March 25, 2008

THE HEALTH CARE CHALLENGE:
BALANCING FAIRNESS AND BUSINESS IMPERATIVES

Bruce G. Bodaken
Chairman, President, &
Chief Executive Officer
Blue Shield of California
BENTLEY is a leader in business education. Centered on education and research in business and related professions, Bentley blends the breadth and technological strength of a university with the values and student focus of a small college. Our undergraduate curriculum combines business study with a strong foundation in the arts and sciences. A broad array of offerings at the McCallum Graduate School emphasize the impact of technology on business practice, including MBA and Master of Science programs, PhD programs in accountancy and in business, and selected executive programs. Enrolling approximately 4,000 full-time undergraduate, 250 adult part-time undergraduate, 1,400 graduate, and 20 doctoral students, Bentley is located in Waltham, Mass., minutes west of Boston. The Center for Business Ethics at Bentley College is a nonprofit educational and consulting organization whose vision is a world in which all businesses contribute positively to society through their ethically sound and responsible operations. The center’s mission is to provide leadership in the creation of organizational cultures that align effective business performance with ethical business conduct. It endeavors to do so by the application of expertise, research, education and a collaborative approach to disseminating best practices. With a vast network of practitioners and scholars and an extensive multimedia library, the center offers an international forum for benchmarking and research in business ethics. Through educational programming such as the Raytheon Lectureship in Business Ethics, the center helps corporations and other organizations to strengthen their ethical culture.

All of us who had the pleasure of attending Bruce Bodaken’s Raytheon Lectureship in Business Ethics were rewarded with an exceptionally forthright and insightful reflection on the issues associated with the health insurance industry. This is a central problem facing the United States and one that simply does not afford quick and easy solutions.

As someone who studied philosophy at the undergraduate and graduate levels, Mr. Bodaken recognizes the profoundly ethical dimension of healthcare. As he sees it, access to health insurance is a matter of social justice. Indicative of his commitment to “walk the talk,” he was the first health plan CEO to offer a specific proposal for universal coverage, thereby foreshadowing legislation enacted in Massachusetts in 2006, as well as proposals made by several presidential candidates in the 2007/2008 campaign season.

As such, this talk was highly relevant to the commitment to ethics and social responsibility that is central to Bentley’s mission. We believe it is possible to teach ethics, but only if it becomes a way of life on campus. Our students and faculty live and breathe these issues through a host of pioneering programs, sponsored by the campus-wide Alliance for Ethics and Social Responsibility—a collaborative effort involving an array of campus-based centers and initiatives including the Center for Business Ethics (CBE), the Women’s Leadership Institute, the CyberLaw Center, the Bentley Service-Learning Center, the Cronin International Center, and the Valente Center for Arts & Sciences.

Looking back over three decades since the founding of the Center for Business Ethics, I can’t help but reflect on how far the business ethics movement has come, while recognizing that the job is far from complete. Ethics may now have entered the mainstream of business, but not yet the bloodstream in many cases. Infusing Bentley students with the kind of ethical consciousness and commitment that will distinguish and inspire them as future business leaders is a critical part of our mission. The Raytheon Lectureship in Business Ethics series, founded and organized by CBE, is a hallmark of this Bentley-wide effort. With Raytheon’s valued support, I am confident that our students and faculty will continue to draw inspiration, understanding and new insight from the dialogue created by the lectures.

W. Michael Hoffman
Executive Director, Center for Business Ethics
and Hieken Professor of Business and Professional Ethics
Bentley College
Ethics in business is about so much more than just following rules. Fundamentally, it is a matter of creating the right culture in our organizations, so that people have the ability and support to make decisions that are not only effective, but consistent with the values and principles we hold dear. Raytheon has worked very hard to establish an ethical business culture that is accepted by our employees and woven into the fabric of the ways in which we work. Our continued growth and profitability depend on it.

Raytheon has supported the Center for Business Ethics at Bentley College for many years, and our sponsorship of its Lectureship in Business Ethics is an important commitment for the company. We recognize the enormous value of the leadership given by the center for over 30 years to promote ethical business practices and cultures in the United States and around the world. And ethical leadership — illuminating and inspiring conduct that is instinctively ethical — is what the Raytheon Lectureship in Business Ethics is about. I’m proud that Raytheon can play a part in bringing to the Bentley campus highly respected leaders of companies that have a manifest and deep-rooted commitment to doing business in the right way. Their insights contribute much to an important discourse on how the business community can and should achieve ethical excellence.

William H. Swanson
Chairman and Chief Executive Officer
Raytheon Company
Founded in 1939 and headquartered in San Francisco, BLUE SHIELD OF CALIFORNIA is the largest not-for-profit health plan serving the state exclusively. It has 3.4 million members, 4,500 employees, one of the state’s largest provider networks, and more than 20 office locations. The company provides a wide range of commercial and government products, including those designed for large and small groups, individuals, Medicare, Healthy Families, TRICARE, and labor trust coverage. Blue Shield of California is an independent member of the Blue Shield Association.

(Bruce G. Bodaken, chairman, president, and chief executive officer of Blue Shield of California with Dr. W. Michael Hoffman, founding executive director of the Center for Business Ethics and Hieken Professor of Business and Professional Ethics at Bentley.)

