



WHERE HAVE ALL THE DOLLARS GONE?

(Or, Why can't we afford universal health care)

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Making profits is no vice; the real vice is making losses.
—Sir Winston Churchill

In the first issue of the Journal I promised that I would use my podium as Editor-in-Chief to explore a variety of medical issues, and now that we're concluding our first year of publication, I plan to start doing so. I hope to offer fresh insights, and perspectives based on facts, but I will not shy from expressing my own opinion. With the disclaimer that my positions have not been reviewed or approved by anyone else, here goes!

In 1960, when I was a medical student, 183,000 out of 278,000 American physicians (66%) were members of the AMA, which generally spoke for them about health policy matters. Though many people lacked health insurance, doctors were rather unified in their opposition to government intrusion into health care, which was seen as the first step down the road to socialism, vilified as "Communism-lite."

How times have changed! Today, only 244,000 of America's 800,000 doctors (30%), belong to the AMA; its unifying voice has been lost. As for government involvement in health care, we are acculturated to Medicare and Medicaid. We call them "single-payer" health insurance, and only a die-hard fringe would consider calling Medicare by the disparaging epithet "socialized medicine."

There are many reasons for this change in attitude. By paying us for care we previously provided *pro bono*, Medicare proved a financial boon, and it soon became a major (often *the* major) source of revenue in most adult medical practices. Furthermore, third party payers have proven so contemptible that to many of us Medicare is better. What word other than "contemptible" suits companies that require multiple resubmissions of claim forms so they can maximize interest on "the float" of delayed payments; or who relentlessly lower payments to physicians so they can raise profits and executive compensation? (About the latter, more below.)

So though it's troubling that some Medicare and FDA bureaucrats are so sympathetic to the needs of drug companies that they're rewarded with lucrative jobs in the pharmaceutical industry after they leave government, at least government employees aren't filling their own pockets directly out of ours.

PAYING FOR THE UNINSURED

Surely as physicians we should be scandalized that 47 million Americans lack health insurance; without Medicare for the indigent elderly the problem would be intolerable. In a speech at Franklin & Marshall College last fall, NY Times columnist Paul Krugman argued that a society that cannot provide health care to a large segment of its gainfully employed population cannot claim to be a middle class society.

Why can't we afford health care for everyone? Given the Federal Government's long experience with Medicare, and its recent effectiveness in revitalizing and eliminating redundancy and waste in the V.A. hospital system, why can't "the richest country in the world" provide some kind of coverage for the growing number of uninsured?

One reason is that although at its best America does provide the best health care in the world, we pay for it in the most wastefully inefficient manner imaginable. We spend 16 percent of gross domestic product on health care - double the median for all industrialized countries, indeed more than any other country. Yet, according to a scorecard devised by the Commonwealth Fund (www.cmwf.org), we are 15th out of 19 developed nations in deaths from causes that can be averted by timely care, such as heart attacks. Only Ireland, Britain, and Portugal score worse. France, though reviled in the U.S. for failing to support the war in Iraq, scores the best, with 75 deaths per 100,000, while the United States has 115 per 100,000. It can't all be due to red wine!

(Though the French have been staunchly protective of their individual liberties since the French Revolution, they recently accepted a *nationwide* ban on smoking in

public places even though France is not a country where smoking is unpopular. They may feel an affection for their Gauloises that matches our NRA's affection for assault rifles, but they will still accept some restrictions on their freedoms for the sake of good health.)

America is also behind in use of electronic medical records (coming soon to LGH), used by only a quarter of U.S. doctors compared to 80 percent in some other countries. Infant mortality here - 7 per 1,000 births - is far higher than in any of the other 23 countries measured, though socio-economic diversity undoubtedly has an influence. Iceland scores best with 2.2 per 1,000.

