Rhode Island Policy Reporter
Issue 3 9 February 2004

Feeling Blue

EVERY YEAR, Blue Cross and Blue Shield of Rhode Island, like all insurance companies based here, files a report on their insurance business with our state Department of Business Regulation. The paper copies of past reports are covered with notations, and have many missing pages, so the evidence is that someone is reading these closely. But the information in them rarely seems to get out to the world in any but the most cursory or slanted form. Whoever it is in the bowels of the Blue Cross hierarchy that has to fill out these reports must occasionally wonder if their work is neglected by the public. These reports require a lot of work, and to think that this is ignored or unappreciated would be a terrible burden, inevitably leading to existential crisis, resulting in broken homes, alcoholism, suicide, and so on. Stepping in to help prevent such catastrophes, we travelled over to DBR to read Blue Cross's last few annual statements and report here on what we found there.

What follows is hardly a forensic audit. All the assertions in the reports have been taken at face value.[1] That is, if Blue Cross says that they paid their president twice as much in 2002 as they paid his predecessor in 1998, we believe it. Another stipulation: we have no reason to believe that Blue Cross has done anything other than what is required of it by state and federal laws or regulations. But we also think that sometimes these regulations are not as protective of the public interest as we'd all like to hope.

An Impasse

The other day we were present as a couple of gentlemen from Blue Cross gently explained to a town council why the health insurance premiums for their employees were going to go up 12% next year. One said, "The town's loss ratio is 98%, and the cost of health care is expected to rise 14% next year. 98 plus 14 is 112, so the town's premiums have to go up 12%." As a debate-ender, this was an extremely effective maneuver. The town councillor who asked the question shut right up, and with a few cavils about expenses from the town manager, they moved on to pondering what to do about this sad state of affairs.

But we're not bound by Robert's Rules here, so let's unpack this statement a bit. There are several claims made here, rolled into one. Stated separately, they are these:

1. We (Blue Cross) paid out 98% of your premium last year.
2. Health care costs will go up next year by 14%.
3. To cover this increased cost, your premiums need to rise by 12% (98% + 14%).

Though predictions like number two are obviously dicey, the others have the ring of incontrovertibility, like statements of arithmetic. But let's look closely at each of the statements in turn, using the information published in the Blue Cross annual statements.

Insurance Expenses

1. We (Blue Cross) paid out 98% of your premium last year.

Let's start with the obvious. That 98% includes both claims made to Blue Cross for medical expenses, as well as the administrative expenses they require to remain afloat. Blue Cross ran an ad campaign during 2003 touting their expense ratio. The claim in the ads was that of each premium dollar, 87% went to pay medical costs, 10% was retained for administrative costs, and another 3% was saved for the loss reserves.

	2002	2001
Admitted assets	433,398	393,829
Total liabilities	226,714	196,560
Total surplus	206,683	197,269
Total premiums	892,603	900,159
Medical expense	775,748	773,130
Claims expense	34,465	39,433
Admin expense	62,795	59,874
Underwriting gain	19,594	27,721
Net investment gain	14,326	14,242
Other income	(18,495)	216
Inome taxes	7,743	10,244
Net income	7,682	31,936
Subscribers	364,553	433,910

Table 1: Blue Cross Revenue (dollar figures in thousands)

Table 1 contains a summary of the last two years of Blue Cross performance. In 2002, they paid $775 million in claims, which is about 87% of the $892 million in premiums collected. The other numbers are more challenging to reconstruct. One obstacle is that "Blue Cross" has at least three major components to their business. One is the insurance company, whose report we're reading here. Another is Coordinated Health Partners (CHP, or BlueCHiP), a wholly-owned for-profit subsidiary. The third is Blue Cross's substantial administrative business, which isn't insurance at all, but is just administration for groups who self-insure (and for Medicare, but this was discontinued on February 1 of this year). For these plans, the premiums are supposed

