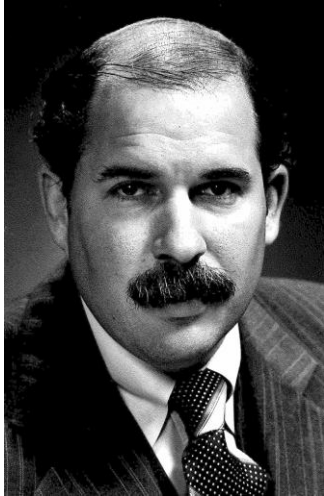
One of my other mentors, Bob Derzon⁸, early in my career said, “Howard, there's no trouble you can get into that I can't get you out of – even if I have to resort to the insanity defense.” I said “Bob, what's that?” He said, “I'll just tell them you're crazy. I mean, if whatever you did is so terrible, they'll believe it.” What that taught me was that you let your people know that you'll take

⁵ Bernard R. Tresnowski (b. 1932) was president of the Blue Cross & Blue Shield Association from 1981 to 1994. His oral history is: Weeks, L.E. (ed.) *Bernard R. Tresnowski in First Person: An Oral History*. Chicago, IL: American Hospital Association and the Hospital Research and Educational Trust, 1986. D. Eugene Sibery (1929-2007) was a hospital administrator, taught at the University of Michigan, and later went on to executive positions with Blue Cross Blue Shield plans and the Blue Cross Association. His oral history is: Weeks, L.E. (ed.) *D. Eugene Sibery in First Person: An Oral History*. Chicago, IL: American Hospital Association and the Hospital Research and Educational Trust, 1988. John Alexander McMahan (1921-2008) was president of the American Hospital Association from 1972 to 1986. His oral history is: Weeks, L.E. (ed.) *John Alexander McMahan in First Person: An Oral History*. Chicago, IL: American Hospital Association and the Hospital Research and Educational Trust, 1987. Gail L. Warden (b. 1938) held leadership positions at the American Hospital Association, Rush-Presbyterian-St. Luke's Medical Center (Chicago), Group Health Cooperative of Puget Sound (Seattle), and the Henry Ford Health System (Detroit). He is now a professor at the University of Michigan. His oral history is: Garber, K.M. (ed.) *Gail L. Warden in First Person: An Oral History*. Chicago, IL: American Hospital Association and the Health Research & Educational Trust, 2010, and can be found here: www.aha.org/chhah. Robert M. Sigmond (b. 1920) is a health policy expert who held executive positions in local planning agencies and worked as an advisor to the Blue Cross and Blue Shield Association for many years. His oral history is: Garber, K.M. (ed.) *Robert M. Sigmond in First Person: An Oral History, Part 2*. Chicago, IL: American Hospital Association and the Health Research & Educational Trust, 2009, and can be found here: www.aha.org/chhah. There was also a Part I, conducted in 1983. These oral histories are in the collection of the American Hospital Association Resource Center.

⁶ David H. Klein is the CEO of Excellus Health Plan (Rochester, NY) and of Lifetime Healthcare, Inc. Cleve L. Killingsworth was CEO of Blue Cross and Blue Shield of Massachusetts (Boston) from 2005 to 2010. Bruce McPherson has been president and CEO of the Alliance for Advancing Nonprofit Health Care since its inception in 2004. He was also with the American Hospital Association and the Blue Cross Association, among other positions.

⁷ Myles P. Lash was the CEO of the Medical College of Virginia Hospital and later the founder of the Lash Group.

⁸ Robert A. Derzon (1930-2009) was the first director of the Health Care Financing Administration. Earlier, he had been the deputy commission of the New York Department of Hospitals and director of the UCSF Medical Center (San Francisco).



the bullet for them. You let your people know that if it is successful, you'll hold their coat while they go take a bow. Then you let them go, and you periodically move them along. You let them go and they're going to do terrific things. You honor their accomplishments and protect them from the downside. Start from the proposition that they're terrific people and just let them run. I don't know where that fits in the management leadership literature – but if you can pick people with the right values and protect them, they're going to do remarkable things. They all have. Cleve Killingsworth ran Mass Blue Cross and Blue Shield. Bruce McPherson is doing a terrific job at the Alliance. Donna Melkonian runs the Foster McGaw program.⁹ Wayne Lerner is doing a terrific job in turning around an inner city hospital.¹⁰ David Klein runs the largest non-profit health plan in New York State. There are others – Paul Boulis ran Illinois Blue Cross Blue Shield Plan.¹¹

D. HOWARD: Walter McNerney, the former president of the Blue Cross and Blue Shield Association had a significant impact on your career. Can you describe the influence he had on you and some of the lessons you learned?

H. BERMAN: He taught me how to think. He and Bob Sigmond probably were most influential in teaching me how to think rigorously about problems. McNerney could see things in ways that other people didn't. When I've been confronted with a problem, I've often literally sat back and said, "Now, how would McNerney think about this?" McNerney also taught me to not be a zealot about a particular idea or technology – to feel comfortable testing competing ideas, and then drawing from them that which worked best and combining it with other experience that worked. Then testing the whole thing again to see what worked best. He also taught me not to live in the past. When something was done, it was done. Keep the lesson, but then go on to the next challenge.

Bob Sigmond, who was a contemporary of McNerney (they knew each other, spent time together in Pittsburgh and in Blue Cross), taught me this remarkable trick of walking around a problem. Once you think you'd figured it out, go and look at it from a completely different perspective. There were times when I'd be working on a problem and I would think I'd figured it out and then I would follow the Sigmond notion and physically get up, walk to the other side of the desk, stare at the empty chair, and see if I could figure out a better solution. Sigmond and McNerney forced me to be more rigorous in analysis, and to understand the solutions I was *rejecting* as well as the solution I wanted to pursue.

To me, thinking is a very hard, solitary, quiet activity. My wife will say, "What do you think about something?" and then there'll be this period of silence. Then she says, "Oh, yeah, you're thinking!" I'm not good enough to think and talk at the same time, so I just need to think. That's a legacy of McNerney and Bob Sigmond.

⁹ Donna Melkonian is Vice President, Member Relations, at the American Hospital Association and responsible for overseeing the Foster G. McGaw prize. Established in 1986, the Foster G. McGaw Prize recognizes health care organizations for their excellence in community service and for making their communities healthier and more vital.

¹⁰ Wayne M. Lerner, DPH (b. 1950) is CEO of Holy Cross Hospital (Chicago).

¹¹ Paul S. Boulis was president of Blue Cross and Blue Shield of Illinois until his retirement in 2009.

D. HOWARD: You've been given credit for influencing Alex McMahon, then president of the American Hospital Association, to push for Medicare prospective payment. Can you describe those discussions and the background of the final Medicare outcome?

H. BERMAN: Alex McMahon was born in Florida, went to Duke, and would like to periodically 'go country.' He'd say, "You can't beat that dogma with this stigma," and I'd keep wondering *what's he talking about?* Or he'd say, "I don't have a dog in that fight," and I finally understood that. Alex would say, "Well, I'm just a country boy," and I'd say, "Alex, I only have two years of high school Latin, but that thing on your wall looks like Harvardus Universitas, juris doctorate?" He said, "Oh yeah, I'm just a country boy."