BRUCE G. BODAKEN is chairman, president, and CEO of Blue Shield of California. A native of Iowa, Bruce earned a masters degree and was a teaching associate in philosophy at the University of Colorado before embarking on a career in health care. During his seven-year tenure as CEO, Blue Shield’s membership and revenue have grown significantly and the company has become a major player in California’s large public-employee market.

Passionate about his company’s not-for-profit mission, in 2002 Mr. Bodaken became the first health plan CEO to offer a specific proposal for universal coverage, thereby foreshadowing the Massachusetts legislation enacted in 2006 as well as proposals made by several presidential candidates in the 2007/2008 campaign season. During Mr. Bodaken’s tenure, the Blue Shield of California Foundation was transformed into one of the state’s largest healthcare grantmakers, with more than $100 million in Blue Shield corporate donations to the Foundation in the past three years. He is co-author with Robert Fritz of The Managerial Moment of Truth, published by Simon & Schuster (Free Press) in 2006.
The Health Care Challenge: Balancing Fairness and Business Imperatives
THE RAYTHEON LECTURESHIP IN BUSINESS ETHICS AT BENTLEY COLLEGE

March 25, 2008

Bruce G. Bodaken
Chairman, President, & Chief Executive Officer, Blue Shield of California

Thank you very much Dr Hoffman! That was a great introduction, especially given your distinguished track record in the area of business ethics. As you know, I engaged in graduate studies in philosophy, and based on this experience, I believe that there is clearly a need for more philosophical thought to help us to respond to the very important issues we face in business. What I’ll try to do in this talk is to take you through a very quick course in how health insurance works and the impact of this process on some of the salient issues we face. I do want to round out these comments by mentioning a little about our company and myself.

In California, the provision of health insurance has been consolidated into five major plans. It’s a very large state with 32 million people and we have over three million of those people enrolled in Blue Shield, which makes us the third largest provider in a very large state with only a few health plans. Like Bentley, we have a proud and long history. We were founded seventy years ago by Californian physicians. While we’ve done reasonably well as a health insurance company, nonetheless, on a daily basis we face challenges that worry me, primarily around the issues of fairness and distribution.

And on a personal note, back in 1970, I thought I would be sitting out there in the audience as a tenured faculty member in a philosophy department, perhaps one as good as the one you have at Bentley, and someone like you would be up here on this stage. Indeed, in graduate school, I had passed my comprehensive exams and started work on my PhD dissertation. I ultimately realized that it was going to be very difficult for me to find a job teaching philosophy. At that time, many students were finding their ways to business schools, as if philosophy wasn’t important for that. I’m hoping for a renaissance in the application of philosophy to business, and the kind of program you have here suggests that one may be taking place. I couldn’t be more thrilled than to be with this particular audience talking about these ideas.

Distinguishing Health Care and Health Care Insurance

First, I want to talk briefly about health care and health insurance. Sometimes when we talk about these issues, the distinction is not clear. The following definitions are to help get us on the right track for understanding the subject we’re looking at. Although I know something about health care (I even tell my kids, I’m almost a doctor), I know a lot less about it than what practitioners know. But “health care,” as I define it here, is simply the provision of the kinds of services ranging from getting your teeth cleaned to having open-heart surgery, and all of the things in between.

What we are concerned with in our discussion here is “health care coverage” or “health care insurance.” In this regard, in this country, we have a big public insurance system, and a very large private insurance system, both of which are having their own challenges. Health care insurance is essentially a guarantee. Some question whether the guarantee is fulfilled. To respond to this concern we need to recognize that as someone who is insured, there is a contract between you and your employer or as an individual you may have a contract for health care insurance with a company like mine. That contract says you are guaranteed certain services as long as it is within the limits of the contract. In either case, the issue of fairness runs through both in very significant ways. I’m particularly interested in access — who has good access, who can afford it, and exactly how does getting good access work in our health insurance system.

I’m not going to discuss problems associated with the inequities in health care provision, although there is much to discuss on this. Instead, I’ll focus on health care insurance. That’s what I know, and there’s plenty to talk about on this.

Framing the Challenge

Health care is a big deal. It is the largest single segment of the US economy — amounting to $2.3 trillion today, i.e., 16 percent of the GDP. It is projected to amount to almost $4 trillion or 20 percent of the GDP in 2015. As a friend of mine says, “If you trace out the future of health care, we’ll all be in a nursing home or working in one.”

Unfortunately, there’s some truth to that: health care is becoming a bigger and bigger part of the economy. It is well known that on a per capita basis the United States spends more on health care than any other country. Now, we spend about $8,000 per capita, for every man, woman and child in the US, and about $12,000 per person on health care premiums for a family of four. It would be a little more
in Massachusetts and a little less in California for an adequate but not comprehensive program, and that is growing about seven percent a year on a compound basis. You get a sense of the enormity of this number if you project it into the future. If it continues to grow at two to three times the rate of inflation, there will not be enough money to handle the health care issue. Medicare will certainly be bankrupt within your lifetime unless we change the system. So if you’re not worried about getting health care over the next thirty, forty, or fifty years, by the time you’re Medicare-eligible, you should be since it is questionable whether or not there will be a system at all.