Remarkably, the Commonwealth Fund reports that in America even adults with private health insurance or Medicare often do not get life-saving and money-saving preventive care; only 49 percent received preventive and screening tests according to guidelines for their age and sex. For minorities, more likely to be uninsured, the situation is even bleaker. On average, Hispanics would need a 20 percent decrease in risk rates to reach benchmark white rates on key indicators of quality, access, and efficiency; for African Americans the difference is 24 percent.

Admittedly, the health care systems in Western European democracies restrict choice more than we do, and have longer waiting lists for certain procedures, but those factors alone can hardly explain the striking discrepancies in access to care. Marcia Angell, MD, a former Editor in Chief of the *New England Journal of Medicine*, says that we are "prisoners of our ideology," by which she means we persist in the conviction that the free market always has the answer. She points out that America is the only advanced country that distributes health care like a commodity, i.e. according to one's ability to pay.

"WHERE HAVE ALL THE DOLLARS GONE?"

The full answer to the question is too complex to analyze in one issue of the *Journal* unless we devote the entire issue to health policy (not out of the question for a future issue!). Discussion of some examples of waste, such as the excessive prices Medicare pays for drugs because the Medicare prescription drug bill passed by the last Congress prohibits Medicare from negotiating drug prices, will have to wait for another time. I'll focus the current discussion on the money taken out of the American health care system by so-called "not-for-profit" intermediaries. The staggering sums they gobble

up would make a serious dent in the bill for care of the uninsured.

Not-for-profit?

The Blue Cross Blue Shield Association (BCBSA) was entirely not-for-profit when it was founded by the merger of Blue Cross and Blue Shield in 1982, but it changed its rules in 1994 to allow BCBS plans to become for-profit corporations. Today there are 64 Plans Licensed by BCBSA: 38 nonprofit; 16 mutual; and 14 for-profit. Winston Churchill, quoted at the top of this article, had the right idea about the importance of profits in public corporations that are responsible primarily to their stockholders. But "non-profit" health intermediaries have much more complex responsibilities, which affect not only the availability and quality of health care, but also the financing of new technologies, the maintenance of public health, and the financial competitiveness of American companies in the global market. The cost of health insurance drives outsourcing, affects pensions, and reduces retirees' health benefits.

WHERE DO "NON-PROFITS" GET SO MUCH MONEY, AND WHAT DO THEY DO WITH IT?

As of December 2003, the 38 nonprofit BCBS plans retained approximately \$20 billion in "surplus," an increase of 30 percent from 2002. (For-profit Blues held another \$9 billion.) Yet, from 2000 till 2006, employer-based health premiums increased a staggering 73 percent, far outstripping increases in wages (15 percent) and inflation (14 percent). According to the *Pittsburgh Post-Gazette*, in 2006 Highmark sat atop a surplus of \$2.8 billion, but still sought to raise its average premium by 6.6 to 7.6 percent for small businesses, after double-digit hikes the previous year. Clearly, there are huge sums of money in the system that are not going to health care.

Despite a central role in the efficiency and cost-effectiveness of our health care system, the 38 "non-profit" Blues have increased executive compensation to levels that make a mockery of that role. Examples abound:

1. Horizon BCBS of New Jersey succumbed to public pressure in 2003 and did not carry out its plan to convert to a for-profit company, but its President and CEO still received \$2.65 million in compensation that year.
2. BCBS of North Carolina ended nearly a decade of controversy in 2003 by also abandoning plans to convert to a for-profit company, but that didn't stop its CEO from being rewarded with \$2.15 million

the next year, nearly doubling his 2002 compensation of \$1.12 million.

3. BCBS of Michigan's President and CEO also nearly doubled his compensation to \$2.3 million in 2004 from \$1.5 million in 2002. Displaying an unintentional knack for irony, in January 2005 he announced a \$1 million grant from BCBS to the free clinics in Michigan "to help make it easier for the uninsured to get needed health care." No one seemed to notice that if his salary had merely stayed at its already ample 2002 level, the grant could have nearly doubled. He also seemed blissfully unaware that the free clinics are staffed by volunteer physicians who work without pay.
4. And not to be outdone, the 2006 compensation of Highmark's CEO jumped from \$1.7 million to \$2.5 million.