I didn't influence Alex. He understood the need to move from a cost-based payment system to a prospective payment system. He understood the work that had been going on at Yale with diagnostic related groups, and the challenge was how do you take that and put it into a pragmatic, mechanism? As opposed to me influencing Alex, Alex said, "That's the challenge. How do you do that, Howard?" Bruce McPherson, Ron Wacker, and Henry Bacher¹² and Cleve Killingsworth and other folks and I said, "Okay, let's figure out how to do that." We would figure out how to do it and we'd come back to Alex. He would go talk to legislators and legislative staff and he'd come back and say, "Well, this'll work, that'll work, but *this* isn't going to work. How you going to fix that, Howard?" I would go back and turn the challenge over to these bright guys and say, "Okay, this is the problem. What's the solution?" They'd come back and say, "This is the solution," and I would say, "How's that going to work in this setting?" We would temper it and then I'd go back to Alex and say, "Here's the solution." I'd translate it and then Alex would take it and then we'd go through the process again until we finally came up with a workable answer.

When I was given the Trustees Award¹³ for the work that we had done on prospective payment, I was really taken aback because I was just the catalyst. Whatever the problem was – give it to us, and we'll give you a solution. If you didn't like that solution, tell us what you don't like about it and we'll give you another solution. Just tell us how quickly you needed the next answer because we'd give it to you by then. We just kept chugging along – but it was Alex's leadership. We were just the guys in the back office spitting out solutions – "I need a size 8!" "Okay, Alex we'll get you a size 8!" He was terrific. We viewed it as the most interesting problem in health care at the moment and we were going to solve it because it was the right thing to do for communities.

I think what you'll sense when you finish off this piece of the oral history is that we just were interested in solving problems – the most interesting problems we could find in terms of how to enable hospitals to better improve the health of their communities, to make their communities better places to live. What we'd always ask ourselves was: *What's the right thing to do?* Nowhere did we ask: *What's the most financially expedient, what's the most profitable;* we just always asked: *What's the right thing to do for communities?* That's a legacy of the Michigan program, where they taught us, almost to the point of writing it on the inside of our eyelids so we can see it when we're asleep, that hospitals are a community resource. Hospitals only validate themselves by how they improve their community – and no other way. McNerney reinforced that every day.

¹² Henry Bacher was a vice president with the American Hospital Association and later with the Centers for Medicare & Medicaid Services.

¹³ The American Hospital Association Board of Trustees Award was given to Howard Berman and O. Ray Hurst in 1984 in recognition of their noteworthy contributions to the work of the Association.

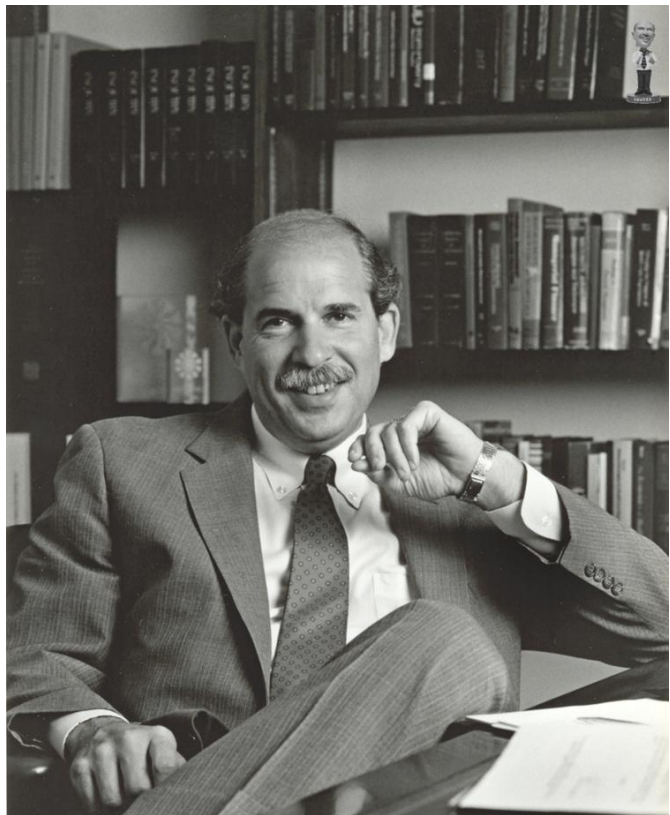
D. HOWARD: Let's go back to the late '60s and your residency in New York City. Why did you choose to work there?

H. BERMAN: One of the attractive features of going to Michigan was that they had an administrative residency. I was a Chicago kid and I assumed that I would find some sort of administrative residency in Chicago and then I would go on to the traditional hospital executive role. I was wrong. Michigan sent me to a couple places to interview for residencies. While they never told me this, I was convinced they probably twisted Joe Terenzio¹⁴ and Bob Derzon's arms to have me go to New York. They said, "You'll have to spend three months at the Brooklyn Hospital." I looked at the New York opportunity and I wasn't smart enough to call it a health system, but the Department of Hospitals *was* a health system. It had about 19 enterprises including a couple of long-term care facilities. I thought, *during a 12-month period with 19 places you're going to see more problems than you can see in one. This is terrific!* Maybe they were the only ones that wanted me, but that was a great place to be wanted.

The three months I spent in the single hospital were very important because it made it clear both the importance of an individual hospital being well run and the limits of an individual enterprise. I began to understand, you could have so much greater impact if you could make a system hum and get those multiple institutions to serve. If you focused on the health of populations you could have this great impact. This moved me away from a focus on institutions and individual patients to a focus on systems and populations and, ultimately, finance.

I had this wonderful experience in New York. Joe Terenzio was the Commissioner; Bob Derzon was the Deputy Commissioner. I worked with a guy named Bill Kerr¹⁵ who ultimately became the CEO of UC Medical Center in San Francisco. We

just did great things. We opened up the new Harlem Hospital.¹⁶ We re-equipped hospitals. John Lindsey was the mayor. There was a belief that we were going to make a difference and that we could make a difference. We worked awfully hard. When the weekends came we were upset because people took time off and there was so much more that had to be done. I was lucky – I fell into this remarkably good experience with these terrific people.



¹⁴ Joseph V. Terenzio (1918-2000) was the first nonphysician to become the commissioner of hospitals in New York City. During his leadership, the Health and Hospitals Corporation, a multi-hospital system, was established.

¹⁵ William B. Kerr succeeded Bob Derzon as director of the UCSF Medical Center (San Francisco) in 1977, where he served for 20 years.

¹⁶ In the late '60s, the Harlem Hospital Center (NY) was updated by the addition of the Martin Luther King, Jr. Pavilion.

D. HOWARD: The issue of cost containment was critical for Blue Cross Blue Shield plans and hospitals in the 1970s. Can you describe your role in getting the plans and the hospitals to adopt a cost containment philosophy?

H. BERMAN: The error that was made, and quickly recognized, in designing Medicare was that financing was not a neutral factor – it could impact cost. That belief was that only *needed* services were provided; the demand and need were consonant and therefore financing wouldn't matter because people wouldn't demand more services than they needed. What was quickly discovered with Medicare was that once you began to finance services, demand far exceeded need. The nation's resources began to be strained. The Blue Cross plans were sitting right in the middle of this because most of the money was going to hospitals. The Blue Cross plans were the people that had to deliver the rate increases. So there was pressure on the Blue Cross plans to do something about escalating, seemingly uncontrollable, costs.

The Blue Cross plans had ridden the demographic boom of the country and grown. They provided a remarkably needed service. People don't fully appreciate it, but the Blue Cross plans began as a social movement. I remember being with some of the original plan presidents from the '30s and '40s and they would talk about how they were accused of being communists and socialists. Blue Cross had gone from being this 'movement' to being mainstream. The movement was to provide access to needed health care services. The belief was that while you couldn't budget on an individual basis, on a community basis you could. From year to year, on a community basis, things were more predictable. There were large numbers, fixed physical capacity, so you could estimate what costs would be.