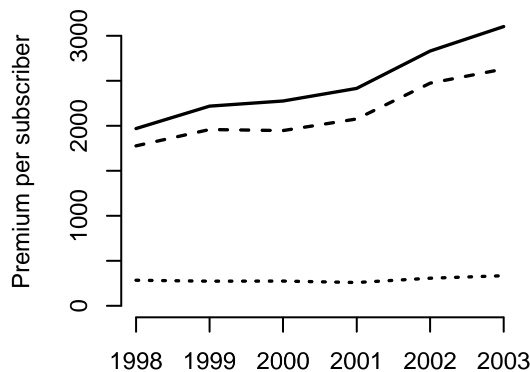

Figure 1: Premiums per subscriber. The solid line on top shows the average premium paid by a Blue Cross subscriber. The dashed line below is the average medical expense paid out, and the dotted line at bottom are the administrative expenses, per subscriber. The expenses have remained fairly constant over the past several years. Premiums are currently outpacing medical expenses, growing 9.6% in the last year, as opposed to 6.3% for medical expenses. This graph and these statistics cover both Blue Cross and BlueCHiP.

[1] The help of Ellen Schwartz, CPA, was invaluable.

to match the medical expenses and administrative costs, period. This is also known as "self insurance," and Blue Cross refers to them as ASC (Administrative Service Contract) plans. The reports we're reading do not cover this side of the business, except in the footnotes. All three components together take in about $1.76 billion, pay out around $1.55 billion in medical expenses, and cover around 670,000 Rhode Islanders.

The relationship between Blue Cross and its CHP subsidiary is (was) a confusing one. They pay management fees to each other, file a single income tax return, and share office space, employees, and financial reserves. It's hard to tell where one ends and the other begins, and that makes analyzing their statements confusing. For example, expenses like rent for one can appear as income for the other. Just a couple of weeks ago, Blue Cross announced that it will fold CHP back into Blue Cross, so apparently the fiction of their separation was getting tiring for them, too. What follows is mostly about the Blue Cross insurance side of things. Where it is not, we have said so.

Blue Cross's expenses are summarized in a table, Part 3 of the Underwriting and Investment Exhibit [2002, p.14], partially reproduced in table 2. Here, expenses are put into categories like "printing and office supplies," "Marketing and advertising," and "Salaries, wages, and benefits." Each category is also split into three columns, one for expenses associated with specific claims, one for general administrative expenses, and one for investment expenses. Marketing is classified as a general expense, stockbrokers' fees are investment expenses, and salaries, like much of the rest, are split between general expenses and claims adjustment expenses.[2]

In an audit, you'd look at how expenses were classified, seeking to determine whether the $3.75 million allocated to marketing and advertising was really a fair picture of those expenses. Since this is not an audit (after all, we can't even get the Blue Cross spokesman to return our phone calls) all we can do is wonder how many of the salaries, consulting fees, and stamps were in service of marketing. But we *can* note that until recently there was a fourth column on this schedule called "Soliciting," covering marketing which, as late as 2000, contained $25.6 million (up 25% from the previous year), or about 45% of the general expenses [2000, p.9, line 30]. Using the same proportion, this would be about $28 million today, or just over three cents of each premium dollar.

Rent Right at the top of the expense exhibit [2002, p.14, line 1] is a notation saying that Blue Cross would pay $4.7 million more than is listed in rent except that it owned its own buildings. This figure is not made up, it's the sum of the property taxes they pay and whatever they categorize as "real estate expenses." But this sum doesn't appear in the expenses deducted from premiums. Instead, these expenses are classified as "investment expenses," and are deducted from the profits earned by investments in stocks and bonds. (This is why it says "net" investment gain in table 1.) Despite the fact that Blue Cross (like many insurance companies) lists its buildings among the assets available to pay claims, few other businesses would classify property taxes as investment expense, even if inventory was financed by a mortgage. Shouldn't this be an expense—like rent?

	Claims	General	Invest
Rent	3,230	3,243	
Salaries & benefits	41,136	42,895	
Marketing & advertising		3,753	
Postage & telephone	2,212	2,221	
Admin plans	(15,871)	(20,748)	
Fiscal intermediary	(6,793)	(2,548)	
Real estate expenses			3,235
Real estate taxes			1,487
Total	34,465	62,795	5,021

Table 2: from Blue Cross Expenses (2002), Part 3 "Analysis of Expenses" (dollar figures in thousands)

What's more, "real estate expenses" make up over two-thirds of the amount here. This presumably includes such expenses as building maintenance, repairs, and the electricity to heat the executives' driveway off Empire Street in Providence (around $50/hour according to an electrician who installed it).