What is happening within my industry is that we are dealing with these issues by managing costs more dearly…frankly, by reducing benefits and by raising deductibles and co-pays. That is a way of keeping the price down, but of course, it is not improving health care.

On the Social Implications of Rising Health Insurance Costs
What are the implications of this? California, which is the third largest state in terms of area, is the largest by a significant margin in terms of absolute numbers of uninsured. About one-fifth of our state does not have health insurance. So we have a very large problem. Across the country, some 47 million, about 16 percent of the population is uninsured. Is there a national solution on the horizon? I do not see one. We have lots of discussions with people in DC and Sacramento about what we might do. There are well-meaning people all over this country trying to deal with this issue. However, they run headlong into the economics, which are very difficult today.

My hat is off to Massachusetts. It’s the single state that has a comprehensive program with universal coverage. There are lots of other states that have tried various programs, but there’s nothing on par with Massachusetts in terms of universal coverage. However, you’re not out of the woods, because you have to finance this going into the future and that’s going to be a real issue for the state.

Still, your problem is much smaller than that of California. Let me give you one statistic: Massachusetts has about 800,000 on Medicaid; California has two million Medicaid members in Los Angeles County alone. The scale for California is very different. Nevertheless, Massachusetts took on the issue, and I think you took it on well. I support the state on all it has done to get it there. I want to applaud the Blue Cross system here in Massachusetts, which has taken steps to be part of the solution.

In the United States there is a correlation between health care insurance and individual health status. We know that millions of people use the emergency room as their primary care physician’s office, because they have no other access. That is a very expensive and ineffective way to get care. Because such people are not getting treated, their conditions tend to be acute. So by the time they get into the system, they often find themselves headed to hospitals for a relatively long time and often are on a merry-go-round in and out of the hospital. The Kaiser Family Foundation shows that about 50 percent of the uninsured don’t purchase the medications prescribed for them. So of course, their condition gets worse. They end up back in the emergency room, but this time for a more acute condition that again requires hospitalization, which raises cost. Even worse, mortality for the uninsured is 13 percent higher than for the insured. It’s a pretty scary statistic. Unfortunately, the uninsured are much sicker and die younger.

The Secrets of Success in the Health Insurance Industry
Now, I would like to talk about what I call the “secrets of success.” Be sure you’re taking notes now, because when you’re the CEO of a health plan, you’re going to want to have this! Clearly, the four ideas I’m about to express can’t be much of a secret because they are on the screen, nor are they complicated because they are basic business principles. However, these ideas will help us think about how to make health insurance work so as to provide decent access.

First, managing cost, both direct and indirect costs, competitively is crucial in the health insurance industry, just as it is in other businesses.

Second, we have to improve the customer experience if we’re going to be competitive. So, all of us are working on that to some degree.

Third, we have to attract and retain great employees. I’ve written a book on management that focuses on this, and my own view is that this is the key to the two previous ideas. Without great people in our organization, we don’t have a chance of doing well in managing costs or improving the customer experience.

The fourth “secret of success” is to grow our company’s reputation, which is really dependent on a company’s historical legacy, as it is for all of the Blues [i.e., Blue Cross and Blue Shield companies]. We are lucky to have the kind of reputation that we do based on the historical legacy that we have built up over decades. The brand has been very important in our history and we demonstrate it in how we serve and fulfill our promise to our customers.
Ultimately our reputation is connected to the degree that we have public trust. The satisfaction ratings for health insurance companies are probably just above those for George Bush. Clearly, we have a lot of work to do. In fact, part of what I’m describing today and what I’m hoping you and our industry are hearing, concerns the changes we have to make to improve health insurance access.

**A Closer Look at Managing Costs**

With all of these points, the thing we have to understand is that to some degree, it all comes down to the economics of what one can afford and what one can successfully provide. So, just as with any other business, we have to be relentless in administrating our costs. At Blue Shield we do a pretty good job of that. For that reason, our overhead costs are generally a little lower than most of our competitors in California.

Let’s now consider provider unit costs, by which I mean what it costs us for our members to stay in a hospital, to be seen in the emergency room, or to see a primary care physician. At Blue Shield of California, it’s our responsibility to contract for those services. Unlike Kaiser Permanente, which provides those services directly, most health insurance in the United States is provided through a network model, that is, we contract for networks of health care providers that we then provide to our members through an insurance policy. In our network we have some very large institutions, some of which are dominant within their area. That means we get a deal as good as anyone. Nevertheless, costs are going up. It is not unusual for us to sit down with representatives of large hospital systems and for them to start a discussion in which they request a rate increase in the neighborhood of 30 to 40 percent a year. Hopefully, we get this down to 10 to 15 percent a year. That’s about as good as we do. Frankly, no one does any better than us. Now, we have competition in southern California, and less so in northern California. Massachusetts is not that different. There are places you have competition and places where you don’t.

The third area of managing our health care costs pertains to individual case management. This is an area that, especially ten to fifteen years ago, was probably the most controversial aspect of managed care. Physicians were saying they didn’t want to be told by health insurance executives how they should manage the care of their patients. In some respects, they were absolutely right. We have changed some in that period of time. In fact, we have opened up our system to a very great extent and our costs have gone up. If Wennberg is right, 30 percent of what is done is harmful or unnecessary.