You had guys like Rufus Rorem and John Mannix¹⁷ (I met them at the end of their lives and to some extent I'm a linking pin) who believed in prepayment and community budgeting. You had these Blue Cross plans that had come from being on the outside trying to create social equality in terms of the access to health care services to now being faced with: What are you going to do about rising costs? The Blue Cross plans had been driven by people who were more marketers and managers than health care people. McNerney, Gene Sibery, Barney Tresnowski and then later people like me and David Klein, Ron Wacker, Donna Melkonian, Louise Kurylo, and others – were the first time that health care people came into Blue Cross. What we began talking about was that the dynamic of financing wasn't neutral. Financing would impact the kind of services that people demanded, the kind of services that were then provided. The notion is 'build it and they'll come.' So what do you want to build?

Everybody else wanted to argue about price. We wanted to focus on utilization. If you could control utilization you would ultimately control total expenditures. So, how do you control utilization? Beyond case review of utilization in individual cases, we saw real potential in community-wide health planning. Yes, if you build it and someone else will pay for it, they'll come. But if you don't build it, then you'll put pressure on utilizing what is there. We knew that in high

¹⁷ C. Rufus Rorem, Ph.D. (1894-1988) was an economist whose work in the area of prepayment led to the development of Blue Cross plans. His oral history is: Weeks, L.E. *C. Rufus Rorem in First Person: An Oral History*. Chicago: American Hospital Association and the Hospital Research and Educational Trust, 1983. John R. Mannix (1902-1990) had a varied career as an executive in hospitals, Blue Cross plans, and as a consultant. His oral history is: Weeks, L.E. *John Robert Mannix in First Person: An Oral History*. Chicago: American Hospital Association and the Hospital Research and Educational Trust, 1983. These documents can be found in the collection of the American Hospital Association Resource Center.

occupancy hospitals, unnecessary services were not being provided because the physicians were self-controlling. We knew that if we could control physical plant decisions to fit community needs, and if we could control utilization to fit what worked, then at the macro level we would be able to manage cost. That's the argument we took and we created this model of prospective payment. Here – we'll pay you a price and if you can do better you can make money, so now go be efficient.

Health planning and utilization review – we began to develop the first crude utilization review management systems. We created semi-turnkey systems for creating prospective payment and utilization review. We focused on health planning. That was the message we took out to the Plans. It was maybe the first time since Rorem that the Plans were being confronted with: You've got to do this. You've got to start to pay attention to your health care system and shaping the health care system for the needs of your community.

D. HOWARD: When you went to work at the American Hospital Association, Alex McMahan was the CEO and Gail Warden was the Executive Vice President. Could you describe the relationship the three of you had?

H. BERMAN: I was hired by Gail and worked for Gail. He was terrific. At the AHA, you had Alex McMahan, who had been the creator and first president of the recently-merged Blue Cross Blue Shield North Carolina. You had Gail Warden, who came out of a big health system here in Chicago. Over on the Blue Cross side, you had Barney Tresnowski, who came to Blue Cross out of a hospital. Walt McNerney had been the head of the Michigan program in hospital administration. His number two guy, Gene Sibery, had been a hospital administrator. They used to say prepaid health care and voluntary hospitals were two sides of the same coin. People at that point moved fairly easily between delivery and finance.

Today, people would say, how could you do that? If you go from one to the other, you're going to 'the dark side.' But at that point, there was this very porous border. Alex McMahan recruited Gail Warden because Gail had great credibility on the delivery side. Alex had great credibility on the finance side. They were both smart enough to be able to take advantage of each other's skills, and to be able to relate to each other in a way that was productive. Gail understood, even beyond Alex, the need for representation within the delivery system. He created constituency centers at AHA so that, for example, the rural hospitals didn't have to go off and create their own association. Health systems didn't have to go create their own association. Gail created a big tent. Alex was then able to take that big tent and use it politically to keep everybody harnessed in the same direction.

I was there to solve the problems that they brought to our table, to bring ideas to their table to see if they were workable, and to begin to give the AHA increased credibility as a source of unique data and consulting ability. We ran a research operation in the Hospital Research and Educational Trust. Cleve Killingsworth ran a data operation. Bruce McPherson ran what people would now call a health policy operation but we just viewed it as management consulting because these were the interesting problems. We wanted to be the best health care intellectual resource in the country. That was our goal. Give us the toughest problems, we'll go after them. We'll go get data where we need to get data. We'll give you data that you can take to the bank because it'll be that accurate. We'll explore ideas through our research operation that others may be afraid of because they may be contrary to current thinking and current positions, but if they're wrong we

better know about it. Gail and Alex tolerated that kind of behavior. I was the junior partner in the whole thing, but they let us go do these things.

D. HOWARD: You're credited with re-purposing the Hospital Research and Educational Trust upon your arrival at AHA. Can you describe that process? How was HRET re-purposed to support policy?

H. BERMAN: In the past, HRET had been used as a tool to simply be able to accept government grants and philanthropic support. What we said is that HRET has got to be an intellectually independent and honest source of thought. If the policy is wrong, better for us to understand that than for somebody else to shove it down our throat.

So we said, "HRET, go do interesting things that are relevant to the management of hospitals and the application of health services for community benefit. Wherever the data and the answers take us, we can live with that. But, you need to focus on: How do we run hospitals better? How do we make hospitals serve their communities better? How do we help them do it?" That's the focus we brought to it and then we went out and hired researchers and we said, "You just told me how smart you are. Okay, if you're so smart, go make things happen." They said, "What do you mean?" "Go do it!" We let them run. The only thing we demanded was that their analysis be rigorous, that no one could take it apart because they made a methodological error. If we were going to get staked out on their findings, they had to be right.

They had to be focused on management and service in the community. So, the research wasn't chosen because it was what their dissertation was on and, "I want to do research here because I've got this data set." Instead, it was, "This is our problem: we've got to figure out how to help hospitals better manage. Got to figure out how to help hospitals individually and as groups better serve communities. If you're interested in looking at that set of problems, we're the place for you." Jeff Alexander¹⁸ came out of that environment. Gary Bisbee¹⁹ came out of that environment. One of the people who was on your dissertation committee came out of that environment, the geographer.

D. HOWARD: Ross Mullner.²⁰

H. BERMAN: That's right. They were people who were anxious to make a reputation as being able to do creative, rigorous management research. We said, "Here's an environment for you."

D. HOWARD: The Rochester Blue Cross and Blue Shield plans remained separate through the 1980s. Can you describe how the plans came together under your leadership as president?

H. BERMAN: Not elegantly! When I came in as the first person to be the CEO of the two separate organizations, we moved to interlocking boards first. Peter Spina was on both Blue

¹⁸ Jeffrey A. Alexander, Ph.D. was with the American Hospital Association from 1980 to 1985. He went on to become a professor at the University of Michigan.

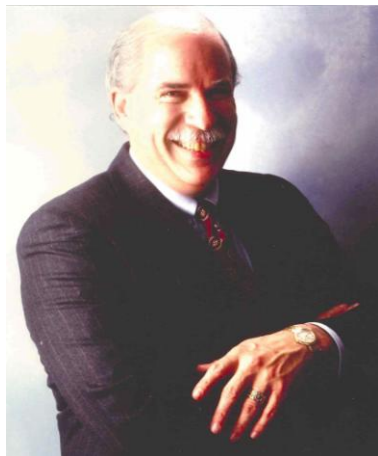
¹⁹ Gerald E. Bisbee, Jr., Ph.D. was president of the Hospital Research and Educational Trust and went on to become the CEO of ReGen Biologics, Inc.