Staff The very next line in the table is "Salaries, wages and benefits," at $84 million. This number was only $64 million in 1998, when Blue Cross counted almost exactly the same number of subscribers. But they are actually larger now, because the growth of their administrative business. Almost 200,000 Rhode Islanders are covered by Blue Cross administrative plans, including all the state employees.

In 2002, there was a technical adjustment to the Blue Cross pension plan, resulting in an $18.5 million expense, which you can see in table 1. Blue Cross accountants put this in the revenue statement [2002, p.4, line 2701], where it counts against profit. But pension contributions are part of employee salary expense. That is, they are usually considered part of the expenses. Accounting rules allow some latitude for categorizing one-time charges like this, but it is interesting that an accounting change that produced the opposite effect in 2001 was stowed away in the Capital and Surplus accounts, where it wouldn't artifically increase profits [2002, p.5, line 41]. If the $18.5 million is a matter of real money rather than accounting fictions, it belongs with the other employee expenses. If it is a fiction, it belongs with the fiction from last year. Is it fair to count accounting changes against the bottom line only if they are in your favor?

Reimbursements Working our way down the table, we come to a negative expense, for $36.6 million. This represents administrative expenses attributable to the ASC (non-insurance) plans. What's interesting about this number is its relation to the amount of medical claims paid for the ASC plans. If we are to believe the reported allocation between insurance plans and ASC plans, they are doing a much better job holding down expenses for the administrative plans. See table 3.

[2] Space considerations prevent us from reproducing the entire tables here. You can read along on the 2002 annual report by retrieving it from *www.dbr.state.ri.us/insurance*. Some material is also taken from earlier reports, and the 2003 third-quarter report.

Rhode Island Policy Reporter
What's really going on, instead of what's said about it.
Box 23011, Providence, RI 02903-3011
www.whatcheer.net/ripr ☙ *editor@whatcheer.net*
subscriptions: $55/11 issues ($110 institutional)
editor: Tom Sgouros
Issue 3 ☙ 9 February 2004 (1.5)
©2003 Tom Sgouros

Editor's Note

This is the third in a series of reports about state and federal policy issues that affect life here in the Ocean State. Each report focuses on particular policy areas of interest. Future issues will examine controversial aspects of environmental policy, health care, property tax reform, and education spending. You can see earlier issues, including a dissection of the state budget, and the beginning of an analysis of the state tax system online at *whatcheer.net/ripr*.

If you'd like to help, please contribute an item, suggest an issue topic, or buy a subscription. If you can, buy two or three, and help get us off the ground.–TS

	Medical	Expenses	percent
Insurance Plans	775,748	102,280	13.2%
ASC Plans	344,848	36,619	10.6%
ASC Plans (poss)	344,848	32,189	9.3%
Other	776,754	14,806	1.9%

Table 3: Dollars paid in medical expenses compared to the administrative costs incurred, for Blue Cross insurance plans and ASC plans. The third line shows ASC plans with the "net gain" applied to the expenses. (Dollar figures in thousands)

The notes go on to explains that of $381.5 million received for these plans, only $377 million was spent [2002, p.25.10], leaving a $4.5 million net "gain" (profit) from these plans. Which is to say Blue Cross could put the overhead costs of those plans even lower and still do fine. (This is shown in the third line of the table.) Of course these numbers could also mean that the insurance plans are subsidizing the administrative costs of the ASC plans. Without knowing more about the details of how expenses are allocated, it's impossible to know.

There's also a negative expense (about $9.3 million total, in line 6) for administrative costs associated with plans for which they Blue Cross is a "fiscal intermediary."[3] The bulk of this is Medicare payments to medical providers. Blue Cross used to manage some aspects of Medicare, but gave up those contracts this year. A Medicare manager in their Boston office told me, "We're a very hard agency to work for because we have a lot of requirements and we do a lot of oversight." Rhode Islanders on Medicare are now having their plans managed by Arkansas Blue Cross, who apparently can withstand the scrutiny.

The interesting thing about this situation is that for years, Medicare administrative expenses have been consistently cited as quite low, on the order of 2-3%, and as a benchmark for how efficiently a medical systam can be run, when it's done properly. The volume of Medicare claims Blue Cross processed in 2002 does not appear in the insurance statement, but in a note in their 2002 audited financial statement (also filed with DBR), they mention over $776 million in expenses adminstering "certain federal and private health care programs" and $14 million in income from those plans. Whether this number is all or predominantly Medicare is not clear from the statement, but it is remarkable that Blue Cross can be so much more efficient when they need to be.

