STANFORD BUSINESS GRADUATE SCHOOL OF

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BLUE SHIELD OF CALIFORNIA

Our biggest risk and challenge as an industry as a whole is that we are pricing a necessity as a luxury good.

— Paul Markovich, CEO, Blue Shield of California

Paul Markovich felt that a time bomb was ticking inside his industry.

Each year, the cost of healthcare was rising steadily, while incomes were only inching upward. In 2018, the median income for a family of four in the United States was $65,000. His company's most popular health insurance product for such a family? A package that would cost them $16,000 a year[1] -- a whopping 26 percent of their gross pre-tax income. That was almost three times the cost of such a plan in 1999.[2]

In the San Francisco Bay Area, where Blue Shield of California (BSC) was headquartered, the situation was even worse. "If you have a Silicon Valley engineer, it would cost the company more to pay for the health benefits of that engineer [in the United States] than to hire one in India for a year," said Markovich, the CEO of BSC.

The problem with insurance companies, Markovich thought, was not out-of-control administrative expenses or fat profit margins. For every dollar that Blue Shield of California customers paid, 87 cents went to pay directly for health care costs, taxes and fees. And as one of the largest not-for-profit health care insurers in the United States, Blue Shield of California capped its profits at just 2 percent per year.

[1] This $16,000 included the cost of premiums out-of-pocket expenses such as copays and deductibles.
[2] Kaiser Health News, 2017 Employer Health Benefits Chart Pack. https://www.kff.org/slideshow/2017-employer-health-benefits-chart-pack/ (January 10, 2019)

Julie Makinen and Lecturer Robert Chess prepared this case as the basis for class discussion rather than to illustrate either effective or ineffective handling of an administrative situation.

"Just being more efficient as an insurance plan is not going to solve the affordability crisis," Markovich believed. "Even if we eliminated our profit and our administrative costs, that would only buy us three years [before costs caught up again]."

Something much more fundamental needed to change, Markovich reasoned. Insurers like Blue Shield of California needed to reimagine their role. No longer could they simply define themselves as middlemen who tried to bring together tens of thousands of scattered physicians, hospitals and pharmacies into a network, and make arrangements for treatment and payments.

Instead, Markovich believed, these middlemen needed to think boldly about how to use their clout and leverage to drive fundamental change throughout the health care system. For example, how might they use their heft in the marketplace to accelerate the development of truly complete digital medical records that would improve patient outcomes and reduce costs? How could they come up with a system that really tied payments to quality care?

"I don't think we have any choice but to get more engaged and influential in the things that are driving the costs and quality of care," said Markovich. BSC aimed to drive down the cost of insuring a family from 26 percent of pre-tax income to less than 18 percent.[3]

But what, he wondered, could and should BSC do on its own? What would require broad industry cooperation and coordination? What would require partnerships with outside tech firms? And what might require policy change and political action? How much time, effort and money should BSC put into these "transformation efforts"? How could it keep its eye both on its immediate business, and the health care model of the future at the same time?

OVERVIEW OF INDUSTRY

The Origins of Health Insurance in the United States: 1870s-1930s

Blue Cross and Blue Shield

Employment-based health benefits programs in the United States date to the 1870s, when railroad, mining, and other industries offered workers the services of company doctors. The Great Depression, which began in 1929, brought economic stresses that catalyzed the development of the modern insurance system.

The Depression sharply curtailed demand for goods and services, and local hospitals were affected too. For example, between 1929 and 1930, Baylor University Hospital, then in Dallas, Texas, saw its receipts drop from $236 to $59 per patient, and occupancy rates fell from 71.3 percent to 64.1 percent. Charity care, meanwhile, jumped 400 percent.[4] The hospital administrator devised a way for people to pay for hospital care. He enrolled 1,250 Dallas public school teachers into the "Baylor Plan." Teachers paid 50 cents a month, and he promised to

[3] Interview with Jeff Bailet, BSC executive vice president for health care quality and affordability. BSC has not specified a time frame for reaching this goal.
[4] Michael A. Morrisey, "Health Insurance," Chicago: Health Administration Press, 2013, p. 6.

provide 21 days of care in his hospital in case they needed hospitalization. Physician advocacy groups opposed the program, so the plan only covered the hospital, not doctors', services.[5] This model—the forerunner of today's Blue Cross plans—spread to other hospitals. In 1932, a plan was established in Sacramento, California. In contrast to the Baylor plan, which covered services at one hospital, the Sacramento plan covered services at any hospital in the community. By 1933, 26 such "hospital service plans" were operating.[6]

During this time, states began to regulate these plans. In the early 1930s, New York's state lawmakers passed legislation specifying that these Blue Cross plans would be nonprofit and exempt from reserve requirements and state premium taxes required of other insurance companies. The insurance commissioner would review their rates. By the end of the 1930s, 25 states had similar legislation.[7]

Blue Cross intended only to cover hospital expenses, but a group of physicians created a competing—yet also nonprofit—set of Blue Shield plans sponsored by county medical societies. The first such plan was the California Physicians' Service, established in 1939. The plans had two key features. First, they required free choice of physician, and second, they worked like a "fee for service" plan. These packages offered a schedule of services, and they assigned costs that the insurance company would cover. For example, a plan might include the cost of an appendectomy. This meant that the plans paid the patient a fixed dollar amount for each covered event; the patient was responsible for paying the physician.[8]

Over time, Blue Cross and Blue Shield plans spread to all 50 states. In 1946, Blue Shield of California became a founding member of the National Association of Blue Shield Plans. (See **Exhibit 1** for a timeline of Blue Cross and Blue Shield companies.)

Fee-for-Service Plans and Prepaid Group Plans

As Blue Cross plans spread in the 1930s, life insurance companies began to take notice, and they started to offer "indemnity insurance." These were also known as "fee-for-service plans." Like the Blue Shield plan, these offered a list of covered services and costs that the insurance company would cover.

At the same time as Blue Cross was developing, an alternative model arose: prepaid group practice plans.

One pioneer in this realm was Henry J. Kaiser, the American industrialist and entrepreneur, who realized that he needed to provide medical care for his workers and their families in remote locations. He contracted with Dr. Sidney Garfield to set up clinics and hospitals to provide care for the workers and their families. Kaiser would pay for these services on a per person, per month basis as opposed to fee for service. In 1933, Garfield founded the Kaiser Foundation

[5] Ibid.
[6] Ibid.
[7] Even today, Blue Cross and Blue Shield plans exist in most states under enabling legislation. This is why they sometimes must go to the state legislature to add a line of business, such as life insurance, or to convert from nonprofit to for-profit status.
[8] Morrisey, op. cit, p.8