²⁰ Ross Mullner, Ph.D., is on the faculty at the University of Illinois, Chicago.

Cross and Blue Shield boards, so he became the president. We interlocked the boards and began to have joint meetings. After a while, the boards got tired of adjourning one meeting and then starting another. Some issues could only be voted on by the Blue Cross members and some issues could only be voted on by the Blue Shield members. So they said, "Let's stop this. Let's just consolidate." I said, "Okay, we can consolidate."

I wouldn't argue that there was a lot of leadership involved. It was mostly some good 'followership' in that when they were ready, we made it happen. But they had to be ready because at one point, they had a ten 'against' and eleven 'for' vote. They were going to consolidate and I told them, "You can't do that. With this kind of decision we've got to have consensus. We can't just have a narrow majority. So let's not make a decision. Let's go back and look for alternatives."

I have a friend named Bob Warshaw,²¹ who was the Deputy Drug Czar who talks about gentle, persistent pressure. What we tried to do was figure out where we wanted to be and add gentle, persistent pressure so that people finally recognized that that's where they wanted to be. When they recognized it, we said, "Okay, that's where you want to be, that's where we're going." I wish I had more sophisticated answers for you.



D. HOWARD: I wonder if you might describe some of the unique products and services for special populations that you were credited with developing at Rochester Blue Cross, such as the deaf and hearing impaired programs, the long-term care products, and home care benefits.

H. BERMAN: The home care benefits started before I got there. I inherited a wonderful legacy from Dave Stewart.²² He and Tony Mott were advocates of health planning. In order to reduce the demand for hospital beds, they decided that you had to provide home care benefits. Therefore, back in the '60s and early '70s, Rochester Blue Cross was aggressive in home care and was instrumental in creating a sort of home care clearinghouse for the Rochester community. Years later when I got there, the first organization that became an affiliated part of the Blue Cross family was our home care operation. Currently, we run the largest home care operation in upstate New York.

Getting back to your question, we kept looking at the community. What did the community need? Rochester is the home of the National Technical Institute for the Deaf, so Rochester has a fairly large deaf and hearing impaired population. One of the things that troubled us was that we didn't want a hearing impaired or deaf parent to go to see a physician and have to use their child as a translator. Because Rochester Blue Cross also owned health centers, and was a direct provider of care, we used our health centers to hire two bilingual physicians, a male and a female, whose languages were spoken English and American Sign Language. We provided those services so that the deaf and hearing impaired would have a more acceptable health care experience.

²¹ Robert S. Warshaw became the Associate Director of the Office of National Drug Control Policy in 1998.

²² David W. Stewart was the head of Rochester (NY) Blue Cross from 1955 to 1985.

We also recognized that children were coming back in the '90s from college and having a hard time finding jobs. But once they finished college, they were off their parents' health insurance. So, well before the current health reform legislation, we were covering dependents to age 26. We said, "When you were in college, you were ours. We'll cover you until you can find a job and get out on your own." We did that and we did it at no cost because, from an actuarial perspective, these kids – except for blunt trauma and accidents – are healthy.

We got involved in hospice through our home care operation. Our home care company owns a hospice. We're probably the only Blue Cross plan in the country that owns a hospice and owns a home care company. But, we recognized that the needs of terminally ill and chronically ill children were different than adults. I asked Patricia Heffernan, the person who was running our hospice operation, to go find the best pediatric hospice and palliative care programs in the country, to go visit them and come back with the best of each so we could cobble together our own program. We created a program called CompassionNet. Its philosophy is that no kid should ever be in pain and no parent should ever have to give up hope. We started to make this program available to Blue Cross Blue Shield members and then, ultimately, to the whole community. People said, "If you're dealing with kids you've got to deal with the whole family." I said, "Okay, deal with the whole family." Fortunately, the number of chronically ill and terminally children is small, so we were able to absorb the cost in our large market share.

We got involved in a program called Healthy Steps, in which pediatricians were to look at parenting and child development as well as traditional well baby visits. Healthy Steps was funded by the Commonwealth Foundation and they had a very rigorous model. We couldn't quite figure out how to do it within the rigor of their model. But, we had health centers and we had pediatricians at our health centers, and we had home care operations. So we said, "Within our system, in the first two or three years of life, not only will we provide vaccinations and well baby visits, but we're also going to use our home care workers to go out and make home visits to look at child development, parenting, and work with parents. That's just the standard benefit that we do." Because we owned a home care agency, we could do it within our home care benefit.

Long-term care is something that David Klein deserves the credit for. David and I believed that long-term care looked like what hospital care must have looked like in the '30s. Long-term care was something that people were likely going to need. They didn't know when they were going to need it. They didn't know what it was going to cost. It was very hard to budget for it on an individual basis. Just like hospital care in the '30s. We created a long-term care company. We had to get permission from the State of New York to do it. We were pretty naive. We thought, *Well, you know, this looks like what hospital care looked like in the '30s. So, therefore, we'll do a service benefit. We'll create the long-term care equivalent of Blue Cross.* The State of New York said no, and they made us do it as a for-profit company.

The magazine *Consumer Reports* was doing rankings of long-term care benefits. They were concerned about inflation protection, and they just beat us up because we didn't have an inflation-adjusted benefit. We had a service benefit. They couldn't understand that a service benefit meant that we were taking all the risk of inflation. They wanted to see a benefit that had an inflation rider on it.

The State of New York required that we be a for-profit long-term care company. *Consumer Reports* pushed us to give up on service benefits and go to indemnity benefits. We built this long-

term care company that, I don't know what its topline is right now, but when I left it was in excess of \$100 million in premium revenue. All the profits from the long-term care company go to subsidize the nonprofit Blue Cross and Blue Shield Plan.

It's an interesting sort of model where a nonprofit owns a for-profit. The distinction we made was that we said, "We're going to run it separately (because we didn't want to cross-contaminate cultures). The only thing we'll do in terms of values is, for the for-profit company, we can never renege on a commitment. There are some things that are clearly not covered. There are some things that are clearly covered, but everything that's gray goes in favor of the beneficiary. Now go run your business." They went out and they're running it. It's a hard business. They're working hard but they're running it. Other people dabbled in it and got out of it. We bought up their businesses. It's doing what we had hoped it would do.

We also said, "You know, when we got there, there was individual coverage and family coverage. But, wait a second, the demographics in our community had changed, you have individuals, two-person families, two adults, single parents with children and then you have families." We began to change the pricing to reflect the sociology of America. What we kept trying to do was understand what people needed to be able to have equitable access to health care services.

We also understood that given our high market share, we were responsible for the health of the delivery system. When you're a small insurer, a small payer, you can get really uppity with a non-unique provider of care and say, "You don't like my prices, I'll take them elsewhere." When you focus on health planning, to try to fit capacity to need, and you have a high market share, then you're responsible for keeping all those providers in business. One of our frustrations was when the country became enamored with the competitive model. We said, "In our environment, the only way we can create a competitive model is if we go out and build more hospitals." Everybody said, "Well that's dumb." We said, "Yeah, isn't it? Maybe competition isn't the answer!" They said, "Oh no, competition's the answer. You guys just don't get it." Now David Klein is responsible for communities that have amongst the lowest per capita health care costs in the country. He worries about delivery as well as finance and focuses on need, not competition.

D. HOWARD: Let's move into policy now. Describe your interest in policy and how you've shaped policy at the American Hospital Association, Blue Cross Blue Shield, and at Excellus.