Incurring expenses Finally, it's worth pointing out that the use of the word "paid" is not the same as how you or I would use it. Blue Cross, like all insurance companies and almost all large corporations, uses accrual-based accounting. The idea is to match the expenses to the income, to assign medical payments to the same year as the premiums that paid for them. But when December 31 rolls around, your recent doctor bills may not have made their way through the billing process yet, or the doctor may not have even submitted them yet. These bills are marked as "incurred," and are deducted from the premiums received as if the money had actually gone out of Blue Cross's hands. There is nothing shabby about this; millions of companies work this way. But insurance companies have a special twist on this, a category called "incurred-but-not-reported," which covers bills that ought to be recorded as in a given year, but, like that unsent doctor bill, hadn't even been heard about when the year ended. There will be more to say about this in the next sections.

Health care inflation

2. Health care costs will go up next year by 14%.

This number, 14%, is what Blue Cross calls the expected "health care trend" for 2004, and is generated by their own actuaries. The trend has a number of components, including costs for hospitalization, costs of technical services, and so on. It's a more complicated factor than just a simple number, and its application to any particular plan is a fairly intricate one, but it's regularly used as shorthand for the increase, as it was during the town council meeting we attended.

Predicting failure Medicine is, despite all the fancy technology, a fairly labor-intensive business. Doctors, nurses, and technicians are the important parts of the system, and all the MRIs and ultrasounds only distract from that point. A vast proportion of the $1.5 billion paid by Blue Cross each year to medical providers goes to pay labor costs. And somewhere around one-eighth of that goes to pay health insurance premiums.

If a hike in health care premiums can cause a hike in health care premiums, then the system has a serious problem.

In other words, around $150 million—almost one tenth—of the medical payments go back to health insurers, and about $100 million of that go right back to Blue Cross itself. And of that $100 million, about $8 million also goes back to Blue Cross, and so on. This means that a hike in premiums is instantly translated into pressure against that new rate. When Blue Cross raises their rates 10%, all the medical practices and hospitals they deal with will see their labor costs rise by more than 1%. In a world where the annual increases are in the range of a few percent, this is not a big deal. A 2% hike, for example, will translate into roughly 2.04%, and nobody notices. But this is

[3] This number was corrected to $14.8 million in the later audited financial report, and that number was used in table 3.

a system that will take a 12% rate hike and turn it into almost 14%. In other words, high increases in premiums beget upward pressure on premiums the next year. This is a system with a built-in propensity to spiral out of control.

As we all know, predicting the future is not something that can be done with certainty. But when Blue Cross actuaries make their guesses about health care trends, because health care is so tightly linked to employment in this country, there are forces working to confirm their guesses—after they've been made. There is no integrity to a system that sets rates by predictions if there is feedback to reinforce that prediction. If a hike in health care premiums can cause a hike in health care premiums, then the system has a serious problem.

But why does Blue Cross have to rely on predictions? Why can't they set their rates based on what happened *last* year? The only reason for this is insurance company accounting rules. Insurance company accounting rules are meant to match premiums for a given year with the losses that occur in that same year. Under the generally accepted insurance company accounting rules, a company that didn't make predictions, but set its rates based on what happened last year could seem to swing wildly between profitability and failure, even if it was just breaking even the whole time. But the generally accepted rules are only that: generally accepted. They were not handed down on stone tablets from on high. They're not even explicitly encoded in law.[4] If they're broken, it should be possible to fix them.

Loss ratios

3. To cover this increased cost, your premiums need to rise by 12% (98% + 14%).

If health care costs are to rise by 14%, and 98% of the premiums were spent last year, why shouldn't next year's premium be 112% of this year's?

For one thing, the town paid more this year than was required. They paid 100% of their premiums and Blue Cross only used 98%. What happens to the leftover 2%? Exactly why can't it be applied to next year's expenses? The only answer to this is custom: this is how insurance companies work. That money will make its way to the company reserves, where it will theoretically act as a cushion against future losses.

Banks don't call the money in their reserves "lost." They say it belongs to their customers.