One of the areas where we can do a much better job is illustrated by one percent of our CALPERS (California Public Employees Retirement System) members who have Blue Shield as a provider, i.e., one percent of the 400,000 members account for 30 percent of their costs. So we have initiated a program to manage the costs associated with that one percent (and frankly it’s even less than one percent) with the result that we’ve been able to return to CALPERS about $10 million to $15 million a year. Most of these costs were associated with people dying and they were dying in hospitals. They didn’t want to die in a hospital nor did their family want them there, but they didn’t have an alternative. We’ve worked with a complex care management provider, and we helped to get those people home and comfortable managing their pain and other symptoms. We provide in-home services and arranged transportation so that they could return to the hospital when they needed to be seen. Just with that one program alone, we were able to take about $15 million out of the state of California’s bill. That’s managed care at its best.

**Balancing Risk**

There is one thing that health insurance executives seldom talk about in a public forum, and if my peers are here, they might be concerned about what I’m about to say next, which is this: We balance insurance risk across things called risk pools. We do this by virtue of bringing in and selecting out groups and individuals that we think represent a reasonable risk for our company. Some call it “risk selection”; we call it “balancing risk.” Cynically, it’s a good euphemism for risk selection. In California, and in other places around the US and the world, we actually have a fair amount of discretion about whom we accept and whom we reject. With individual coverage, where we have the most direct control, we may refuse coverage to those who have poor health. If you have hypertension and a history of it, you’re not going to get coverage with Blue Shield and it doesn’t matter how much money you have. It’s not going to be a matter of you paying an extra $100 or $1,000 or even $10,000 a month — we simply won’t cover you and neither will Blue Cross, Kaiser or United Pacific Care. People in this condition simply can’t get coverage. We play in a world that is voluntary, and we have the right to refuse coverage for poor health.

We sometimes accept individuals and ask them to sign something called a “waiver.” So if, for example, you have hypertension, you sign a document that says that you won’t receive coverage for that condition during the first six months of your contract. So, if you get a $50,000 hospital bill during period, it will be your responsibility and not ours. We can adjust the rate for risks in our “Small Group” products; we may underwrite you for an additional 10 percent. Most controver-
sial and a matter of huge lawsuits in California today is what is called “rescinding” coverage, which is dropping people because we believe they fraudulently represented their health history. This controversy was made more complicated by a public debate pertaining to the results of a recent Gallup survey in which about 70 percent of people stated that they believe that it is OK to lie to one’s health insurance company to get coverage. That tells us something about their view on health insurance and how desperate people are to get coverage.

The Results

Health insurance companies have the right to decide who gets coverage; that’s how we balance risk. As a result, healthy people can get coverage that is still pretty cost-effective. It’s certainly more expensive than it was ten years ago, and it will be more expensive ten years from now. But for the people in this room for the most part, unless you have an unusual condition, come on down! We need your good health in our risk pool. If you’re a large employer or in a public program, you can get health care coverage too. That’s true if you’re very poor or if you’re with a good employer. At Blue Shield of California, we not only provide coverage to our employees, we subsidize our own employees for the coverage they get through us. For anyone who works at Blue Shield and earns less than $50,000 a year, we actually provide about 50 percent of the costs of coverage. There are other employers who do the same thing, or something similar.

If you happen to be healthy and in one of those groups, you’ll be fine. But not everyone is healthy, and as Dr. Hoffman said, at some point in time you won’t be. For those who do not qualify for individual coverage in California, if they qualify for Medicare or Medicaid, that is, if they’re old or poor, they can get coverage. For those who are 45 or older and don’t have a job, regardless of their income, they are unlikely to get health care coverage in California on an individual basis.

I am proud of a lot of what Blue Shield does. I think we do some things as well as they can be done. However, rather than competing on quality and service, health plans also compete on how good our actuaries are — in addition to managing risk, our focus is on how good are we at risk selection.

Is This Fair?

You might ask — and I think you should ask — is this fair? Is this the right way to do things? It sure doesn’t seem fair to exclude coverage to those people that need it the most. And it doesn’t seem fair that some employers, employees, and individuals are paying their fair share but others aren’t. Among the 20 percent of uninsured in California, about one-third of them earn over $70,000 per year. They can afford health insurance and have access to it, either through their employer or through a public program, and they choose not to take it. Indeed my guess is that if you’re 22 and you’re healthy, and you’ve got some discretionary income, getting health insurance might not be the first thing on your list. First, you don’t think you need it, and second, if you do get a broken leg, or experience a problem you can’t afford to treat, so far, in the United States we don’t let you die on the street. You will get health care. It may be in a public system and not exactly what you wanted, but you will get treated. People know that, and there is a set of people in the United States who can afford to pay for insurance and don’t take it. These are “free-riders” and we’ll talk about why that is the case. This represents a huge cost-shift that is going on in the United States, between public and private shares, and between the uninsured and the insured.

How Costs are Distributed

Private Payers Pay Hospitals at a Higher Rate than Medicare and Medicaid

Note: Payment-to-cost ratios indicate the degree to which payments from each payer cover the costs of treating that provider’s patients. Data are for community hospitals and cover all hospital services. Imputed values were used for missing data (about 33 percent of observations). Most Medicaid managed care patients are included in the private payers’ category.