H. BERMAN: It's taken me a while to understand that we were working on policy issues, because when we started we weren't working on 'policy.' We were working on what were the most interesting health care management problems. We were all trained as managers. We were all educated as managers. To us, managing was how you utilize scarce resources to best serve your communities. So, we weren't focusing on policy, we were focusing on management. We were focusing on pragmatic solutions to operational problems and if they worked, as measured by value added health status, trying to get them adopted (even if modified) in as many places as we could.

Over time, that's morphed into something now called policy. I'm not sure I understand policy. I understand management problems. How do you get this hospital that's in an economically bad neighborhood to take care of these people with all these needs? How do you, as a Blue Cross Plan, drive your profits back into the community by reducing premiums or providing more services? Those are management problems and you have different solutions to them. I guess I'm frustrated by the policy people who aren't getting on the ground and getting their hands dirty trying to solve

the management problems. I don't think we ever worked on policy, we just worked on management. Policy doesn't have to have any relevance to today's problem. We wanted to spend our energy on solving today's problems and avoiding tomorrow's problems. I apologize for not being a good policy wonk.

D. HOWARD: But you were! There's been a cultural shift in how we view health care, particularly the nonprofit orientation. Could you describe your reactions to the Blue Cross Blue Shield Plan conversions and the impact on hospitals and other providers?

H. BERMAN: I think that it is unfortunate that the Blue Cross Plans that converted, converted. The reason is that it's impossible to serve two masters. If you're for-profit, you have a clear obligation to serve your owners, to do what you can to increase owners' wealth. That's difficult to do if you say, "I'm a Blue Cross Plan and I'm here to serve my community. I'm here to improve the health status of my community. I'm here to assure that people have access to services." You can't serve the community and your owners and harmonize those two interests. Once you allowed the Blue Cross plans to go for-profit, you created this competition that the owners had to win because they're the owners. That's unfortunate, and that applies to hospitals also. You can serve the community or you can serve your owners – you can't serve both, unless your owners are the community.

The movement towards for-profit, while perhaps inevitable within our economic DNA, has not been beneficial. I don't know if the genie can ever be stuffed back into the bottle – probably not. American society will pay a big price for dabbling in for-profit health care – people will be hurt.

The irony is that if nonprofits had access to some form of capital they would be able to compete with for-profits on a level footing. It's the access to capital that enables the for-profits to buy nonprofits, install services that have high ROIs, and become profitable, whether or not the communities really need those services.

It probably goes back to a basic failing in that, at the time, at least amongst the Blue Cross Plans, the debate which was going on could be characterized by people saying, "Well, you've got to do what you got to do." I would say, "No you've got to do what you *should* do." Doing what you should do is an idea that doesn't attract a lot of followers because sometimes what you should do is more difficult and at times even harder than the alternatives.

D. HOWARD: It has been reported that you supported keeping the AHA Chicago policy initiatives separate from the Washington DC advocacy office. Is this statement accurate? Could you describe the rationale for your philosophy?

H. BERMAN: Yes, it's accurate. It's a McNerney lesson that once you get inside the Beltway you get captured by that culture and environment and you lose contact with America. He wanted to have a foot in both places. He wanted the analysis and the problem solving to start outside the Beltway and then move to the Beltway.

It may be a way to see the morphing from 'let's solve the best management problems' to 'policy analysis.' Inside the Beltway you do policy analysis. Outside the Beltway you do management. I thought that a strong AHA Washington office which could translate what the legislative and administrative branches were looking for to people in the field who could then give

them pragmatic answers was better than having to just operate within the discipline of the Beltway's political environment. I think that something's been lost with the shift in focus to Washington.

D. HOWARD: Could you describe the relationships between AHA, the American Medical Association, Blue Cross Blue Shield, the Joint Commission and some of the collaboration issues in which you were involved?

H. BERMAN: They ebbed and flowed. Walt McNerney had a wonderful relationship with Ed Crosby.²³ Then Dr. Crosby passed away unexpectedly. Alex McMahon succeeded him. McNerney and Alex had a good relationship. Barney Tresnowski and Alex had a good relationship. Alex and Jim Sammons²⁴ at the AMA had a terrific relationship. All of these leaders worked hard at keeping their associations in a good constructive friendship. Alex and Barney and Jim Sammons deserve a world of credit for keeping all the personalities of the volunteer, association leadership in harness.

D. HOWARD: Do you think that the same relationship could be cultivated today?

H. BERMAN: I've been away from it for so long that I don't know the players well. I do know that with the health reform law, we're all being given another chance to see if we can get it right. So I would hope that they all take advantage of that chance, that we learn from the experiences and failures of the last couple of decades. As an aside, I'm intrigued when we talk about going from 'volume' to 'value.' How did we ever get away from value to start with? Shame on us. So I'm hopeful and sort of envious of the new breed of young Turks who are going to have this chance – wishing it were still my chance, but it's not.

D. HOWARD: Could you please discuss the McNerney Fellowship and what it means to continue it?

H. BERMAN: I was a McNerney Fellow and I used my fellowship year to do a couple of things. One was to create a McNerney Forum in *Inquiry*²⁵ where rigorous opinion pieces could be published. We also used that period to create the Alliance for Advancing Nonprofit Health Care²⁶ to try to give nonprofit delivery and finance a voice. I used it also to work on a book which was ultimately published by HRET called, *A Great Board*.²⁷ The fellowship year gave me an opportunity to do some things that would've been difficult to do outside of having a fellowship. I was fortunate in that I didn't need the money that went with the Fellowship award, and was able to say to HRET – use whatever money is available to publish *A Great Board*, and keep all the proceeds.

I think the Fellowship got a bit off track when it became a retiree's award. McNerney had a bias toward action. McNerney had a bias toward developing and exploring provocative ideas. That's what the Fellowship should have continued to do. That's what I tried to do with it. The

²³ Edwin L. Crosby, M.D. (1908-1972) was Executive President of the American Hospital Association from 1954 to 1972.

²⁴ James H. Sammons, M.D. was Executive Vice President of the American Medical Association from 1974 to 1990.

²⁵ *Inquiry* is a quarterly journal that publishes scholarly articles related to health policy and finance.

²⁶ The Alliance for Advancing Nonprofit Health Care was incorporated in 2003. More information can be found here: www.nonprofithealthcare.org

²⁷ Berman, H.J. *A Great Board: Building and Enhancing Nonprofit Boards*. Chicago: Health Research & Educational Trust, 2003.

others did whatever the others did. I would hope that it would continue. I don't think it should be a monetary award because I think the real value is in the imprimatur of being a McNerney Fellow which gives you permission to do some things that you might not otherwise be willing or able to do.

I would give it to people who are still in practice and still are fighting the fight and need some external recognition to say, "Hey, you're doing good things. We see that, we support that. Now go do some more good things." I don't think it's a question of money. I think people would cherish being McNerney Fellows because it would give them the encouragement and recognition to keep doing the innovative things they're doing. It's not enough money to give up your job, so the title and the 'certificate suitable for framing' are worth more. I apologize for whoever's toes I've just stomped on.

D. HOWARD: Could you share your reactions to the hospital and the insurance environments and what future trends you see?

H. BERMAN: I wish I were smart enough to know, Diane. I think that we will, as a nation, ultimately do the right thing, at least when we run out of other alternatives. The question is: Will we find the leaders to move us there quicker? Will we find the leaders in medicine who will move us towards evidence-based care where it can be done, as opposed to focusing on where it can't be done and therefore let's not do anything. Will the academic medical centers step up and say, "This is what the standard of care should be in this country"? Will the hospitals understand that it always had to be a value proposition and not try to dignify their behavior by saying, "Well, that's what the financial incentives were, so we just followed the financial incentives." Will the health insurers stand up and start to take care of their communities?