Insurance companies are not the only institutions whose generally accepted accounting practices are very different from the norm. Banks also have their own set of accounting rules. A bank has a similar relation to its customers as does an insurance company: both have thousands of creditors who pay money into the company's coffers, any of whom can require to take money back out at any time. Bank customers do so of their own volition, and insurance company customers do so when they need to, but the relation is similar from an accounting perspective. But banks don't call the money they have in reserves "lost" or "spent." Ask a bank about its reserves, and they'll tell you that money belongs to the bank's customers.

So when Blue Cross tells a town that they've spent 98% of last year's premiums, the other 2% is said to disappear, just like that. It's functionally gone, absorbed into the reserves. It's not really gone, but insurance accounting rules allow them to treat it so. The town's claim on that money is lost, and they have to start the next year fresh. Blue Cross will claim that this is a good thing, and that if the loss ratio was 102%, they would make up the difference. And so they would, but they'd also raise the town's premium the next year, whether or not they expected the same thing to happen again. What's more, they would do it even if the company as a whole made a profit.

Insurance companies are for sharing risk among their customers, not for assuming risks you don't want to take.

It's said that insurance companies take the risk for their customers, but that's not quite true. When a company has a bad year, they raise their premiums the next year in order to keep their reserves up to whatever their auditors or their peers in the industry deem proper. Blue Cross lost money for three years in the 1990's, and have been recouping their losses ever since. They now have more than $100 million more than they had before the bad years. Despite their press, most insurance companies function as a mechanism for sharing risk among their customers, not for assuming risks you don't want to take.

But if you and I are sharing the risk with each other, why can't we share the reserves, too? Companies may say that the claims would conflict; there might be more claims on the reserves than reserves to satisfy those claims. But banks (abetted by bank regulators) have for years successfully managed precisely that situation. The risk in banking is for the bankers to keep everyone from claiming their money at the same time. Insurance companies who want to do a service to their community should figure out what is the minimum reserve amount necessary to safely allow all its risk pools to maintain a claim on the reserves they've contributed, and then allow their groups to claim it.[5]

Expense inflation And another thing. A substantial portion of our town's spent premiums went toward expenses that should not scale with the cost of health care. This is not a subtle point. 14% is the expected inflation of health care costs. But it takes no extra work to pay a $114 X-ray invoice than a $100 invoice. Of course some of the increase is for things that will be used more often, and this will increase the load on those who pay the bills. MRIs, for example, are often used in conjunction with the X-rays they have not replaced. Medical practice changes quickly, but not that quickly. From one year to the next, utilization changes are only a small component of health care inflation. The point remains that a 14% rise in health care costs should create a 14% rise in only that part of the premium that goes for medical expense. For Blue Cross, this is about 10-12% of

[4] There are freestanding bodies of accountants that set these rules. Most companies use what are called "Generally Accepted Accounting Principles", or "GAAP," which are set by a body called FASB. Insurance company accounting rules are set by the National Association of Insurance Commissioners (NAIC).

[5] There's a legitimate question here about whether the proper customers of the insurance company are the individual subscribers, or the managers of the various risk pools that make up the subscribers. The town in question here, for example, might be a more appropriate "customer" of Blue Cross than one of its employees.

the total. Therefore, a 14% increase in health-care costs should only produce a premium increase of around 12.5%.

In fact, Blue Cross's expenses have risen slightly, but not nearly as fast as medical inflation, over the past five years (figure, page 1). In the period 1998 to 2002, the expenses, per subscriber, went up about 8%, while the money paid out to medical providers went up almost 30%. In spite of this slow growth in expenses, the premiums paid per subscriber went up more than 35%. Blue Cross has been on a program to raise the level of its reserves, and it's possible this is prudent, but who would complain if they decided to take a little bit easier pace?[6]

The annual statements include a 5-year history of the important numbers. Until 1999, the line reading "Total administrative expenses" [2002, p.32, line 7] included both expenses allocated to claims adjustment and general administrative expenses. In 2000, and after, the expense line contains only general administrative expenses, and the claims-specific expenses have been omitted. Just reading this table, one would get the erroneous impression that expenses had come down considerably.