Source: Adapted from the American Hospital Association and Avalere Health Trend Watch Chartbook 2007: Trends Affecting Hospitals and Health Systems
When a company like ours goes into contract negotiations with a hospital, they will lay out statistics just like the ones in this chart. They wouldn’t have done that five years ago, but now they’re unabashed about it. What this shows is that for every Medicare/Medicaid patient they get, they get paid less from the federal or state governments than it costs to provide the care they give. For physicians, it’s even worse. In the state of California, we have the lowest per capita physician payment in Medicaid in the United States. They get about 50 percent on the dollar, if they take Medicaid patients at all. For Medicare patients, they get a little closer to about 90 percent. The uninsured don’t pay at all. So if someone has a broken leg and doesn’t have insurance, he’ll go to an emergency room for treatment, and typically that hospital will provide charity care.

What this means for those of us who pay is that we have to make up the difference so health care providers have a positive bottom line in spite of government underfunding. On average, we pay about 30 percent more. The surcharge of 30 percent for private insurance companies offsets their losses for uncompensated care. If we had everyone insured today in the United States, the insurance premium of those who have coverage would go down, or should go down by about 15 percent overall (the 30 percent impact on hospital care equates to 15 percent of the total health care expense), because the folks who now are getting free care would then be paying their way. And if government programs paid their fair share of costs, we would then have a lot more money in the system, so that private individuals and private companies would get a better deal. Hospital charity care would be a thing of the past because it would be unnecessary.

Why Doesn’t Blue Shield Lead the Way?

You might say, well, Mr. Big Shot, if you know so much about health insurance and if you know this isn’t fair, why don’t you do something about it? Let me explain why this isn’t so easily fixable. The actuary term, “adverse selection,” means that if we take on more than the average risk for any population, we have to charge a premium for the risk we’re bearing. So if it costs $1.10 to provide coverage for which we get a $1.00 premium, then we have to raise our rates by ten percent to at least break even. If we have adverse selection, we raise our rates. And if health plans are not taking the folks who have poor health status and we have open doors, two things are going to happen: Our competitors are going to have lower prices and they’re going to attract the people that don’t have health care problems, which means we will get adverse risk even to a greater extent, and we’ll have to raise our prices even more, and that leads to something you don’t want to get near...it’s what the actuaries call a “death-spiral.” Because as the risk-pool just gets sicker, we raise prices, we lose our good customers, and the pool of remaining customers is even sicker. We raise prices more, we lose more healthy customers, and it becomes a vicious cycle from which you can never emerge.

We have a foundation to which we give $30 million to $40 million on an annual basis. Our foundation, in turn, provides half of that money to community care clinics across California. So in some very small way, we’re responding to a piece of the health care access problem. However, at the end of the day, we are playing the same game as all the other health insurance companies. If we didn’t play this game, we’d be out of business. We would have attracted the folks that couldn’t get coverage anywhere else and we’d have to raise prices, which unfortunately would drive away the healthier risk. That’s the way it works.

A New Model Proposed by Blue Shield in 2002

In 2002, we did try to do something about it. We thought it had to be a systemic change and proposed a system called “Universal Coverage Universal Responsibility.” This system isn’t very far from what Massachusetts has adopted in which everyone would be eligible at least for basic benefits. According to our proposal, if you couldn’t afford it, we would subsidize your enrollment. There would be no restrictions based on health status. We would take all customers, but you would be required to provide payment. This is bad news for all of you that were thinking about buying that new sports car instead of getting health insurance. Under this program, you’re going to have to pay for health insurance if you can afford it, either through your employer, through your individual coverage, or in fact, through a public system. We would cover everyone. This was proposed for California, but the same could apply nationally.

What would this universal coverage program cost? We thought at the time, it would cost about $10 billion to $12 billion. In 2007, however, the estimate looked more like $12 billion to $14 billion. This is the proposal Arnold Schwarzenegger sent to the California legislature. His was almost a mirror image of what we proposed. It was changed in the process, and didn’t pass. That was tough, because we supported it all the way. It would have cost California about $12 billion from a variety of sources. If this were applied to the entire US, the total cost would be about $80 billion to $100 billion. That’s a lot of money, and in California this led to many discussions as to how it would be financed in such a way that nobody would get a free lunch. In the end, however, I would argue that it’s not only money we need to spend, it’s money we must spend.
There are those who say we can insure everyone in the United States and save money; therefore we don’t need to finance it. Yet, from what I know about the system, introducing 7 million uninsured California residents to coverage will cause costs to go up. At least for a period of time, they will certainly go up and this is something we wanted to be honest about. Since the state was running a $14 billion deficit, we recognized that there was no money in the state budget to finance the program. We asked ourselves how this program could be funded. We held that broad-based funding made the most sense, and we favored a general sales tax in part because we knew it would be very hard to garner support to add this to the income tax since California already has one of the highest income tax rates in the United States. The amount of the sales tax increase that would be required for California would have been about a half-percent. For this modest amount we could get health coverage for every person in California, and that, we felt, would have been a reasonable cost.

You could also do it other ways. In Maryland, for example, they have a provider tax on medical services. Both the charging of higher rates for coverage and the sales tax on the coverage are on the hospital bill.

You could even finance it through income tax or fees, as mentioned, but politically, this would be very difficult.