The health insurance reform aspects of the health reform bill are long overdue. It's a reflection of bad behaviors and those can't be tolerated. If we get leadership, some wonderful things can happen. If not, we will go and struggle through and fail and perhaps ultimately get to a single payor because we'll run out of alternatives. Once we get to a single payer, we'll start to create new alternatives with complementary and supplementary benefits the way it's gone in other countries. I think it's a neat time to be a health care manager, but it's a time for courage and a time to walk your values. That's hard. Given the last two decades, that's particularly hard to do.

D. HOWARD: You've been a prolific author. Can you describe the contribution you wanted to make to the health care field with your publications?

H. BERMAN: I wrote because I needed to explain things to myself. Sometimes it got out of control and went on for chapters instead of pages. The *Financial Management of Hospitals*²⁸ began as an attempt to create a primer on health care finance. Lew Weeks and I thought that it may have a useful life of four or five years. It went on for 25. *Economics in Health Care*²⁹ and *Financing of Health*

²⁸ Berman, H.J., and Weeks, L.E. *The Financial Management of Hospitals*, 1st ed. Ann Arbor, MI: University of Michigan, 1971. There were 7 subsequent editions of this text.

²⁹ Weeks, L.E., and Berman, H.J. *Economics in Health Care*. Germantown, MD: Aspen Systems Corporation, 1977.

*Care*³⁰ were two anthologies that were simply an attempt to take the best of the *Inquiry* publications and make them available in a convenient form – prior to the Internet.

*Shapers of the American Health Care Policy*³¹ was a labor of love. Lew Weeks had started to do these oral histories and wanted to get to people who had ‘made it happen’ while they were still able to tell their story. Lew was this very gentle interviewer who’d go out and put his tape recorder on a coffee table and talk to people and over time he befriended them. After a number of these interviews and a lot of conversation (Lew and I spoke at least once a week for probably 25 years), we had this idea – what if we could create the image that various people were all sitting around a table and we would ask a question, such as: How did Medicare happen? Then we’d go into their oral histories and excerpt their response to that question as if they were talking to each other. *Shapers* became the attempt to create this conversation. If we had understood how much work it was going to be, we never would’ve started it. We had hoped that it would become basic reading in all health care management programs, because if you don’t know your history you’re doomed to repeat it. We thought that it was really a special contribution.

What I can see in each of these books is how I’ve been changing. I was, at one point in my life, a fairly competent technician in the financial management of hospitals – when I knew the literature of health care and, because it was only about an inch thick, I could remember it all. I went from being a technician to wondering about how we got to where we are with American health care policy to focusing on governance. As a CEO working for a board, I became fascinated by the importance of governance in creating productive social enterprises serving a community. *Making a Difference*³² reflects how I went from governance to saying, “You know these non-profit enterprises are really special things. How do we manage these special things – so that they make a difference?”

I look at the books and I see how I’ve evolved as an individual. I don’t know that I’ve grown, but I’ve evolved in terms of how I’ve been thinking about things and what I’ve been spending time thinking about. At their core, each book has a degree of selfishness to it because I wanted to explain to myself what this is. *Shapers* is basically explaining to me – how’d we get to where we are? *Financial Management* is – if I’m going to have a well-run hospital, how do I need to manage the finances of it? How do I do that?

I had fairly modest aspirations because I was trying to explain something to myself. That said, I hope that other people will say, “Oh! This is interesting.” I hope somebody even says, “This is good.” I’m always taken aback, but pleased, when I run into somebody who says, “I read *Making a Difference*, you know it was pretty good.”

D. HOWARD: Could you describe your relationship with Lewis Weeks?

H. BERMAN: We were quite the odd couple. Lew Weeks – I always thought he was old. I have no idea how old he was, but he was old enough so that he became a pharmacist without

³⁰ Weeks, L.E., Berman, H.J., and Bisbee, G.E., Jr. (eds.) *Financing of Health Care*. Ann Arbor, MI: Health Administration Press, 1979.

³¹ Weeks, L.E., and Berman, H.J. *Shapers of American Health Care Policy: An Oral History*. Ann Arbor, MI: Health Administration Press, 1985.

³² Berman, H.J. *Making a Difference: The Management and Governance of Nonprofit Enterprises*. Rochester, NY: CCE Publications, 2010.

going to college. He worked in a pharmacy and took the exam. He was a very good retail pharmacist, making enough money that he could start to go to college. He went to Michigan and decided he still liked school. He got his undergraduate degree and decided he still liked school and got a masters degree and then a Ph.D. in communications. After he graduated, he was going to go buy a weekly newspaper. He was a good businessman, but he couldn't find what he was looking for, so he went to work at the Bureau of Hospital Administration, which was the research and publication side of the Michigan program in hospital administration. Lew and I had offices that were either next door or there was one separating us. I was this young kid from Chicago and he was this fairly well to do Brahmin from rural Michigan. Periodically, we'd run into some problem and I'd say, "Well, Lew, I'll just take the guy out in the alley and we'll have a talk." He would say, "Howard, I think we need to explore other strategies." This was before Bob Sigmond taught me about walking around a problem. I'd say, "What other strategy could there be?" He said, "Let's talk about it tomorrow."

As I said earlier, Lew and I spoke to each other at least once a week for 25 years. During that entire time, I don't think he ever gave me any advice. He just let me talk. In that whole period, we did eight editions of the *Financial Management of Hospitals*, two anthologies, and *Shapers*. He was the editor of *Inquiry*. He created the oral history collection. We just did what was interesting. No one could understand the relationship because it was so different. We were just there for each other, and we worked well together. We developed this model where we'd begin a project by starting with the table of contents. Then we would pick the chapters that each of us was going to write. The rule was that you wrote your chapter and then you gave it to the other to read. The other could say whatever he wanted and gave it back to you. The next time you saw the chapter was when it was printed. We would comment, but we never had to satisfy each other. It worked very well for us.

As I think back about Lew, I'm struck by how remarkably lucky I've been to have worked with, and for, all these great people; and then, through the oral history project, to be exposed to leaders like George Bugbee and John Mannix. Bob Sigmond I've known since '69. I've been remarkably lucky in being able to spend time with, and at the feet of, these giants. Whenever I reflect on it, I'm struck with how tall they are and how frustrating it is to me personally that I've never been able to reach their heights.

D. HOWARD: Your retirement from Excellus has been full of a lot of activities. Can you describe some of the activities like your executive in residence position at St. John Fisher College at the Bittner School Business?

H. BERMAN: When I left Blue Cross Blue Shield, I made a decision that it would have been inappropriate and unfair to my successor David Klein to dabble in local health – that he had to be the Blue Cross Blue Shield spokesperson on anything relating to local health. I didn't want to do anything in local health and I became fascinated with nonprofits. I went to the President of St. John Fisher College, Katherine Keough, who I had known and been part of the committee that recruited her and said, "I'd like to teach a class in the management of nonprofit organizations. I'd like to teach it in the undergraduate school and I would like to do it from a perspective of exposing students to this wonderful world of nonprofits. I want to do it pro bono, as a volunteer." She said okay.

They let me teach this class in the school of business on the management of nonprofit organizations. It's got a different title, but I think of it as the management of nonprofit organizations. One of the by-products has been *Making a Difference*, the book. I was unhappy with the first set of lectures and said – I've got to do a better job on them. As I began to work my way through that, it turned from pages to chapters.