Salaries At the same time that expenses have remained fairly constant, the salaries of the top echelon have grown quite substantially. In 1998, Blue Cross paid its top ten executives a total of $1.79 million. The figure was $3.02 million in 2002, a 69% increase. In fact, the expenses grew by only $1 million during that same period, so apparently there are ways to cut expenses, for some purposes. In 2002, Blue Cross also put about $1 million into a "Supplemental Executive Retirement Plan" (SERP) a benefit plan restricted to "certain executives as designated by the Board of Directors" [2002, p.25.6]. The entire sum put into the plan was paid out in 2002.

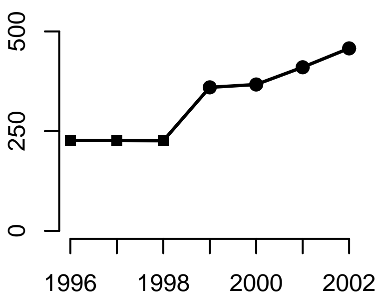

Figure 2: Blue Cross president's salary (in thousands of dollars). The change from squares to circles indicates a change in the president. The figures do not include bonuses. In 2002, the president received a $121,000 bonus in addition to his salary.

In a world of ever-rising premiums, it would be nice to know that Blue Cross was taking a stand against waste. But our mailboxes continue to fill with paper we paid for, our newspapers fill with advertising we paid for, and now it seems that each Blue Cross member pays a little bit less than $8 every year just to cover the raises and special pensions granted to the top executives and the board of directors since 1998. (This is each person, not each plan. If you are part of a family, you can do the multiplication.) If there has been any kind of effort to reduce costs at Blue Cross, it doesn't show up in these statements. The percentage of premium money that goes to expenses has declined, but that's only because premiums have risen so fast.

Of course, the years 2002 and 2003 are also when Blue Cross was arranging to outsource large amounts of claims processing work (much of it to Perot Systems), and laying off and retiring many of its older employees. Presumably we will see the payoff in next year's reports, if not the premiums. But it is a shame that the first thing to go was good jobs, and not the full-page newspaper ads, the excessive mailings, or the SERP.

Reserves From the latest report [2003Q3, p.3, line 28] you can see that Blue Cross's surplus currently runs around $251.2 million. To calculate the adequacy of the reserves, you figure out how much it costs to run the company for a month, and divide to see how many months the reserves can carry the company. Using the numbers from [2003Q3, p.4, line 18,20,21], you get a monthly cost of $76.8 million. The reserves alone would carry the plan for 3.3 months. Since the statutory goal is "not less than one month," the company plan is plenty healthy. How much, one wonders, will they decide is enough? They have around two-thirds of Rhode Island's market. Their competitors are in retreat, or have collapsed. Where is the pressing need to gather reserves?

The point is this: given the way Blue Cross (or any insurance company) is run, the need for reserves is not debatable. But the desirable level of those reserves is. But if the market won't tell them to stop, who will?

Undercounting reserves Using the generally accepted accounting rules, an insurance company will always undercount its reserves, because the calculations never include money intended to be spent, but not yet out the door. As of September, and including Coordinated Health Partners, their subsidiary, Blue Cross reports reserves of about $242 million (CHP reported negative reserves). But they have $679 million in assets they can use to pay claims.[7] They list $302 million in debts, but much of this money they won't have to pay for a long time, and some of it they'll never pay (and the money they do pay will be replaced by similar amounts). Around 10-12% of their claims are still outstanding after 12 months. And because some of the incurred claims are guesses listed in the "incurred but not reported" category, there is potentially even more slack.[8] With hundreds of millions of dollars of claims paid each year, the sum of outstanding claims is huge.

Referring back to our beleaguered town, of the 98% of premiums "spent" last year, at least one-tenth of that is not actually spent yet. Those funds are invested and earning interest, but the interest accrues to the company, not to the former owner of the spent-but-unspent funds.

Again, the comparison to a bank is interesting. For very liquid accounts, like checking accounts with low balances, banks keep all the investment income earned by their deposits. But for accounts with substantial balances, banks feel compelled to

[6] In the same period, CHP costs per subscriber have risen much more dramatically. Expenses per subscriber have risen 20%, medical costs 83%, and premiums by 107%. One wonders if the failure of CHP as a cost-control model may also have something to do with Blue Cross's decision to reabsorb it.