**Why a Public/Private Rather than Single Payer System?**

I’ve often been asked, “If you want a solution, why not just make it a public system?” I obviously have a vested interest since I’m a CEO of a private system. But central to our mission is access to good health care. If our board and I believed the best way to achieve that was through a single-payer system, we would promote it — even to our demise. Our mission says we must! However, there are at least two reasons why we don’t believe that a government single payer system is the solution.

In California, we need to increase access — that is the first order on the agenda. However, we also have to minimize costs; if we don’t, no matter how much we try to make this work, it won’t. And yet, costs are outstripping inflation at a rate of two to three times. That has to be turned around, and I think there are reasons why the private sector will actually take care of that. Also, public systems, at least in California, are affected by the politics of the day.

Let me give an example: in 1994, there was the Northridge earthquake; one person out of all of the hospitals in Southern California died as a result of that natural disaster. Within weeks, the California State legislature had made it a state law that every hospital had to be seismically retrofitted by 2012. The cost of seismically retrofitting every hospital in California is about $100 billion. That would pay for the plan I just prescribed to insure everyone in California for five to seven years. Now, one death is awful for that person and his or her family, but considered in the context of whether earthquakes are going to cause massive death from collapsing hospitals, it’s apparent that massive deaths are not likely. We’ve had plenty of earthquakes — literally hundreds of them have occurred in Northern and Southern California, and all of those earthquakes have resulted in one death only. However, because the public system is very politically motivated, it would be very difficult to undo this policy, even though it would be much better to spend that money on insurance coverage.

**A Philosophical Perspective: Rawls’ “Veil of Ignorance”**

In preparing for this talk, I visited my philosophy books — the ones that I haven’t read in 30 to 40 years — to refer to my copy of John Rawls’ magnum opus, *A Theory of Justice*. I was excited to give this lecture and talk about the “veil of ignorance,” which, I imagine many of you understand. John Rawls was in big demand when I was in graduate school. *A Theory of Justice* had been published a few years earlier, and one of its central ideas that I could never forget was the notion of the “veil of ignorance.” The veil of ignorance is a term that John Rawls coined on how to get a just and fair society. According to this notion, as rational self-interested individuals, we should put ourselves behind a “veil of ignorance,” that would prevent us from knowing our social position and where we would be once the veil was lifted. The question we then should ask was what social policies would we prescribe when behind the veil if we didn’t know we were going to be the CEO of a health care plan or a student at Bentley College, old or young, black or white, insured or uninsured. What kind of rules would I construct under such circumstances? Before I lifted the veil, I would ask myself questions such as, what if I didn’t have health care coverage or couldn’t afford health care coverage, what kind of system would I want operating? Well, one of the things I would want would be to have a guarantee of coverage, and the system I’ve proposed gives us that.
I don’t think Rawls mentions health care in the book. Instead, he writes about a much broader sense of social justice and comes up with two principles, which I will not go over here. However, I raise this because I wonder if the health care proposal that I have proposed to you here today would pass John Rawls’ test?

According to our proposal, regardless of my social position, I would get basic coverage. So even if I couldn’t afford it, such as if I were a student or wanted to teach philosophy, I would have health insurance. I would want a system that would subsidize coverage for those unable to afford it. The system we’ve proposed does that. If I wanted to buy up, I should be able to. This is one of the criticisms made against some public systems; providers of care could not provide coverage under a private system in Canada until recently. So if you were a physician and wanted to provide private care, which is 10 percent to 15 percent of the care, you actually participated in a separate private care relationship with your patient. However, 90 percent of most practices are still public. Now, in the system we proposed, if people can afford it and want to buy additional services, we suggest they should be able to do that and providers ought to be able to accommodate that.

How would our proposed system be financed? Well certainly if I’m rich, I will not want to pay for the entire cost of the program. But if I’m poor, I won’t be able to pay my fair share either. So a broad-based tax seems to make sense. Finally as a physician, or as a hospital, I will want to make sure I am compensated for at least the fair share of my costs, if not receive a modest profit. With the rebalancing of the cost shift that I talked about, it would be fair if at least I got my costs back from my participation in the public systems and profits based on work done in a private system.

In summary, I think this proposal satisfies the Rawlsian test. (Fortunately, Rawls passed away so he can’t judge it, because, in fact, it might not be up to his standards.) The funny and tragic thing with our current system is that fairness is understood on a procedural basis and accordingly, we are told, “The system is fair.” Under the current rules, not only is Blue Shield doing what’s fair, it’s doing the only thing it can do in a system that has voluntary coverage under a public system organized as it is. It’s fair for employers not to provide coverage to their employees, and it’s fair for an employee in good health not to take coverage. It could be argued that based on some notion of freedom or autonomy that ought to be the case. Yet, we don’t hold such views about fairness for public education, nor do we for social security. We don’t let twelve-year-olds decide whether or not they are going to get a public education in the United States. In fact, we mandate it. Why not health insurance?

Concluding Reflection

I would suggest that John Rawls had it right —that if we put our current system of health care coverage to the test of any serious notion of social justice, we would need a new system. I know this is a long-term prospect and I am very realistic — we are a considerable distance from the program I have proposed. The economics work against it and in fact, a lot of people disagree about what’s fair. These are discussions that have to be held. But we are moving inevitably toward a crisis, and a crisis that I hope will be resolved by reasonable people working together in good faith.