Another by-product has been an amazing sense of humility about how tough it is to teach undergraduates – or at least how tough it is for me to teach undergraduates. How hard you have to work to get them to become curious and intellectually inquisitive. I'm getting better at it and, hopefully, I'll still get better at it. I teach this class and it's an anomaly to have faculty who teach an entire class as a volunteer. But that's consistent with my value system. *Making a Difference* was a by-product of this effort and all the proceeds from *Making a Difference* go back to the college. Not just the profits, all the revenue. It's been interesting. I'm glad I've done it. If I get better, maybe the students will be glad I'm doing it, too!

D. HOWARD: What is the Alliance for Advancing Nonprofit Health Care?

H. BERMAN: The Alliance is a by-product of the efforts that began during my McNerney Fellowship year. It's a reflection of the fact that you've got Pharma representing for-profit pharmacy. You've got the for-profit health insurers with their own effort. You've got the for-profit hospitals and then you have the nonprofits that don't have a distinct voice. The notion was: Can you get together a group of nonprofit financing and delivery entities who will just talk about protecting 'nonprofit' because that's in communities' best interests? After some exploratory meetings, there was enough interest to say let's go ahead and do this. It's been a struggle.

Bruce McPherson has done a terrific job. But nonprofits seem reluctant to fight for their own interests. It ranges from – “If we spend money to argue for what's in our interest that's money that we're not spending on serving our communities,” (as opposed to understanding that not spending that money is like burning your seed corn) to – “We do good work, people will ultimately discover us and won't hurt us.” That's not going to happen. At some point you've got to fight your own fights. It's been very difficult to get a critical mass, but Bruce is working away at it and I'm there to support him.

D. HOWARD: You've been instrumental in having served as a member of the Foster McGaw Prize committee that recognizes hospitals that have distinguished themselves in serving their communities. People who have worked with you on the committee say you have a skill for honing in on what's important and relevant. How did you develop that skill?

H. BERMAN: I think what the members of the committee have said is, “Let's have Howard ask that question.” I don't think they've said he's honed in on it. They've honed in on it and said, “Howard'll ask that question.” To ask the hard questions, you just have to listen. You just listen. You're starting from the perspective of how are you serving your community, and you listen. If they're not putting any of their own money into it, if this is so important – why aren't you putting your own money into it? If this is so important, why did you just start it last year? If you've been doing this for the last five years, tell us about some of your successes. And you just listen. I don't think it's an ability to hone in on the core; I really think it's a willingness to ask the question. I think everybody understands it, but most people aren't comfortable asking the question. When John

Dunlop³³ was on the committee he would always want to go last in the questioning but he would say, “But before I do this, Howard, you ask about this.” I would always say, “Yes, Professor!”

D. HOWARD: What would you most want to be remembered for?

H. BERMAN: I think simply that I left things better than I found them. I’ve never worried or even thought about creating a legacy. All I wanted to do was make a positive difference by leaving things better than I found them. If I did that, that was okay. The only person I really had to satisfy was Marilyn. If she thought I was doing the right thing, and behaving the right way, then I was golden. I didn’t worry about a legacy. Just like I don’t understand ‘policy,’ I don’t understand ‘legacy.’ If we each just do what we should do, and make it better, we’re okay. (You’d think I grew up on a Midwest farm!)

D. HOWARD: What advice or recommendations would you give to students who are entering the health care field?

H. BERMAN: First, understand what your values are. Second, make a decision whether or not you’re going to compromise on them. Then third, presuming that you say, “These are my values; I’m not going to compromise,” commit yourself to not leaving anything in the locker room.

I don’t know if I did a good job or a bad job in my years as CEO at Lifetime Healthcare. But I do know that I did the best job I could. When I was done, there was no point where I said to myself, *I could’ve done better if I’d tried harder*. Obviously, I could’ve done better if I’d done some other things, but I couldn’t have tried harder. I didn’t leave anything in the locker room. I left it all out on the field.

That’s what those starting out have to do. Values, commitment to those values, and then commitment to do everything you can to make things happen. Go to work for good people, even if it involves less money. Good people do good things. You may not know what they’re going to be, but good people do interesting things. Good people take care of their employees. If you go to work for good people, you’ll be in a position to be satisfied with what you’re doing.

Don’t worry so much about the job, worry about who you’re going to go work for, and whether they have the same values and commitments as you. My challenge was always: Can I live up to McNerney’s values? Can I live up to Alex’s commitment? Can I walk the same walk that Gail’s walking? I have these icons – was Sigmond going to yell at me if I did this? Because these were the people that I kept measuring myself against. Would Barney Tresnowski be satisfied with what I was doing at Blue Cross?

D. HOWARD: That’s really powerful.

H. BERMAN: I don’t know that it’s smart, but that’s the best I can do.

³³ John T. Dunlop, Ph.D. (1914-2003) was a professor and dean at Harvard and also served as US Secretary of Labor.

D. HOWARD: About family, friends, and colleagues. Bob Sigmond advises anyone who wants to approach you or to ask you for anything to go through Marilyn. Can you describe your relationship with Marilyn and her influence on your career?

H. BERMAN: Marilyn is quite simply the love of my life. We started dating when she was 14 and I was 16. We got married when she was 21 and I was 23. We've grown up together. She's the only one who I have to be held accountable to. Even if something goes right in a business sense, if she says that I didn't do it the right way or that I wasn't being fair, then it doesn't count. I've got to go back and undo it.

On the other hand, she will tell you that I never listen to her. I've been remarkably fortunate. We met as kids and we grew up and I can't tell you how fortunate I am. But at the same time, she won't do things unless she thinks they're right. So, just getting to her isn't enough! But, she trusts Bob. Before we went to Rochester, she called Bob to see if it was okay. When Bob told her it was okay, then she said, "It's okay. You can go on an interview." Of course she didn't think I'd get the job, but



Howard and Marilyn Berman

Bob has also been a real influence. When he would come to Chicago, he'd come over for dinner. He'd sleep overnight. He'd read stories to our children. Our children would think that Bob came to play with them. At our son's wedding in May 2010, Bob was there telling stories about our son as a little kid. Bob's a remarkable guy and a real role model. But Marilyn is the love of my life.

I was in Budapest in October and we went to Friday night services and they separated the men from the women. Marilyn was going off and I was standing next to the rabbi as Marilyn went off and I said to him, "Now I'll have NO social inhibition control." The rabbi put his arm through mine and said, "Howard, I'll take care of you." So, she's special and I'm fortunate.

D. HOWARD: A story has been shared about Stephen Loeb, the former chairman of Ohio State's program in Health Administration who had you as a graduate student when he was faculty at the University of Michigan. Legend has it that you asked him not to call on you in class because you knew more than he did about finance.

H. BERMAN: We both tell that story and it's one of those stories that should never be inhibited by fact. Steve was teaching a one credit hour course on hospital finance. He was assigned to teach it because he was the junior faculty guy. We sort of reached an agreement that I'd sit in the back and I would say nothing. Let him say whatever he was going to; I would say nothing, and he would leave me alone. I'd do all the work that was required; but, we would never have any sort of

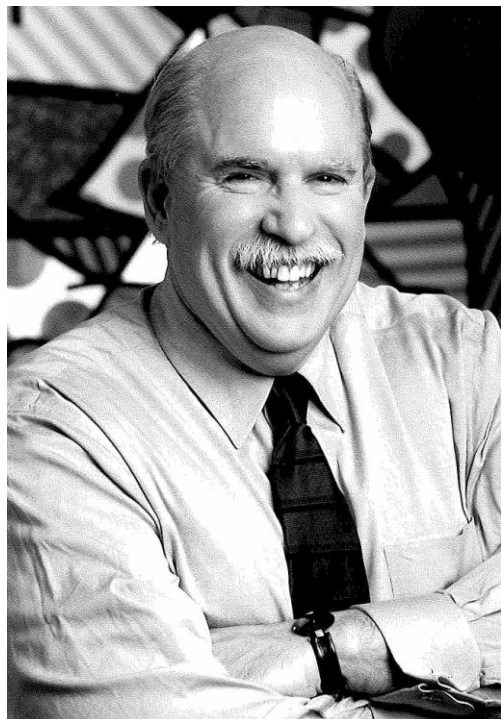
public exchange. It worked out just fine. Steve and I, and our families, have been friends for all these years. In fact, Steve was also at our son's wedding.