[7] This is by their own definition. Insurance companies must list which assets they own can be used to cover claims ("admitted" assets) and which cannot. Assets that can be used to cover claims include stocks, bonds, and cash. Assets that cannot are things like furniture and computers. Blue Cross lists their buildings as admitted assets (worth $20 million), as well as quite a lot of unrealized capital gains, as do many insurance companies. These assets aren't very liquid (or are imaginary), and perhaps shouldn't be included with other admitted assets, but their subtraction would not damage the main point here.

[8] In the five years shown in the 2002 report, Blue Cross guessed high in all of them where there's enough history to tell. Sometimes by as much as $25 million, as in 2000 [2002, p.12 (Grand Total)]. This money will eventually make its way out of the loss column, but not soon.

share the income earned by those deposits with the depositors. Insurance companies, of course, feel no such obligation.

Bottom line So about the tautology presented by the Blue Cross account executives to the town, each of the three points is debatable. The only reason to accept these kinds of increases is the grinding sense of futility health care costs have produced. Even if you think that health care costs are going up 14%, this is not a justification for insurance costs to rise at the same rate.

Why do we hold Blue Cross to a high standard? There are two reasons. One is that they now rule the roost here: around two-thirds of our citizens rely on them to pay their medical bills. But it's not certain that they came by that position honorably. Blue Cross lost quite a lot of money in the 1990's, not in the accounting sense, but in the actual sense. Which is to say that they were operating at a loss during the very years that Harvard Health, Pilgrim and Tufts were driven out of business here. But which is cause and which the effect? Were those companies driven away because they offered an inferior product, or because they didn't have the cash to outlast a wealthier competitor?

Insurance regulation is designed to keep insurers solvent. The reports examined at DBR have everything to do with making sure companies earn enough money to service the claims of their customers, and nothing to do with keeping rates down. The marketplace is supposed to do that. But DBR allowed Blue Cross to operate at a big loss for three years, with the result that now there's not enough of a market to hold down costs. Now that we're in this pickle, DBR is not in a position—legally or logistically—to enforce any kind of substitute for market discipline.

The other reason to expect much from Blue Cross is that they are a non-profit. The non-profit form of organization is a form of public trust. It's for schools, hospitals, and community-service organizations. It's not intended for businesses. When a non-profit looks and acts like a business, when it pays its president absurd sums, when its account executives always have the sharpest equipment for their presentations, when it spends vast amounts of money on PR, when it abandons lines of business on which many Rhode Islanders depend because they aren't profitable *enough*, in short when it is abundantly clear that it could do much more to serve the public, we are entitled to question whether it still is acting in our best interests.

There are many more aspects of Blue Cross's business that should be scrutinized: their abandonment of Medicare administration, the way they manage their taxes, the way they allocate expenses to their various businesses. But this is a six-page newsletter, not a treatise. We could go on—and probably will, in future issues—but for now it is probably worth pondering what alternatives there are. In some ways, Blue Cross is a creature of the rules it lives by. Its executives didn't invent these rules, and in important ways they are powerless to change them. (Though this is not granting license to abuse them, either.) The rules encourage certain kinds of behavior, and discourage others. It is not altogether obvious that a different organization, operating under the same rules, would be much better.

What to do? So who is it that can insure properly? If actuaries aren't to be trusted, accrual accounting invites abuses, reserves are problematic, then what is to be done? It might not be possible to run a company whose losses this month will be covered by the premiums next month. Probably the only player that could take on a role like this is a government who doesn't have to worry about running low on reserves. And here is a case for single-payer health insurance that comes from an unexpected quarter: fairness in premiums.

And here's another: the feedback problem due to linking employment with health insurance. If rising premiums can cause rising premiums, then we have an inherently unstable system, and that's a problem for all of us. When Blue Cross decided to build up their reserves after the bloodletting in the 1990s, they may have triggered something beyond their power to control, and now it's our problem, too.

There are a lot of reasons for health-care cost inflation. Medical technology, changes in utilization, obesity, whatever. But a big fat one is our employment-linked system of health insurance. Employment and health care have nothing to do with one another, and the fact that they are linked in our society is only an unhappy historical accident. Until this linkage is broken, we have little to look forward to but more increases in health-care costs, more families who can't afford coverage, and more people wondering how to stop the madness. ■

Rhode Island Policy Reporter
Box 23011
Providence, RI 02903