I would like to end with this quote:

“A man has made at least a start in discovering the meaning of life when he plants shade trees under which he knows full well he will never sit.” – D. Elton Trueblood

I don’t know if I’ll see universal coverage in my lifetime. My fear is if I don’t, you won’t see coverage at all. This is not only an issue of fairness or equity; it is an issue of basic human life. It’s an issue that Blue Shield of California takes seriously, and many others have joined us. We are still a minority and for some good reasons, we have a big deficit in California, and a big deficit in the United States. Financing these things will not be easy, but as I see it, we finance other things that are a lot less central to human life than health care coverage. I would suggest that we look at our priorities and that we reorder those priorities and institute the system here propose or a system like it that secures coverage for those who need it most as well as for the rest of us. We will all need it at some point in our lives. Thank you.
The new insurance situation in Massachusetts has created circumstances where people have more choices, and they are moving about to various hospitals to respond to their healthcare needs. Ironically, in Massachusetts, the places that were providing free care, like Cambridge Hospital and Boston Medical Center, are experiencing unprecedented cutbacks because they used to be able to bill the state through the free-care pool, and now they cannot. Do you want to comment on that?

BRUCE G. BODAKEN: This is why I think the competitive system is one that we should take a long hard look at. If, for example, the hospital next door can afford to continue its work and Cambridge Hospital cannot, because the costs cannot continue to go up at 7 percent on a compounded annual growth rate, as much as Cambridge Hospital may be a revered institution, they’re going to have to face competitive forces and find a way to provide quality coverage. Incidentally, in California for example, the proposal we’ve put forth would increase the allocation of funds to public hospitals considerably, because they’re currently getting paid at Medicaid rates that are significantly less than their costs. Maybe it was the reverse here in Massachusetts. Like I said, Blue Shield should be willing to look first at its mission and then at the effect of the plan. Our mission is to provide access. If we do that by in fact turning ourselves inside out into some kind of public entity, so be it. That’s the first responsibility I have as a CEO, and I would say to the Cambridge Hospital CEO, that is his or her first responsibility as well.

Just to follow up briefly on your comment, you’re talking about Medicaid and Medicare. But what I’m talking about is the free-care pool for people who are presenting themselves to emergency rooms and aren’t covered by Medicaid or Medicare. I also want to comment on your earlier point about being tempted to buy a sports car, rather than purchase health insurance. It should be noted that most people who can buy sports cars also have some housing or some other assets that can be seized to cover their health care bills, so they’re not getting off free.

BRUCE G. BODAKEN: I can speak more to the situation in the state of California than to that of Massachusetts. In California, such care is called “share-to-care.” It is simply provided at no expense to the individual who doesn’t have assets. People who have assets have a responsibility to pay. The best way to solve this problem is to deal with it in a way that is similar to the
way we deal with public education, which is to see health care coverage as a social good. So we all need to participate in health care coverage, including those who are healthy and those who are not so healthy. We should all participate in the system on an equal and fair basis. I’d say that if we use this as a first principle, we will end up in a good place. That does not mean that an individual institution or an individual health plan is going to come out on the positive side of the ledger. That will depend on how efficient we are at administrating and how good our services are.

Speaking on the behalf of a class here called “History of the Drugs Trades,” meaning drugs as in pharmaceuticals, my question applies both to the cost of pharmaceuticals and to health care generally. In Canada, the state will not only decide how much it will reimburse for a particular procedure, but how much it is willing to pay for a particular drug. The market operates in that system because companies who cannot provide that service or that drug in that price or that profit get out of the business. So the companies who remain will make a slim profit. Now isn’t such a single-payer system a better solution than what we have here?

BRUCE G. BODAKEN: There are a couple of reasons why I would not support this approach. Pharmaceutical manufacturers are global and not domestic. The cost shift I talked about in hospitals is exactly the same thing the pharmaceutical industry faces except in a more extreme way. Where they don’t make money in nationalized insurance areas, they make up in the United States. The insurance gap, which is about 30 percent, is more like 50 percent to 100 percent for pharmaceuticals. It’s not like they’re charging a fair amount and making a profit in states like Canada that regulate costs. In fact they’re going to the United States and charging egregious amounts — or a fair amount based on the system — so they can return about 20 percent to their investors. There are other ways to do that, one of which is to make prescription drug coverage part of basic coverage. Incidentally, there’s no reason why a private system can’t also operate on fixed-costs budgets, just as there’s no reason why a private system couldn’t also negotiate with pharma. In any case, global budgets toward the end of the year get used up, the queue of people waiting for services gets longer, and the ability to provide services that are arguably discretionary decreases. As a result, even things such as hip replacements simply don’t get done. I think we can do better than that. I would argue that a private system can do that and also balance the budget.

I’m interested to hear your views on the financial stress that is put on your company and others like it, especially in states like California, Texas, and Florida, from the folks who are there illegally. And specifically, I wonder how one would respond to this problem if one were to apply to it John Rawls’s “veil of ignorance.”