Critics of excessive executive pay relaxed in 1993 when Federal regulators finally forced companies to disclose details of pay and perks for top officials. Watchdogs assumed that the spotlight would deter corporate boards from granting unjustified raises. How wrong they were! Since then, the average pay for CEOs of large corporations has quadrupled! As the Wall St. Journal reported on Oct. 12, 2006, it turns out that disclosure has paradoxically pushed pay higher, because now that executives actually know what their peers receive, they want more.

Keep in mind that generous executive compensation is uniquely costly for non-profits. In the case of for-profit, publicly traded corporations, executive rewards such as stock options don't consume corporate assets; the cost is borne only by the stockholders, because the additional stock simply dilutes their ownership of the company. And since salaries are business expenses, salary increases reduce corporate income taxes. "Non-profits," on the other hand, can't issue stock (or stock options), and their executive pay must come straight from capital assets. Since they don't pay taxes anyway, there is no offsetting tax saving.

But rather than seeing excessive "surplus revenue" (a euphemism for profit) as a sign that premiums are too high and/or payments to providers are too low, BCBS executives pat themselves on the back for being outstanding managers, which in turn justifies ever higher salaries. Their argument is unconvincing.

Unlike executives of health systems that actually provide health care, where increased efficiency is linked to management skill that actually lowers costs and should be appropriately rewarded, health insurers *add* cost into the health system, and encounter few impediments to raising premiums to reach predetermined levels of profit (oops, I mean surplus). They seem to spend much less time worrying about managing for greater efficiency, and far more time looking for mergers and acquisitions. But these are not evil or ignorant people. They doubtless view themselves favorably, and have rationalized their exorbitant salaries and inefficient management as simply their just due for their successful effort (so far) to keep the health care system mainly subject to the forces of the free market.

Humans are peculiar. We can live for a week without food, but not one day without rationalizing.

Administrative costs account for about 20 percent of each health-care dollar. An important portion of the revenue for these "health insurance" companies consists of processing claims paid by *other* parties, such as Medicare or self-insured employers, for which the intermediaries take a generous cut. In providing these administrative services, they aren't functioning as at-risk insurance companies, and in the communities they serve, they often enjoy a near monopoly or share an oligopoly. As regional administrators for Medicare, they generate considerable revenue from operations that involve no risk, and there is often little free market competition that demands efficiency and transparency.

This phenomenon leads to an unending upward spiral in premiums and revenue, which also takes even more money *out* of the system for executive compensation. Last year, the 10 top executives at Highmark received 41 percent pay increases, raising their aggregate pay from \$8 million to \$11.3 million in one year. It also means that "non-profits" have succumbed to the same disease of unbridled executive compensation that has infected major publicly held corporations, though for different reasons. Publicly traded corporations don't ordinarily have near monopolies or oligopolies in their region or industry, and they cannot simply raise prices.

The "non-profits" are also sheltered by the public's illusion that their sole concern is the commonweal, so they can go merrily on their inefficient ways because they all have similar levels of inefficiency and similarly overpaid executives.

They have inadequate incentive to improve their efficiency and return the savings to the health care system.

In 2005, the Pennsylvania Insurance Commissioner moved to define acceptable levels of surplus capital for the four BCBS plans. On February 7, Governor Rendell signed an agreement with BCBS that commits them to spend approximately \$1 billion in surplus funds over 6 years on various state health programs, including providing health coverage to those who lack it.

Pennsylvania is the first state to negotiate such a program with health insurers.

WHAT NEXT?

So much for “non-profits.” In future columns we’ll talk about money taken out of the system by for-profit health insurance companies and hospital systems, drug company advertising, and other wasteful diversions of precious resources.