But I'll tell you a different story about Steve. The Program in Hospital Administration had its offices in a downtown Ann Arbor office building because there wasn't room in the School of Public Health. They had their own library and I'd go to the library to study every night. I'd leave and I'd see that the light was always on in Steve's office. I couldn't figure out how this guy could work harder than me. I kept looking and looking, and then I found that he never turned the light off. He wasn't there, the light was just on.

But he's just a terrific guy. He did a great job at Ohio State keeping them focused on hospital management and building the alumni association. The fact that there's the Loeb Professorship that the alumni funded is a real credit to Steve. He was also my thesis advisor. He left me alone on that, too, for which I was always grateful.

D. HOWARD: Cleve Killingsworth, who's the former President of Blue Cross Blue Shield of Massachusetts, and his wife appointed you to be their children's guardian. Can you explain the power of professional relationships that you have had that have expanded into personal relationships?

H. BERMAN: These people are my friends and that's what you do for friends. Myles Lash and I have known each other since he was a student at Michigan and I was a junior faculty member. We have grown up together, sharing life's passages. David Klein and I have known each other since he was a student at the University of Chicago in probably '72. We worked together for years. We never saw each other socially until after I left Blue Cross. Cleve was the same kind of thing. We went through life passages together. You're there for friends, that's all. They're friends because we started with common values and learned to trust one another. It's like career planning.



You just do what's interesting. In this case you associate with good people and you take care of each other. That doesn't seem hard and it sounds sort of naive. But that's all it is. You just take care of each other. In Cleve's case, all I needed to know was what he wanted and that's what I would've done.

D. HOWARD: You've served on hospital boards at the Rehabilitation Institute of Chicago and also at Holy Cross Hospital when Wayne Lerner was CEO. Why would you fly in from Rochester, NY, to Chicago to serve on two nonprofit hospital boards?

H. BERMAN: Wayne Lerner is a friend. He was working on interesting problems and presented something where I thought I could be helpful. Holy Cross was a hospital that was serving 400,000+ people in an underserved area and was struggling to do that. It was important to that community that it survived. The Chairman, who is you, Diane, recruited Wayne. Wayne was committed to the hospital serving its community. I

viewed it as a prototype for what could become the new urban community hospital. I liked that Diane Howard was Chair. I liked that the independent directors, the non nuns, non physicians, were knowledgeable health care people. It was a problem worthy of working on. The people were as committed to solving the problem as I thought I was, so it was an easy call. I think in the fullness of time it will be recognized that Wayne did the heavy lifting. The board played a significant role in enabling him to be successful, led by a very good chair.

D. HOWARD: The Howard J. Berman Prize was established by 160 donors in 2004. Can you discuss what the prize commemorates and why it was established?

H. BERMAN: I think it was established to make sure I left! To some extent it's a baby McGaw – to recognize the grassroots organizations that are struggling to make a difference. They don't have to be health care organizations. One was a youth center that would send out a van at night to serve homeless teenagers. Others have been more health-related. I'm pleased that Lifetime Healthcare took the lead in making that happen. I don't make the selections. They have their own process and they tell me who they've selected and I think they've always made solid choices. It's a sort of a living reflection of what I was trying to do – make things better for people who couldn't do



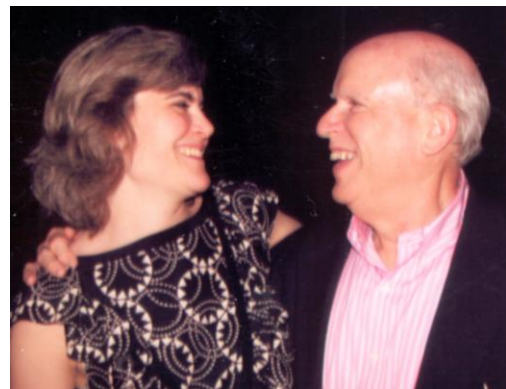
Howard Berman with son Seth

it on their own. I'm both grateful and a bit in awe that they would do it. Therefore, to keep from screwing it up, I stay away from it. But it's a nice thing and Marilyn and I go to the award ceremony.

I don't know what else to tell you. I'm a kid who grew up on the west side of Chicago who was very fortunate to have been given some opportunities that I probably didn't recognize; so, I was even more fortunate to have been put near people who were able to help me capitalize on them. I have a terrific wife and two children who are now adults and are good people – and I attribute that to Marilyn. Both children are artists and have taught Marilyn and me to see the world in new and delightful ways. I envy them for their talent and wish I had some of it. I wish I had their imagination and world view. I've just been one very fortunate, lucky guy. Nothing special. I don't know how you could've gotten luckier: to have been born when I was born, to have the opportunity to spend a career in health care at that stage, to have the patience of real leaders to help me grow up. I couldn't have asked for more.

D. HOWARD: Thank you, Howard.

H. BERMAN: You're welcome, Diane.



With daughter Lindsay

CHRONOLOGY

- 1945 Born February 23, Chicago, IL
- 1967 University of Illinois (Champaign, IL)
Bachelor of Science (Finance)
- 1968 Married June 16 to Marilyn Millstone of Chicago, IL
Children: Seth (1973), Lindsay (1977)
- 1968-1969 New York City Department of Hospitals, Office of the Commissioner
Residency
- 1969 University of Michigan (Ann Arbor, MI)
Masters in Hospital Administration
- 1969-1971 University of Michigan (Ann Arbor, MI), Program in Hospital Administration
1969-1970 Instructor
1970-1971 Assistant Professor
- 1971-1977 Blue Cross Association (Chicago, IL)
1971-1973 Senior Director, Health Care Services
1973-1975 Vice President, Health Care Services
1975-1977 Vice President & Program Director, Research and Development
- 1971-1975 University of Chicago (IL), Program in Hospital Administration
Faculty
- 1977-1985 American Hospital Association (Chicago, IL)
Group Vice President
- 1985-2003 BlueCross BlueShield of the Rochester Area / Excellus / The Lifetime Healthcare
Companies (Rochester, NY)
President/CEO
- 2003- St. John Fisher College (Rochester, NY)
Chair, Center for Community Engagement
Faculty, Bittner School of Business

MEMBERSHIPS AND AFFILIATIONS

Alliance for Advancing Nonprofit Health Care
Board chair

Blue Cross Blue Shield Association
Board member

Chase Northeast Region Advisory Board
Board member

Commission on Accreditation of Healthcare Management Education
Commissioner

Foster McGaw Prize Committee
Chair

Holy Cross Hospital (Chicago, Illinois)
Board member

Jewish Home of Rochester
Board chair

Metropolitan Development Association of Central New York
Board member

New York State Business Council
Board member

Partnership for Nonprofit Enterprise Excellence
Board chair

AWARDS AND HONORS

- 2011 President's Medal for Service to the Community and the College, St. John Fisher College (Rochester, NY)
- 2004 Lifespan's Second Half Hero Award
- 2001 McNerney Fellowship, Hospital Research and Educational Trust
- 1984 Board of Trustees Award, American Hospital Association
- 1967 Bronze Tablet, University of Illinois

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