BRUCE G. BODAKEN: That’s a very good question: let me begin by addressing the first part. One thing that is true in California is that most of the people there, particularly the folks coming from Mexico, are in fact employed. Probably 70 percent of people in California have health insurance by virtue of having access to their employer’s health insurance plan. So while they [i.e., the immigrant population] are certainly putting some pressure on the system, if you look at the statistics, the pressure is not particularly different as a result of immigrants. The problem is simply that we don’t have enough public funding in the system, due to Medicaid, and to some extent, Medicare, not paying their fair share. So while the immigrant population is a factor, it’s not nearly as severe in California as in some other states.

In terms of considering that issue from behind the veil of ignorance, I think you are raising a really interesting point as this applies to corporate social responsibility as a global issue. If you think about it, corporate social responsibility has to be global. I participated in a conference on global warming and I heard a statistic — I’m not entirely sure it’s true — but I was told that about 35 percent of Los Angeles’s pollution is from China. If you think about that and the global implications of what we do in this economy, you might also have to start thinking about health care in that way. So when I apply the veil of ignorance to this problem, if I’m a global citizen, I come up with the same solution except I would come up with a universal solution. Now I’m not naive; I don’t think Mexico or Canada is going to be adopting this solution. I think philosophically the answer would be the same. The reality is that different countries would come up with slightly different answers. The US system is going to be peculiar to the US economy and thus would respond to the US demand for convenience. We have certain expectations of the health care system that I don’t think we would be comfortable forgoing whether we were behind the veil of ignorance or in the light of day.
There are many tests now that will inform a pregnant woman if she's going to have a child who is not quite normal. In reality, this raises the question about whether or not she will have an abortion. At the other end, in dealing with end-of-life issues, when someone has serious illnesses and there is no hope, how long do they get to stay? What are the insurance companies doing to respond to these life and death issues? What is your company doing?

BRUCE G. BODaken: Excellent question. This is the reason why I distinguish between health care and health care access. Health care and access to health care insurance are different issues. The issues you raise are fundamental ones that we’re going to have to wrestle with in society. I don’t think they’re peculiar to health insurance companies, nor do I think health insurance companies should be making those decisions. I think health insurance companies should be working with ethicists and economists to try to come to a solution that is representative of whatever social contract we as a society are comfortable with. The end-of-life issues are heartbreaking in one respect, but if you look at the statistics, you find that most of health care is delivered in the last two years of one’s life.

When I consider the issue I brought up earlier concerning seismic retrofitting of hospitals, the problem is relatively clear: We are balancing one death against billions of dollars [that could be allocated to enhance the entire system of health care access]. I don’t struggle with that. But I find end-of-life issues more difficult to wrestle with. Health insurance companies will have to come up with policies to deal with these issues, but they should come to decisions with the support of physicians, providers of care, and ultimately with the voters. Because if we do it outside that political context, I don’t think there is any basis for us to make policies regarding what are really issues of fundamental human values that we’re not qualified to evaluate.

With respect to the testing, one thing that’s interesting is how much people fear that health insurance companies are going to discriminate based on genetic testing. In fact, at least in California, and I think this is true nationally, this problem has already been taken care of. While we can exclude someone for a current health issue or a previous health issue that’s documented, we cannot discriminate against anyone for any genetic test that has been run, or ever will be run. That’s California state law and I think it’s national law. We can know that your predilection for cancer is 99 percent, but we still have to accept you from a health status issue. The issue I worry about concerns people taking preemptive measures, for example when a woman looks at the data and sees a family history of breast cancer and decides to have proactive mastectomies. I think these are very tough issues for the patients and the physicians, and I don’t think these are issues with which insurance companies should be involving themselves. I don’t think we’re wise enough; we’re not empowered to make those decisions, nor should we be.

You’ve been talking a lot about costs and one of the ways to lower costs is to get quality right the first time, for example, through preventive medicine. I’d like to hear your view on what health insurance companies can do proactively to work with providers and patients to encourage things like preventive medicine, to monitor health outcomes, and to get the quality better as ways to reduce costs?

BRUCE G. BODaken: Great question. I’m really pleased to say we’re doing a lot and others are doing a lot as well. We provided a cash incentive to all of our members for taking care of themselves. If you’re a Blue Shield member you can go to our Healthy Lifestyles Rewards website and participate in our health-stress management program by not smoking, and by engaging in weight management, or whatever program you choose to participate in. You self-report at the beginning, in the middle, and at the end, and then we look at your claimshistory. We pay you either way, but we actually look at your claimshistory so that we can give you feedback through the web as to whether or not we can see the improvement that you’re reporting. As members of Blue Shield, our employees get the same cash incentive as other members of Blue Shield to participate in taking care of themselves. That’s the carrot. The next piece is the stick. We also created disincentives for employees that smoke, or who have a particular condition such as being overweight or obese for example, but don’t enroll in a program. That is a difficult road to take and it has led to some legal disputes. We will start gently, but we think we need to be more aggressive in using those tools.

If you believe John Wennberg and the studies he did at Dartmouth, around 30 percent of the care provided is unnecessary, partly because it’s truly unnecessary, and partly because the problems could have been prevented. I’m not really fond of the term “managed care,” which was created by insurance companies. I started my career in a company that was called a “Health Maintenance Organization,” which is a term I’m fonder of. Our concern was truly around preventive care. But we lost our way about ten years after that started and our organizations really became insurance companies that worried less about prevention. We need to get back to our mission of promoting good health.